Passage of the

Certification of Death (Scotland) Bill 2010

SPPB 164
Passage of the

Certification of Death (Scotland) Bill 2010

SP Bill 58 (Session 3), subsequently 2011 asp 11

SPPB 164

EDINBURGH: APS GROUP SCOTLAND
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Foreword

Purpose of the series

The aim of this series is to bring together in a single place all the official Parliamentary documents relating to the passage of the Bill that becomes an Act of the Scottish Parliament (ASP). The list of documents included in any particular volume will depend on the nature of the Bill and the circumstances of its passage, but a typical volume will include:

- every print of the Bill (usually three – “As Introduced”, “As Amended at Stage 2” and “As Passed”);
- the accompanying documents published with the “As Introduced” print of the Bill (and any revised versions published at later Stages);
- every Marshalled List of amendments from Stages 2 and 3;
- every Groupings list from Stages 2 and 3;
- the lead Committee’s “Stage 1 report” (which itself includes reports of other committees involved in the Stage 1 process, relevant committee Minutes and extracts from the Official Report of Stage 1 proceedings);
- the Official Report of the Stage 1 and Stage 3 debates in the Parliament;
- the Official Report of Stage 2 committee consideration;
- the Minutes (or relevant extracts) of relevant Committee meetings and of the Parliament for Stages 1 and 3.

All documents included are re-printed in the original layout and format, but with minor typographical and layout errors corrected. An exception is the groupings of amendments for Stage 2 and Stage 3 (a list of amendments in debating order was included in the original documents to assist members during actual proceedings but is omitted here as the text of amendments is already contained in the relevant marshalled list).

Where documents in the volume include web-links to external sources or to documents not incorporated in this volume, these links have been checked and are correct at the time of publishing this volume. The Scottish Parliament is not responsible for the content of external Internet sites. The links in this volume will not be monitored after publication, and no guarantee can be given that all links will continue to be effective.

Documents in each volume are arranged in the order in which they relate to the passage of the Bill through its various stages, from introduction to passing. The Act itself is not included on the grounds that it is already generally available and is, in any case, not a Parliamentary publication.

Outline of the legislative process

Bills in the Scottish Parliament follow a three-stage process. The fundamentals of the process are laid down by section 36(1) of the Scotland Act 1998, and amplified by Chapter 9 of the Parliament’s Standing Orders. In outline, the process is as follows:
• Introduction, followed by publication of the Bill and its accompanying documents;
• Stage 1: the Bill is first referred to a relevant committee, which produces a report informed by evidence from interested parties, then the Parliament debates the Bill and decides whether to agree to its general principles;
• Stage 2: the Bill returns to a committee for detailed consideration of amendments;
• Stage 3: the Bill is considered by the Parliament, with consideration of further amendments followed by a debate and a decision on whether to pass the Bill.

After a Bill is passed, three law officers and the Secretary of State have a period of four weeks within which they may challenge the Bill under sections 33 and 35 of the Scotland Act respectively. The Bill may then be submitted for Royal Assent, at which point it becomes an Act.

Standing Orders allow for some variations from the above pattern in some cases. For example, Bills may be referred back to a committee during Stage 3 for further Stage 2 consideration. In addition, the procedures vary for certain categories of Bills, such as Committee Bills or Emergency Bills. For some volumes in the series, relevant proceedings prior to introduction (such as pre-legislative scrutiny of a draft Bill) may be included.

The reader who is unfamiliar with Bill procedures, or with the terminology of legislation more generally, is advised to consult in the first instance the Guidance on Public Bills published by the Parliament. That Guidance, and the Standing Orders, are available free of charge on the Parliament’s website (www.scottish.parliament.uk).

The series is produced by the Legislation Team within the Parliament’s Chamber Office. Comments on this volume or on the series as a whole may be sent to the Legislation Team at the Scottish Parliament, Edinburgh EH99 1SP.

Notes on this volume

The Bill to which this volume relates followed the standard 3 stage process described above.

Volume 2 (incorporating Annexes B – E) of the Health and Sport Committee’s Stage 1 Report was originally published on the web only. This material, including the written and oral evidence taken by the Committee and the reports of other committees, is included in full in this volume.

The Scottish Government made a written response to the report of the Subordinate Legislation Committee at Stage 1, in addition to the Government’s general response to the Stage 1 Report of the Health and Sport Committee. At its meeting on 22 February 2011, the Subordinate Legislation Committee noted the response without debate. No extracts from the minutes or the Official Report of that meeting are, therefore, included in this volume. Relevant papers for that meeting, including the Scottish Government’s response, are, however, included.
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Schedule 1 — Status and appointment of medical reviewers
Schedule 2 — Minor and consequential modifications
Certification of Death (Scotland) Bill

[AS INTRODUCED]

An Act of the Scottish Parliament to make provision about the certification of death and still-birth certificates; to make provision for medical reviewers, the senior medical reviewer and their functions; and for connected purposes.

Medical reviewers

1 Medical reviewers

1. Medical reviewers are to exercise the functions conferred on them by this Act or any other enactment on behalf of Healthcare Improvement Scotland.

2. The senior medical reviewer is to exercise the functions conferred on that person by this Act or any other enactment on behalf of Healthcare Improvement Scotland.

3. Schedule 1 (which makes further provision about the appointment and status of medical reviewers) has effect.

Referral of medical certificates of cause of death for review

2 Referral of certain medical certificates of cause of death for review

After section 24 of the 1965 Act insert—

24A Duty to refer certain certificates of cause of death for review

1. The Registrar General must ensure that randomly selected certificates of cause of death are referred for review under section 8(1) of the 2010 Act prior to registration of the death to which each certificate relates.

2. The Registrar General must ensure that certificates of cause of death of such descriptions as may be specified in a request by medical reviewers under section 3 of the 2010 Act are referred for review under section 8(1) of that Act.

3. A district registrar for a registration district may refer for review under section 8(1) of that Act a certificate of cause of death where the district registrar considers it appropriate to do so.

4. The following certificates may not be referred under subsections (1) to (3)—

(a) a certificate of cause of death relating to a body in respect of which a direction has been given by a Health Board under section 90(2) of the Public Health etc. (Scotland) Act 2008 (asp 5) (restrictions on release of infected etc. bodies from hospital),
(b) a certificate of cause of death which has already been referred under this section,

c) a certificate of cause of death which has been (or is being) reviewed under section 8(1) of the 2010 Act following an application made under section 4(1) of that Act,

d) a certificate of cause of death which is a replacement certificate attested and transmitted in response to an invitation to do so under section 10 or 11 of the 2010 Act,

e) a certificate of cause of death where the cause of death of the deceased person has been (or is being) investigated by a procurator fiscal,

(f) a certificate of cause of death attested prior to the coming into force of this section.

(5) The Scottish Ministers may give directions to the Registrar General about the referral of certificates under this section; and the Registrar General must comply with any such direction.

(6) A direction under subsection (5) may in particular specify—

(a) the minimum number of certificates of cause of death which are to be selected for referral under subsection (1) in any year, and

(b) the method of determining which certificates are to be selected for referral under subsection (1).

(7) The Scottish Ministers may by order made by statutory instrument suspend the referral of certificates under this section—

(a) during an epidemic, or

(b) where the Scottish Ministers consider, on reasonable grounds, that it is necessary to do so to prevent, or to prevent the spread of, infectious diseases or contamination.

(8) An order made under subsection (7)—

(a) may include such supplementary, incidental, consequential, transitional, transitory or saving provision as the Scottish Ministers think necessary or expedient,

(b) may be exercised so as to make different provision for different purposes.

(9) A statutory instrument containing an order under subsection (7) is subject to annulment in pursuance of a resolution of the Scottish Parliament.”.

3 Medical reviewer requests

(1) A medical reviewer may request that the Registrar General ensure that medical certificates of cause of death of such description as the medical reviewer may specify are referred for review under section 8(1).

(2) A request under subsection (1) may relate to a certificate in respect of which the death has been registered.
4 Application for review of certificate by interested person

(1) An interested person may apply to a medical reviewer for a review under section 8(1) of an eligible medical certificate of cause of death.

(2) An application under subsection (1)—
   (a) may relate to a certificate in respect of which the death has been registered,
   (b) must be made within three years of the date of death of the deceased person to whom the certificate relates.

(3) Where the medical reviewer considers an application under subsection (1) to be vexatious, the medical reviewer may reject it.

(4) A medical reviewer must notify the Registrar General of an application received under subsection (1) (other than one which is rejected under subsection (3)).

(5) For the purposes of subsection (1), an interested person is—
   (a) a person who, under the 1965 Act, is required or stated to be qualified to give information concerning the deceased’s death,
   (b) a health care professional (or other carer) who was involved with the deceased’s care prior to the deceased’s death,
   (c) the funeral director responsible for the funeral arrangements of the deceased,
   (d) the person having charge of the place of disposal of the body of the deceased,
   (e) such other persons as the Scottish Ministers may by order specify.

(6) For the purposes of subsection (1), an eligible medical certificate of cause of death is a medical certificate of cause of death other than—
   (a) a certificate relating to a body in respect of which a direction has been given by a Health Board under section 90(2) of the Public Health etc. (Scotland) Act 2008 (asp 5) (restrictions on release of infected etc. bodies from hospital),
   (b) a certificate which has been referred under section 24A of the 1965 Act (duty to refer certain certificates of cause of death for review),
   (c) a certificate which has already been (or is being) reviewed under section 8(1) following an application made under subsection (1),
   (d) a certificate which is a replacement certificate attested and transmitted in response to an invitation to do so under section 10 or 11,
   (e) a certificate where the cause of death of the deceased person has been (or is being) investigated by a procurator fiscal,
   (f) a certificate attested prior to the coming into force of this section.

(7) The Scottish Ministers may by order suspend the application of this section—
   (a) during an epidemic, or
   (b) where the Scottish Ministers consider, on reasonable grounds, that it is necessary to do so to prevent, or to prevent the spread of, infectious diseases or contamination.

(8) The Scottish Ministers may by regulations make provision about applications under subsection (1) including, in particular, provision about—
   (a) the procedure for making applications,
(b) the form and content of applications,
(c) the action to be taken by medical reviewers in respect of applications.

5 Stay of registration of death pending review
In section 25B of the 1965 Act (registration of deaths)—
(a) in subsection (1), after “subsection (2)” insert “and (2A)”, and
(b) after subsection (2) insert—

“(2A) The registrar is not to register a death in respect of which the certificate of cause of death has been referred under section 24A or where the Registrar General has been notified under section 4(4) of the 2010 Act of an application for review having been made until the first occurrence of any of the following events—

(a) a medical reviewer, under section 7(2)(b) of the 2010 Act (request for review not to stay registration), notifying the registrar that it is appropriate in the circumstances to register the death before the review is complete,

(b) the certificate or its replacement being approved by a medical reviewer—

(i) under section 9 of the 2010 Act (action following satisfactory review), or

(ii) under section 10 of that Act (action following unsatisfactory review: medical reviewer),

(c) the certificate or its replacement being approved by the senior medical reviewer under section 11 of the 2010 Act (action following unsatisfactory review: senior medical reviewer),

(d) the senior medical reviewer, under section 11(8)(a), (9)(a) or 12(5)(a) of the 2010 Act, signifying that the review has been conducted,

(e) a medical reviewer, under section 12(2)(a) of the 2010 Act (action where relevant medical practitioner is unavailable or incapacitated), signifying that the review has been conducted, or

(f) a procurator fiscal approving the certificate or providing a replacement certificate attested by a registered medical practitioner.”.

6 Request for review not to stay registration
After section 24A of the 1965 Act insert—

“24B Request for review not to stay registration

(1) This section applies where a certificate of cause of death is referred under section 24A(1).

(2) A district registrar for a registration district must, following a request by a qualified informant, refer the certificate to a medical reviewer for a determination under section 7 of the 2010 Act (medical reviewer to determine whether review to stay registration).”
(3) Such a referral must include a statement by the qualified informant of the circumstances which the qualified informant believes justify registering the death before the review is complete.

(4) The qualified informant must also provide such other information as the medical reviewer may reasonably require.”.

7 Medical reviewer to determine whether review to stay registration

(1) This section applies where a medical reviewer receives a referral under section 24B(2) of the 1965 Act (request for review not to stay registration).

(2) The medical reviewer must—

(a) determine whether it is appropriate to register the death to which the referral relates before the review of the certificate under section 8(1) or, as the case may be, any further review under section 11(2) is completed, and

(b) notify the relevant registrar of the determination.

(3) The medical reviewer may determine under subsection (2)(a) that it is appropriate to register the death before the review (or further review) is completed only where the medical reviewer is satisfied that—

(a) the circumstances of the case justify such registration, and

(b) there are no obvious indications that the medical certificate of cause of death is not in order.

(4) The medical reviewer may make such enquiries as the medical reviewer considers appropriate when making a determination under subsection (2)(a).

Review of medical certificates of cause of death

8 Review of medical certificates of cause of death

(1) A medical reviewer must review any medical certificate of cause of death—

(a) referred under section 24A of the 1965 Act, or

(b) in respect of which an application has been made under section 4(1) (other than one which has been rejected as vexatious under section 4(3)).

(2) In conducting a review, the medical reviewer may—

(a) examine the health records of the deceased person to whom the certificate relates,

(b) seek the views of the medical practitioner who attested the certificate,

(c) make such other enquiries and examine such other things as the medical reviewer considers appropriate.

(3) Following a review under subsection (1) the medical reviewer must come to a view on whether the certificate is in order.

(4) For the purposes of this Act, a certificate is in order 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.
(5) The Scottish Ministers may by regulations make further provision about the review of certificates including, in particular, action to be taken by medical reviewers when conducting a review or by senior medical reviewers when conducting a further review.

9 **Action following satisfactory review**

(1) Subsection (2) applies where, following a review under section 8(1), a medical reviewer is of the view that a medical certificate of cause of death is in order.

(2) The medical reviewer must approve the certificate and notify the relevant registrar accordingly.

10 **Action following unsatisfactory review: medical reviewer**

(1) This section applies where, following a review under section 8(1), a medical reviewer is of the view that a medical certificate of cause of death is not in order.

(2) The medical reviewer must—

   (a) inform the relevant medical practitioner of that view and the reasons for coming to that view, and

   (b) invite the relevant medical practitioner to attest and transmit to the medical reviewer a replacement certificate which takes account of the reasons.

(3) If the relevant medical practitioner attests and transmits a replacement certificate which in the view of the medical reviewer is in order, the medical reviewer must approve the replacement certificate and transmit it to the relevant registrar.

(4) If the relevant medical practitioner attests and transmits a replacement certificate which in the view of the medical reviewer is not in order, the medical reviewer must refer the review to the senior medical reviewer.

(5) If the relevant medical practitioner declines to attest and transmit a replacement certificate in response to the invitation under subsection (2)(b), the medical reviewer must—

   (a) approve the certificate and notify the relevant registrar accordingly, or

   (b) refer the review to the senior medical reviewer.

11 **Action following unsatisfactory review: senior medical reviewer**

(1) This section applies where a review is referred to the senior medical reviewer under section 10(4) or (5)(b).

(2) The senior medical reviewer may conduct a further review of the certificate.

(3) If the senior medical reviewer conducts a further review under subsection (2), the senior medical reviewer may exercise the powers conferred on a medical reviewer by section 8(2).

(4) The senior medical reviewer must come to a view on whether the certificate is in order (and for that purpose references in section 8(4) to a medical reviewer are to be read as references to the senior medical reviewer).

(5) If the senior medical reviewer comes to the view that the certificate is in order, the senior medical reviewer must approve the certificate and notify the relevant registrar and the relevant medical practitioner accordingly.
(6) If the senior medical reviewer comes to the view that the certificate is not in order, the senior medical reviewer must—
   (a) inform the relevant medical practitioner of that view and the reasons for coming to that view, and
   (b) invite the relevant medical practitioner to attest and transmit to the senior medical reviewer a replacement certificate which takes account of the reasons.

(7) If the relevant medical practitioner attests and transmits a replacement certificate which, in the view of the senior medical reviewer, is in order, the senior medical reviewer must approve the replacement certificate and transmit it to the relevant registrar.

(8) If the relevant medical practitioner attests and transmits a replacement certificate which, in the view of the senior medical reviewer, is not in order, the senior medical reviewer must—
   (a) signify that a review has been conducted and notify the relevant registrar accordingly, or
   (b) refer the certificate to the procurator fiscal for investigation into the cause of death of the deceased person to whom the certificate relates.

(9) If the relevant medical practitioner declines to attest and transmit a replacement certificate, the senior medical reviewer must—
   (a) approve the certificate, or otherwise signify that a review has been conducted, and notify the relevant registrar accordingly, or
   (b) refer the certificate to the procurator fiscal for investigation into the cause of death of the deceased person to whom the certificate relates.

(10) Subsection (11) applies where—
   (a) the senior medical reviewer has come to the view that the certificate or, as the case may be, its replacement, is not in order because the senior medical reviewer is not satisfied that information (other than the cause of death) contained in the certificate (or its replacement) is correct, or
   (b) the relevant medical practitioner declines to attest and transmit a replacement certificate in response to the invitation under subsection (6).

(11) The senior medical reviewer may (in addition to the action to be taken under subsection (8) or (9)) take such steps as the senior medical reviewer considers appropriate to inform such persons as the senior medical reviewer considers appropriate of the relevant information.

12 **Action where relevant medical practitioner is unavailable or incapacitated**

(1) Subsections (2) and (3) apply where—
   (a) a medical reviewer has conducted a review under section 8(1),
   (b) the medical reviewer has come to the view that a medical certificate of cause of death is not in order, and
   (c) the relevant medical practitioner is unavailable or unable to attest and transmit a replacement certificate in accordance with section 10.

(2) The medical reviewer must—
(a) signify that a review has been conducted and notify the relevant registrar accordingly, or

(b) refer the certificate to the procurator fiscal for investigation into the cause of death of the deceased person to whom the certificate relates.

(3) Where the medical reviewer has come to the view that the certificate is not in order because the medical reviewer is not satisfied that information contained in the certificate (other than the cause of death) is correct, the medical reviewer may (in addition to the action to be taken under subsection (2)) take such steps as the medical reviewer considers appropriate to inform such persons as the medical reviewer considers appropriate of the relevant information.

(4) Subsections (5) and (6) apply where—

(a) a medical reviewer has referred a review to the senior medical reviewer under section 10(4) or (5)(b),

(b) the senior medical reviewer has come to the view that a medical certificate of cause of death is not in order, and

(c) the relevant medical practitioner is unavailable or unable to attest and transmit a replacement certificate in accordance with section 11.

(5) The senior medical reviewer must—

(a) signify that a review has been conducted and notify the relevant registrar accordingly, or

(b) refer the certificate to the procurator fiscal for investigation into the cause of death of the deceased person to whom the certificate relates.

(6) Where the senior medical reviewer has come to the view that the certificate is not in order because the senior medical reviewer is not satisfied that information contained in the certificate (other than the cause of death) is correct, the senior medical reviewer may (in addition to the action to be taken under subsection (5)) take such steps as the senior medical reviewer considers appropriate to inform such persons as the senior medical reviewer considers appropriate of the relevant information.

13 Duty to inform following review

(1) This section applies where a medical reviewer has conducted a review under section 8(1).

(2) The medical reviewer must, when a relevant requirement is first complied with in relation to the certificate to which the review relates, inform the persons mentioned in subsection (3) of the outcome of the review including, in particular, any changes made to the medical certificate of cause of death.

(3) The persons are—

(a) the person who gave information of the particulars required to be registered concerning the death to the district registrar under section 23(1) of the 1965 Act,

(b) in the case of a review conducted by virtue of section 4, the interested person (unless that is the same person as mentioned in paragraph (a)).

(4) In subsection (2), “relevant requirement” means a requirement imposed by any of the following sections—

(a) section 9(2),
(b) section 10(3) or (5)(a),
(c) section 11(5), (7), (8) or (9),
(d) section 12(2) or (5).

Powers of medical reviewers when conducting review

5 14 Power to require documents

(1) A medical reviewer may, for the purposes of reviewing a medical certificate of cause of death under section 8(1) or, as the case may be, section 11(2), require any person who is able, in the opinion of the medical reviewer, to produce relevant documents (including health records) to do so.

(2) Where a requirement under subsection (1) is imposed by the medical reviewer, the person in question must be given a notice specifying—
   (a) the documents or types of documents which the person is required to produce,
   (b) the date by which the person is required to produce them, and
   (c) the name of the deceased person in respect of whom they are required.

(3) For the purposes of this section, a person is to be taken to comply with a requirement to produce a document if that person produces a copy of, or an extract of the relevant part of, the document.

(4) In this section, references to the medical reviewer include references to the senior medical reviewer.

15 Documents: offences

(1) Any person to whom a notice under section 14 is given commits an offence if the person—
   (a) deliberately alters, suppresses, conceals or destroys any document which that person is required to produce by the notice, or
   (b) refuses or fails to produce any such document.

(2) It is a defence for a person charged with an offence under subsection (1)(b) to prove that there was a reasonable excuse for the refusal or failure.

(3) A person is not obliged under section 14 to produce any document which that person would be entitled to refuse to produce in a court in Scotland.

(4) A person who commits an offence under this section is liable on summary conviction to a fine not exceeding level 5 on the standard scale or to imprisonment for a period not exceeding 3 months.

(5) Where an offence under this section which has been committed by a body corporate is proved to have been committed with the consent or connivance of, or to be attributable to any neglect on the part of—
   (a) a director, manager, secretary or other similar officer of the body corporate, or
   (b) any person who was purporting to act in any such capacity,
that person, as well as the body corporate, commits the offence and is liable to be proceeded against accordingly.
**Duty to report suspicions of criminality**

**16 Involvement of procurator fiscal**

(1) A medical reviewer (including the senior medical reviewer) must report any suspicion of criminality arising from the review of a medical certificate of cause of death (or a number of such reviews) to the procurator fiscal.

(2) A medical reviewer (including the senior medical reviewer), having reported a suspicion under subsection (1), must follow the directions of the procurator fiscal as to the appropriate action to take.

**Deaths outwith Scotland**

**17 Medical reviewers to authorise cremation**

(1) This section applies where—

(a) an individual ("A") died outwith Scotland, and

(b) it is intended that A be cremated in Scotland.

(2) A medical reviewer must, on an application by a person who wishes to arrange the cremation of A, determine whether it is safe for A’s body to be cremated.

(3) If the medical reviewer determines that it is safe for A’s body to be cremated, the medical reviewer must give the applicant a certificate authorising the cremation.

(4) The Scottish Ministers may by regulations make provision about—

(a) the form and content of applications under subsection (2),

(b) the procedure to be followed by medical reviewers in relation to applications under subsection (2),

(c) the form and content of the certificate authorising the cremation to be given under subsection (3).

**18 Post-mortem examination of person who died outwith United Kingdom**

(1) This section applies where—

(a) a person ("A") dies outwith the United Kingdom,

(b) the body of A is to be disposed of in Scotland, and

(c) no cause of death is available.

(2) A medical reviewer may, on an application by a relevant person—

(a) assist the relevant person in making arrangements for a post-mortem examination of A’s body for the purpose mentioned in section 23(a) of the Human Tissue (Scotland) Act 2006 (asp 4), and

(b) meet the cost of such an examination.

(3) For the purposes of subsection (2), a relevant person is a person who, under section 30, 32 or 33 of the Human Tissue (Scotland) Act 2006, may authorise a post-mortem examination of A’s body.

(4) The Scottish Ministers may by regulations make provision about the form and content of applications under subsection (2).
Other functions of medical reviewers

19 Training and information functions

(1) A medical reviewer (including the senior medical reviewer) has the functions mentioned in subsection (2).

(2) The functions are—

(a) to collate and analyse information relating to or contained in medical certificates of cause of death,

(b) to provide training, guidance and support to persons who are required to complete medical certificates of cause of death,

(c) to provide guidance and support to district registrars in relation to medical certificates of cause of death,

(d) to liaise with such persons as the medical reviewer considers appropriate with a view to improving—

(i) the accuracy of the information (and in particular the causes of death) recorded in medical certificates of cause of death, and

(ii) the administrative processes relating to the disposal of bodies.

20 Duty to co-operate

Health Boards, Special Health Boards, the Common Services Agency for the Scottish Health Service and medical reviewers (including the senior medical reviewer) are to co-operate with one another in the exercise of their respective functions in relation to—

(a) the completion and review of medical certificates of cause of death (including in particular the recording of causes of deaths),

(b) the collation and analysis of information relating to the causes of death,

(c) the disposal of bodies.

21 Guidance

In exercising functions under this Act, medical reviewers (including the senior medical reviewer) must have regard to any guidance issued by the Scottish Ministers for the purposes of or in connection with this Act.

22 Annual report

(1) The senior medical reviewer must—

(a) prepare a report for each financial year on the activities of medical reviewers (including the senior medical reviewer) during the year, and

(b) provide such further information as the Scottish Ministers may reasonably require.

(2) As soon as reasonably practicable after the end of each financial year, the senior medical reviewer must—

(a) send a copy of the report to the Scottish Ministers, and

(b) arrange for it to be published.

(3) The Scottish Ministers may by regulations—
(a) make further provision about the information to be contained in a report,
(b) require reports to be prepared on a more frequent basis,
(c) specify other persons to whom a copy of the report must be sent.

Fees

23 Fees in respect of medical reviewer functions

(1) The Scottish Ministers may charge a fee in respect of—
(a) the review functions,
(b) the functions exercised by the Common Services Agency for the Scottish Health Service in connection with the review functions,
(c) an application under section 17(2).

(2) The persons liable for the fee in respect of the functions mentioned in subsection (1)(a) and (b) are the personal representatives of every person whose death requires to be registered in accordance with Part 3 of the 1965 Act; and any such fee is to be treated as part of the general testamentary and administration expenses of the estate of the deceased.

(3) The Scottish Ministers may by regulations make provision about the charging of fees under subsection (1).

(4) Regulations made under subsection (3) may in particular—
(a) set the amount of any such fee,
(b) make provision about the arrangements for collection of any such fee (including specifying persons (or types of person) who must collect the fee on behalf of the Scottish Ministers),
(c) specify circumstances in which no fee is payable.

(5) The Scottish Ministers, in setting the amount of fees under this section, must have regard to the reasonable costs of the exercise of the functions in respect of which the fee is to be charged.

(6) Before making any regulations under subsection (3) the Scottish Ministers must consult such persons as they consider appropriate.

(7) In subsection (1), the review functions are the functions of the medical reviewers (including the senior medical reviewer) under this Act (other than sections 17 and 18).

Disposal of bodies

24 Prohibition on disposal of body without authorisation

After section 27 of the 1965 Act insert—

“27A Offence of disposal of body without authorisation

(1) A person having charge of a place of interment, cremation or other means of disposal of human bodies who inters, cremates or otherwise disposes of the body of a still-born child or a deceased person (or who knowingly permits such interment, cremation or disposal) without the certificates or other documentation specified under subsection (2)(a) for such purpose commits an offence.
(2) The Scottish Ministers may by regulations made by statutory instrument—
   (a) specify the certificates or other documentation required for the interment, cremation or other disposal of the body of a still-born child or a deceased person,
   (b) make provision about the form and content of such certificates (other than those which are to be prescribed by the Registrar General under this Act).

(3) A person who commits an offence under subsection (1) is liable on summary conviction to a fine not exceeding level 3 on the standard scale.

(4) It is a defence for a person charged with an offence under subsection (1) to prove that there was a reasonable excuse for the interment, cremation or disposal of a body (or for that person permitting such interment, cremation or other disposal) without the certificates or other documentation specified under subsection (2)(a).

(5) Where an offence under subsection (1) which has been committed by a body corporate is proved to have been committed with the consent or connivance of, or to be attributable to any neglect on the part of—
   (a) a director, manager, secretary or other similar officer of the body corporate, or
   (b) any person who was purporting to act in any such capacity,
that person, as well as the body corporate, commits the offence and is liable to be proceeded against accordingly.

(6) The power conferred by subsection (2)—
   (a) may be exercised so as to make different provision for different purposes,
   (b) includes power to make such incidental, consequential, transitional, transitory or saving provision as the Scottish Ministers think necessary or expedient.

(7) A statutory instrument containing regulations under subsection (2) is subject to annulment in pursuance of a resolution of the Scottish Parliament.

(8) In subsections (1), (2) and (4) reference to a body includes reference to a part of a body.”.

Certifying medical practitioner to provide additional information

(1) In section 21(2)(a) of the 1965 Act (certificates relating to still-births), after “death” insert “, any other relevant medical information”.

(2) In section 24(1) of that Act (certificates of cause of death)—
   (a) after the words “death of” where they first appear insert “, and any relevant medical information about,”,
   (b) after the words “belief the cause of death” insert “and such other medical information as may be prescribed”.

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26 **Still-birth declarations**

In section 21 of the 1965 Act (still-births)—

(a) in subsection (2), paragraph (b) and the word “or” immediately preceding it is repealed,

(b) in subsection (3)(a), the words “paragraph (a) of” are repealed.

27 **Ancillary provision**

(1) The Scottish Ministers may by order make such supplementary, incidental, consequential, transitional, transitory or saving provision as they consider necessary or expedient for the purposes of, in consequence of, or for giving full effect to, any provision of this Act.

(2) An order under this section may modify any enactment, instrument or document.

28 **Orders and regulations**

(1) Subject to subsection (4), any power conferred by this Act on the Scottish Ministers to make an order or regulations—

(a) must be exercised by statutory instrument,

(b) includes power to make supplementary, incidental, consequential, transitional, transitory or saving provision,

(c) may be exercised so as to make different provision for different purposes.

(2) No—

(a) regulations are to be made under section 23(3),

(b) order is to be made under section 27 containing provisions which add to, omit or replace any part of the text of an Act,

unless a draft of the statutory instrument containing the regulations or order has been laid before, and approved by resolution of, the Parliament.

(3) Subject to subsection (4), any other statutory instrument containing an order or regulations is subject to annulment in pursuance of a resolution of the Parliament.

(4) Subsections (1) and (3) do not apply in relation to an order made under section 31(3).

29 **Minor and consequential modifications**

Schedule 2 (which makes minor modifications and modifications consequential on this Act) has effect.

30 **Interpretation**

(1) In this Act (unless the context otherwise requires)—

“the 1965 Act” means the Registration of Births, Deaths and Marriages (Scotland) Act 1965 (c. 49);

“the 1978 Act” means the National Health Service (Scotland) Act 1978 (c. 29);
“funeral director” means a person whose business consists of or includes the arrangement and conduct of funerals;

“Health Board” means a Health Board constituted under section 2 of the 1978 Act;

“health record” means a record which—

(a) consists of information relating to the physical or mental health of an individual, and

(b) has been made by or on behalf of a health professional in connection with the care of that individual;

“medical certificate of cause of death” means a certificate mentioned in section 24 of the 1965 Act;

“medical reviewer” means a person appointed under paragraph 7A(1) of Schedule 5A to the 1978 Act;

“registration district” has the meaning given in section 5 of the 1965 Act;

“Registrar General” has the meaning given in section 1(2) of the 1965 Act;

“relevant registrar” means—

(a) the district registrar for a registration district—

(i) to whom a medical certificate of cause of death was transmitted under section 24 of the 1965 Act,

(ii) in the presence of whom a death registration form (within the meaning of section 23(1A) of the 1965 Act) was attested under section 23(1A)(a)(ii) of that Act, or

(iii) to whom a death registration form was submitted under section 23(1A)(b) of that Act, or

(b) where the information mentioned in paragraph (a) is not known to the medical reviewer (or, as the case may, the senior medical reviewer), the Registrar General;

“relevant medical practitioner” means the registered medical practitioner who attested the certificate of cause of death under section 24 of the 1965 Act;

“senior medical reviewer” means the person appointed under paragraph 7A(2) of Schedule 5A to the 1978 Act;

“Special Health Board” means a Special Health Board constituted under section 2 of the 1978 Act.

(2) Unless the context otherwise requires, any undefined expression used in this Act but defined in section 56 of the 1965 Act is to be construed in accordance with section 56 of the 1965 Act.

31 Short title and commencement

(1) This Act may be cited as the Certification of Death (Scotland) Act 2010.

(2) This section and sections 27 and 28 come into force at the beginning of the day after the day on which the Bill for this Act receives Royal Assent.
(3) The remaining provisions of this Act come into force on such day as the Scottish Ministers may appoint by order made by statutory instrument.

(4) An order made under subsection (3)—
   (a) may make transitional, transitory or saving provision,
   (b) may make different provision for different purposes or different areas.
SCHEDULE 1
(introduced by section 1)

STATUS AND APPOINTMENT OF MEDICAL REVIEWERS

1 Schedule 5A to the 1978 Act (Healthcare Improvement Scotland) is amended as follows.

2 After paragraph 7 insert—

“Medical reviewers

7A(1) HIS must appoint persons employed under paragraph 7(5) to exercise the functions of medical reviewers; and when doing so those employees are to be known as medical reviewers.

(2) HIS must appoint a person employed under paragraph 7(5) to exercise the functions of the senior medical reviewer; and when doing so that employee is to be known as the senior medical reviewer.

(3) A person appointed as a medical reviewer or the senior medical reviewer must—

(a) be a medical practitioner;

(b) have been so throughout the 5 years prior to appointment; and

(c) have such other qualifications, training and experience as may be specified by regulations.

(4) A member of HIS may not exercise the functions of—

(a) a medical reviewer; or

(b) the senior medical reviewer.

(5) An employee of HIS (other than a medical reviewer) may not exercise the functions of a medical reviewer.

(6) An employee of HIS (other than the senior medical reviewer) may not exercise the functions of the senior medical reviewer (except by virtue of arrangements made under paragraph 11(2B)).

(7) An appointment as a medical reviewer or the senior medical reviewer does not affect the appointed person’s status as employed under paragraph 7(5).”.

3 In paragraph 11 (delegation of functions), after sub-paragraph (2) insert—

“(2A) Any function conferred on a medical reviewer or the senior medical reviewer may not, subject to sub-paragraph (2B), be delegated by HIS.

(2B) The senior medical reviewer may, with the approval of HIS, make arrangements for the functions of the senior medical reviewer to be carried out by a medical reviewer where the senior medical reviewer is absent or otherwise unavailable.”.
SCHEDULE 2
(introduced by section 29)

MINOR AND CONSEQUENTIAL MODIFICATIONS

Cremation Act 1902 (c. 8)

1 In section 8(1) (penalties for breach of regulations, &c), after “incur” insert “other than an offence under section 27A(1) of the Registration of Births, Deaths and Marriages (Scotland) Act 1965 (c. 49) (offence of disposal of body without authorisation)”.

Registration of Births, Deaths and Marriages (Scotland) Act 1965 (c. 49)

2 Section 21(5) of the 1965 Act (person having charge of place of interment to give notice of burial of still-born child without certificate) is repealed.

3 In section 24 of the 1965 Act (certificate of cause of death), after subsection (1), insert—

“(1A) A registered medical practitioner may, where invited to do so under section 10(2)(b) or 11(6) of the 2010 Act (action following unsatisfactory review), attest and transmit a replacement certificate to a medical reviewer or, as the case may be, the senior medical reviewer.”.

4 Section 27(2) and (3) of the 1965 Act (transmission of certificate of registration) is repealed.

5 In section 56(1) of the 1965 Act (interpretation)—

(a) before the entry for “birth” insert—

“the 2010 Act” means the Certification of Death (Scotland) Act 2010 (asp 00);”,

(b) after the entry for “local authority” insert—

“medical reviewer” means a person appointed under paragraph 7A(1) of Schedule 5A to the National Health Service (Scotland) Act 1978 (c. 29);”,

(c) after the entry for “relative” insert—

“senior medical reviewer” means a person appointed under paragraph 7A(2) of Schedule 5A to the National Health Service (Scotland) Act 1978 (c. 29);”.

Registration of Births, Deaths and Marriages (Scotland) Act 1965 (c. 49)
Certification of Death (Scotland) Bill

[AS INTRODUCED]

An Act of the Scottish Parliament to make provision about the certification of death and still-birth certificates; to make provision for medical reviewers, the senior medical reviewer and their functions; and for connected purposes.

Introduced by: Nicola Sturgeon
On: 7 October 2010
Bill type: Executive Bill
CERTIFICATION OF DEATH (SCOTLAND) BILL

EXPLANATORY NOTES

(AND OTHER ACCOMPANYING DOCUMENTS)

CONTENTS

1. As required under Rule 9.3 of the Parliament’s Standing Orders, the following documents are published to accompany the Certification of Death (Scotland) Bill introduced in the Scottish Parliament on 7 October 2010:

- Explanatory Notes;
- a Financial Memorandum;
- an Executive Statement on legislative competence; and
- the Presiding Officer’s Statement on legislative competence.

A Policy Memorandum is printed separately as SP Bill 58–PM.
EXPLANATORY NOTES

INTRODUCTION

2. These Explanatory Notes have been prepared by the Scottish Government in order to assist the reader of the Bill and to help inform debate on it. They do not form part of the Bill and have not been endorsed by the Parliament.

3. The Notes should be read in conjunction with the Bill. They are not, and are not meant to be, a comprehensive description of the Bill. So where a section or schedule, or a part of a section or schedule, does not seem to require any explanation or comment, none is given.

SUMMARY OF THE BILL

4. The Bill introduces a new system of scrutiny of medical certificates of cause of death. It creates the post of medical reviewer and senior medical reviewer whose functions are to review for accuracy the certificates referred to them from a variety of sources. A number of certificates will be referred at random by district registrars. The Registrar General will be responsible for ensuring that certificates are referred according to the chosen selection scheme. Persons with some connection to the deceased can apply for a review and certificates may also be selected by the medical reviewers themselves for scrutiny.

5. Medical reviewers will be involved in the training of doctors in the completion of medical certificates of cause of death and information derived from reviews will directly feed into that training.

6. The Bill provides for the form of medical certificates of cause of death to be amended to show additional relevant medical information to indicate, for example, whether it is safe to dispose of the body by cremation. The Bill also provides for the form of still-birth certificates to be amended to show additional relevant medical information, to indicate whether the body presents a risk to public health.

7. Where a person has died outwith Scotland and the body is to be cremated in Scotland, medical reviewers will determine whether it is safe to cremate the body. They may also assist persons to make arrangements for a post-mortem examination (including meeting the cost of the examination) in such cases from outwith the UK if no cause of death is available.

8. A fee may be charged to pay for the review system and in cases where authority to cremate a body from outwith Scotland is required.

9. It will be an offence to dispose of a body or body parts without authorisation.
COMMENTARY ON SECTIONS

Medical reviewers

Section 1: Medical reviewers

10. This section introduces medical reviewers and the senior medical reviewer who will exercise their functions on behalf of Healthcare Improvement Scotland (HIS), a body set up in Schedule 5A to the National Health Service (Scotland) Act 1978. They will be appointed by and be employees of HIS. This section also gives effect to schedule 1 to the Act which provides further detail regarding the status and appointment of medical reviewers and the senior medical reviewer.

Referral of medical certificates of cause of death for review

Section 2: Referral of certain certificates of cause of death for review

11. Under the new system for scrutiny of medical certificates of cause of death, certificates will be sent for review from a variety of sources. One of these is the General Register Office for Scotland (GROS), which is responsible for the registration of deaths. GROS is expected to use computerised systems to identify a random selection of certificates for review.

12. Section 2 amends the Registration of Births, Deaths and Marriages (Scotland) Act 1965 (c.49) (“the 1965 Act”) by inserting a new section 24A. Section 24A(1) requires the Registrar General to ensure that randomly selected certificates of cause of death are referred to medical reviewers for review prior to the completion of the registration process (and therefore before the registrar’s certificate of registration has been issued). Subsection (2) imposes a duty on the Registrar General to ensure that medical certificates of cause of death requested by medical reviewers under section 3 are referred for review. Subsection (3) allows a district registrar to refer a certificate for review, where he/she decides this is appropriate.

13. Some certificates, listed in subsection (4), are not eligible to be referred to the medical reviewer for investigation. The first category consists of cases where the body presents a risk to public health and a direction has been issued by a Health Board under section 90(2) of the Public Health (Scotland) Act 2008 (asp 5) to the effect that an infectious or contaminated body may not be removed or may only be removed from a hospital by a specified person for immediate disposal. Also ineligible for review are any certificate which has already been referred for review, any replacement certificate (described in sections 10 and 11), certificates signed before section 2 comes into force and any certificate relating to a death which has already been (or is being) investigated by the procurator fiscal.

14. Subsection (5) gives the Scottish Ministers power to direct the Registrar General as to the minimum number of certificates to be referred in the random sample and the method of determining the random sample. The sample size and method could be amended from time to time for statistical reasons.

15. The Scottish Ministers have the power to suspend by order the referral of certificates to the medical reviewer during an epidemic or if it becomes necessary to do so for public health reasons in order to prevent the spread of infectious disease or contamination. Suspension of the...
referrals could be judged necessary in such situations to expedite the disposal of bodies and free up medical personnel. The power is subject to negative resolution procedure as is set out in subsection (9) with ancillary powers in subsection (8).

Section 3: Medical reviewer requests

16. In addition to the random sample of certificates provided for in section 2, medical reviewers may request any medical certificate of cause of death for review, including certificates where the death has already been registered. This will allow medical reviewers to conduct additional scrutiny where they feel this is required e.g. in response to a particular issue of concern.

Section 4: Application for review of certificate by interested person

17. This section provides for a list of “interested persons” who may also apply to a medical reviewer for a review. These applications may relate to deaths either before or after they have been registered but applications must be made within three years of the date of death. A medical reviewer may reject an application that is considered vexatious.

18. The medical reviewer must notify the Registrar General of the application. The purpose of this is to stay the registration process, as provided for in section 5, where the death has not already been registered. This also provides the medical reviewer with a means for discovering whether the certificate has already been reviewed (and therefore is ineligible).

19. Subsection (5) sets out the list of interested persons, which may be added to by order of the Scottish Ministers. Interested persons either have some personal connection to the deceased or are in a position to have informed concerns about the accuracy of the medical certificate of cause of death.

20. Certain certificates are excluded from this type of review. These are cases where a Health Board direction has been issued regarding a contaminated or infectious body, where the certificate has already been referred or reviewed, a replacement certificate has already been issued under sections 10 or 11, or the death has been referred to the procurator fiscal.

21. Subsection (7) allows the Scottish Ministers to suspend applications for review from interested persons during an epidemic or when necessary to prevent or halt the spread of infectious diseases or contamination. This mirrors the provision in section 24A(7) of the 1965 Act (introduced by section 2) which allows for the suspension of referrals under that section in the same circumstances. Suspension of applications could be necessary in situations where there are large numbers of deaths and it becomes a priority to expedite the disposal of bodies and free up medical personnel.

22. Subsection (8) allows the Scottish Ministers to prescribe in regulations the content of and procedure for making “interested person” applications and the actions to be taken by medical reviewers in respect of such applications.
These documents relate to the Certification of Death (Scotland) Bill (SP Bill 58) as introduced in the Scottish Parliament on 7 October 2010

Section 5: Stay of registration of death pending review

23. Section 5 amends section 25B of the 1965 Act. The purpose of this section is to ensure that the registrar does not complete the registration of any death where the certificate of cause of death has been referred for review under the provisions in section 24A of the 1965 Act or where an application for review has been made under section 4 prior to the death being registered.

24. Registration must usually be suspended until the review has been completed. In certain circumstances, however, a medical reviewer may confirm that it is appropriate for the registration process to proceed prior to the review being completed (see sections 6 and 7). This is the process set out in section 6 which may apply in certain circumstances where speed is of the essence.

Section 6: Request for review not to stay registration

25. Section 6 provides for a request for the registration of a death not to be stayed. This is available where there has been a referral of the certificate under the random sampling provision in section 24A(1) of the 1965 Act, inserted by section 2. Requests for this process are to be made to the registrar who will then refer the case to the medical reviewer for a decision. The application must include a statement by the applicant of the circumstances that might justify use of the process. In practice a copy of the medical certificate of cause of death will be sent to the medical reviewer (the original certificate will follow the copy by the usual means).

Section 7: Medical reviewer to determine whether review to stay registration

26. It is for the medical reviewer to decide whether it is appropriate to register the death before the review is complete and to notify the registrar of the decision. The medical reviewer must be satisfied that the circumstances of the case justify this and that the certificate appears on the face of it to be in order. This process may reduce any delay to the funeral and so may be useful in cases where it has to take place more quickly than usual. The circumstances to be considered by medical reviewers will be set out in guidance.

Review of medical certificates of cause of death

Section 8: Review of medical certificates of cause of death

27. Section 8 provides that the medical reviewer must review the certificates of cause of death referred under section 24A of the 1965 Act or those referred to the medical reviewer under section 4 (provided they are not rejected as vexatious under section 4 subsection (3)).

28. Subsection (2) describes the conduct of a review. Medical reviewers may review the medical records of the deceased, discuss matters with the certifying doctor and make other enquiries as they consider appropriate. This might include speaking to other health professionals involved in the care of the deceased, speaking to relatives and, possibly, (arranging to) view the body before coming to a view as to whether the medical certificate of cause of death is in order.

29. Subsections (3) and (4) provide that medical reviewers must come to a view on whether the given cause of death is a reasonable conclusion and that other information in the certificate is correct.
These documents relate to the Certification of Death (Scotland) Bill (SP Bill 58) as introduced in the Scottish Parliament on 7 October 2010

30. Subsection (5) allows the Scottish Ministers to make further provisions regarding the conduct of reviews in regulations.

Section 9: Action following satisfactory review

31. If the medical reviewer is satisfied with the medical certificate of cause of death, then he or she must approve it and notify the relevant registrar (in practice, this will mean sending the certificate back to the relevant registrar for registration to occur).

32. The relevant registrar is defined in section 30 and will usually be the district registrar who has made the referral or, where that person is unknown to the medical reviewer (as might be the case in an interested person application), the Registrar General.

33. In cases where the registration of the death has been stayed, the registrar will then be free to complete it and notify the informant, that is the relative or other person who came to register the death.

Section 10: Action following unsatisfactory review: medical reviewer

34. Section 10 sets out the next steps if the medical reviewer is not satisfied that a medical certificate of cause of death is in order. The medical reviewer must inform the doctor who certified the cause of death, giving reasons for their view, and invite the doctor to replace the certificate which takes account of the reasons why the medical reviewer considers that the certificate is not in order, thus allowing the medical reviewer to then approve and notify the registrar. However, if the certifying doctor issues a replacement certificate which the medical reviewer considers is not in order then he or she must refer the review to the senior medical reviewer.

35. The certifying doctor may decline to issue a replacement certificate. In such cases the medical reviewer may be persuaded in discussion with the doctor that the cause of death does, after all, represent a reasonable conclusion as to the cause of death or that the other information on the form is in fact correct. In such instances the medical reviewer can then decide to approve the certificate. If not persuaded, the medical reviewer must refer it to the senior medical reviewer.

Section 11: Action following unsatisfactory review: senior medical reviewer

36. This section applies where a medical reviewer has been unable to agree with the certifying doctor that a medical certificate of cause of death is in order and has referred the matter to the senior medical reviewer.

37. The senior medical reviewer must also come to a view on whether the given cause of death is a reasonable conclusion and that other information in the certificate is correct. To do so, he or she may conduct a further review of the certificate in the same manner as a medical reviewer.

38. If the senior medical reviewer is of the view that the certificate is in order, the certificate will be approved and sent to the relevant registrar for registration to proceed.
These documents relate to the Certification of Death (Scotland) Bill (SP Bill 58) as introduced in the Scottish Parliament on 7 October 2010

39. However, if the senior medical reviewer does not think that the certificate is in order, he or she must inform the doctor who certified the cause of death, giving reasons for their view, and invite the doctor to replace the certificate. There is no obligation on certifying doctors to change their opinion but they may agree to issue a replacement certificate which takes account of the reasons why the senior medical reviewer considers that the certificate is not in order, thus allowing the senior medical reviewer to then approve and notify the registrar. If the certifying doctor issues a replacement certificate but the senior medical reviewer does not agree with the revised cause of death information, or the certifying doctor does not issue a replacement certificate and the senior medical reviewer is not persuaded of the doctor’s original view as to the cause of death, the senior medical reviewer must refer the certificate to the procurator fiscal for investigation.

40. In cases where the senior medical reviewer agrees with the cause of death, but believes that other information contained in the certificate, or its replacement, is incorrect (such as whether a pacemaker is fitted), or where the doctor will not issue a replacement certificate, the senior medical reviewer can take steps to alert whomever he or she considers appropriate as to what he or she believes to be the relevant information. This might typically be the family of the deceased or the person in charge of the burial or cremation of the deceased.

41. The senior medical reviewer can also take such steps when referring a certificate to the procurator fiscal.

Section 12: Action where relevant medical practitioner is unavailable or incapacitated

42. This section deals with the situation where the relevant doctor is unavailable or unable to issue a replacement certificate, for example, when that doctor is unwell. If a medical reviewer is not satisfied as to the cause of death given in the certificate but the relevant doctor is not available or is incapacitated and so could not issue a replacement certificate, the death must be referred to the procurator fiscal for investigation. If there is some other defect in the certificate not related to the cause of death, the medical reviewer can take steps to alert whomever he or she considers appropriate as to what he or she believes to be the relevant information. If the doctor becomes unavailable after a certificate has been referred to the senior medical reviewer, who is not satisfied that the certificate is in order, the senior medical reviewer can take the same actions as the medical reviewer.

Section 13: Duty to inform following review

43. Specified persons are to be informed of the outcome of a review including any changes made to the medical certificate of cause of death. An interested person who made an application under section 4 will be informed as will the person who gave information in order to register the death. Such notification will take place after a review has been conducted and the registrar has been notified or when the case has been referred to the procurator fiscal.

Powers of medical reviewers when conducting review

Section 14: Power to require documents

44. Medical reviewers and the senior medical reviewer have the power to require any person who, in their opinion, may have relevant documents, to provide them with documents including
medical records. Medical reviewers (and the senior medical reviewer) must make a request for these in a formal notice in accordance with subsection (2). Copies or extracts of the document are sufficient.

Section 15: Documents: offences
45. This section creates an offence where a document referred to in section 14 either is not provided and there is no reasonable excuse for the failure to produce it or it has been deliberately altered, suppressed concealed or destroyed. There is no obligation to produce a document that a person would be entitled to refuse to produce in court. The penalty for the offence is level 5 on the standard scale or imprisonment for up to 3 months.

46. This section applies to individuals and organisations. Subsection (5) of section 15 confirms that in cases where the offence is committed by a body corporate, the person in charge of that body (for example, the manager of a private nursing home) commits the offence, as well as the body corporate.

Duty to report suspicions of criminality

Section 16: Involvement of procurator fiscal
47. This section requires the medical reviewer or senior medical reviewer to report any suspicion of criminal activity to the procurator fiscal and follow any directions from the procurator fiscal after a suspicion has been reported.

48. The role of the procurator fiscal in Scotland is not altered by the establishment of the system of medical reviewer scrutiny.

Deaths outwith Scotland

Section 17: Medical reviewers to authorise cremation
49. Medical reviewers have the additional function of ensuring that it is safe to cremate the body of anyone who died overseas and who is to be cremated in Scotland. This means, for example, that the reviewer will check medical records to see if the individual has any implants or a pacemaker that would need to be removed prior to cremation. Medical referees at crematoria currently perform this function but this role will be abolished when the new system is introduced.

50. Anyone wishing to arrange the cremation of a body in such a case must apply to the medical reviewer. The form and content of the application and authorisation and any further procedure to be followed by medical reviewers may be specified in regulations by the Scottish Ministers.

Section 18: Post-mortem examination of person who died outwith United Kingdom
51. The persons listed in subsection (3) may apply to the medical reviewer for assistance, including financial assistance, to arrange a post-mortem examination in situations where the body of someone who died outwith the UK has been returned to Scotland for disposal. The
persons who can make an application under subsection (3) are the same persons who are entitled to authorise a post-mortem under sections 30, 32 or 33 of the Human Tissue (Scotland) Act 2006. An application may only be made under this section for the purpose of providing information about the cause of death where none is available. It will allow the small number of families in this position an opportunity to have the cause of death established.

**Other functions of medical reviewers**

*Section 19: Training and information functions*

52. This section sets out additional functions of the medical reviewer and senior medical reviewer. These are: collating and analysing information relating to medical certificates of cause of death; providing guidance, training and direct support to doctors and other healthcare professionals; providing guidance and support to district registrars in relation to certificates; and liaison with other individuals or bodies. The purpose of this is to improve the quality of medical certificates of cause of death and the administrative processes for dealing with the disposal of bodies.

*Section 20: Duty to co-operate*

53. The new system of scrutiny has to connect with agencies and systems in the NHS. The Common Services Agency, for example will provide statistical support services for the review system. This section provides that NHS Boards, the Common Services Agency for the Scottish Health Service and medical reviewers (including the senior medical reviewer) have a duty to co-operate with one another in connection with the review of medical certificates of cause of death, the information gathered and analysed and the administrative processes for the disposal of bodies.

*Section 21: Guidance*

54. This section requires medical reviewers (including the senior medical reviewer) to have regard to guidance issued by the Scottish Ministers in the exercise of their functions under the Act. Guidance can help to ensure consistency of approach, for example, in situations where medical reviewers (or the senior medical reviewer) may be exercising discretion.

*Section 22: Annual report*

55. This section requires the senior medical reviewer to prepare and publish an annual report for the Scottish Ministers on the activities of medical reviewers. The Scottish Ministers may by regulation make further provision for additional information to be included, for greater frequency of reporting, or to specify additional people who must receive copies.

**Fees**

*Section 23: Fees in respect of medical reviewer functions*

56. This section allows for a fee to be charged in two situations. One is a charge to cover the costs of the new system of scrutiny of medical certificates of cause of death including the associated statistical support provided by the Common Services Agency. This fee may be
charged to the personal representatives of the deceased and will be payable out of the deceased’s estate.

57. The other fee is for the application for authorisation to cremate the body of a person who died outwith Scotland. The medical reviewer has to determine whether it is safe to do so in such cases (section 17).

58. The Scottish Ministers may make regulations about the charging of fees, the arrangements for collection and any circumstances in which no fee is payable. When setting a fee they must have regard to the reasonable costs of the functions paid for by the fee.

**Disposal of bodies**

*Section 24: Prohibition on disposal of body without authorisation*

59. This section inserts a new section 27A into the 1965 Act making it an offence to dispose of the body of a still-born child or a deceased person without authorisation. The offence is committed by a person in charge of a place where the disposal of human bodies takes place, for example, a superintendent of a crematorium or burial ground. The Scottish Ministers may by regulation prescribe the types of documentation required and make provision for the form and content of such documents, except where these are already prescribed by the Registrar General. For instance, it is likely that in many cases one of the documents required will be the registration certificate issued by the district registrar.

60. The penalty for the offence is a fine not exceeding level 3 on the standard scale. When the offence has been committed by a body corporate, its officers can also be convicted.

61. Under subsection (4) a defence is available to a person charged with such an offence, if that person can prove that there was a reasonable excuse for disposing of a body without the relevant authorisation.

*Section 25: Certifying medical practitioner to provide additional information*

62. This section paves the way for replacing the current death certification system. It amends section 21(2)(a) and section 24(1) of the 1965 Act. These sections provide respectively for a prescribed still-birth certificate and the medical certificate of cause of death. They are amended to allow “any relevant medical information” to be added to the certificates. The purpose of this section is to widen the information that doctors may be required to provide on the still-birth certificate and medical certificate of cause of death. In relation to the latter, for example, this will allow a requirement to be added for certifying doctors to confirm that there are no implants requiring removal before cremation or that the body is not infectious. Medical reviewers will perform this task for bodies returned from outwith Scotland (see section 17). The function of checking for implants is performed by medical referees at crematoria. This role will be abolished with the setting up of the new system.
Section 26: Still-birth declarations

63. Section 26 repeals paragraph (b) of section 21(2) of the 1965 Act (still-births). This paragraph provides for a declaration that the child was not born alive and that no medical practitioner or midwife was present. Such cases will in future be referred to the procurator fiscal.

General

Sections 27-31

64. Sections 27 and 28 set out various general provisions.

65. Section 29 introduces Schedule 2.

66. Section 30 sets out definitions for key words and phrases. This includes the medical certificate of cause of death, the form used by the certifying doctor which gives details of the person who has died and the cause of death. It is these certificates that will be scrutinised by medical reviewers under the new system.

67. Section 31 provides for the short title and commencement.

Schedule 1

68. Schedule 1 amends Schedule 5A to the National Health Service (Scotland) Act 1978 in order to provide for the appointment of persons to carry out the functions of the medical reviewers and senior medical reviewer. Other members or employees of Healthcare Improvement Scotland are expressly prevented from exercising those functions.

69. The minimum qualification required for medical reviewers or the senior medical reviewer is to have been a medical practitioner for 5 years prior to appointment. The Scottish Ministers have the power to prescribe in regulations additional requirements for qualifications, training or experience.

70. The medical reviewer and senior medical reviewer functions may not be delegated. However, the senior medical reviewer is entitled, with the agreement of Healthcare Improvement Scotland, to arrange for one of the medical reviewers to carry out those functions if he or she is absent or unavailable. This would enable a deputy to cover for the senior medical reviewer during times of illness or annual leave, for example.

Schedule 2

71. Schedule 2 (which is introduced in section 29) makes consequential amendments to the 1965 Act by updating definitions in that Act to reflect the new system set out in the Bill and allowing doctors to sign a replacement medical certificate of cause of death. Section 21(5) and section 27(2) and (3) of the 1965 Act are repealed. Sections 21(5) and 27(3) require a person having charge of a burial ground to give notice to the registrar where a still-born child is buried without a still-birth certificate or a body is buried without a death certificate. In addition, section 27(2) requires a person to transmit the certificate of registration to the person in charge of the
place of interment or cremation. These sections are replaced with a new section 27A in the 1965 Act inserted by section 24.

72. The Cremation Act 1902 (c.8) is also amended to prevent an overlap of offence provisions between section 8 of that Act and the new section 27A(1) of the 1965 Act.

FINANCIAL MEMORANDUM

INTRODUCTION

73. This document relates to the Certification of Death (Scotland) Bill introduced in the Scottish Parliament on 7 October 2010. It has been prepared by the Scottish Government to satisfy Rule 9.3.2 of the Parliament’s Standing Orders. It does not form part of the Bill and has not been endorsed by the Parliament.

74. The Bill will introduce a new death certification system which will aim to:

- introduce a single system of independent, effective scrutiny applicable to deaths that do not require a Procurator Fiscal investigation;
- improve the quality and accuracy of the medical certificate of cause of death (MCCD);
- provide improved public health information and strengthened clinical governance in relation to deaths.

75. While the events surrounding the Harold Shipman case were the original driver for change in systems of death certification throughout the UK, no death certification system is able to guarantee that the kind of criminal activities carried out by Shipman could be prevented. Instead, the proposed new system covers only those cases which are not investigated by the Procurator Fiscal Service and therefore not within the scope of the criminal justice authorities. As such, it focuses on the aims outlined above, although in doing so it will establish arrangements which should also act as a deterrent to criminal activity or malpractice.

76. The Bill provides for the newly created positions of Medical Reviewers (MRs) (referred to in consultation documents as Medical Investigators); these will be doctors who will perform the scrutiny role. MRs will also be given the power to assist persons to make arrangements for a post mortem examination (including meeting the cost of the examination) in such cases where a death has occurred abroad, where the cause of death is unknown and disposal is to take place in Scotland. In addition, the MRs will have a role in checking the paperwork for implants for bodies from outwith Scotland where the chosen method of disposal is cremation, as the posts of medical referees who currently perform this role will be abolished.

DEATH CERTIFICATION

The Medical Reviewer Model
77. The new death certification model will remove current inconsistencies between the processing and scrutiny of cremations and burials and will streamline procedures. Following consultation and stakeholder engagement, the new system will have a strong focus on education and training for doctors, as well as on changing the culture relating to death certification within the NHS in Scotland.

78. MRs will scrutinise around 500 randomly selected deaths per year as part of an audit cycle of activity by examining the MCCD form, speaking to the certifying doctor and other relevant healthcare professionals and reviewing medical records. They may also speak to relatives, if required, and (arrange to) view the body in rare cases. In addition, persons with a legitimate interest, for example, funeral directors, or relatives, may refer cases for scrutiny to the MRs. This is referred to as an ‘interested person review’ and is expected to lead to at least a further 500 deaths annually being reviewed. The Policy Memorandum sets out in more detail the ability of MRs to conduct further checks as issues arise and also details the relationship between the MRs and NHS Boards’ clinical governance systems.

79. The proposed role of a national statistician is a critical part of the MR model. The production of national statistics will underpin the scrutiny function. It will allow the analysis of national trends and unusual patterns of activity, and it will identify through close working with the MRs, further cases for review. Important links can then be made from this information to the clinical governance processes of Health Boards.

80. MRs will also directly support certifying doctors in making decisions in relation to death certification through, for example, phone support as well as offering on- and off-the-job training of doctors and other healthcare professionals. MRs will support and guide registrars where information provided on MCCDs is inaccurate, incomplete or requires further inquiry.

81. The Bill also proposes to establish a Senior MR (SMR) with a national strategic role involving professional leadership, national education and training support, management of the MRs, providing a second opinion, liaison with the Crown Office and Procurator Fiscal Service (COPFS) and the Chief Medical Officer, and Continuing Professional Development (CPD) and revalidation.

COSTS ON THE SCOTTISH ADMINISTRATION

82. These costings are based on assumptions made of likely workload and tasks initially agreed by an independent Review Group which met between 2005 and 2007.1 Assuming that 500 cases are sampled and a further 500 are referred for investigation (“interested person reviews”) this would mean that around 1,000 deaths would be scrutinised annually, around 19-20 cases per week. It is estimated that reviewing a single case would take an MR around half a working day. However, clearly the number of cases referred by an “interested person” or district registrar will vary. There is some spare capacity within the model, to also cover additional scrutiny initiated by MRs and the costings will allow for this.

1 Information about the Burial and Cremation Review Group is available on the Scottish Government website: http://www.scotland.gov.uk/Topics/Health/burialcremation/intro. It submitted a report to the Scottish Government which was published in 2008 which is also available on the Scottish Government website: http://www.scotland.gov.uk/Publications/2008/03/25113621/0.
83. The Review Group report recommended that four individuals should be appointed with one assuming a management role (a separate SMR role was not envisaged by the Review Group). However, the Scottish Government has since consulted extensively on the proposals and has put forward the strengthened scheme described in the Policy Memorandum. Additional functions are now proposed for the MRs as follows:

- to perform additional checks in the light of information gathered by the national statistician, where MRs believe further scrutiny is required e.g. at regional, hospital, practice or individual level (up to 100% of deaths if required);
- to directly support certifying doctors in taking responsibility for making effective decisions in relation to death certification through, for example, phone support;
- to directly support registrars in assessing the quality and accuracy of MCCDs;
- to offer ‘on-the-job’ and/or ‘off-the-job’ education and training of doctors and other healthcare professionals.

84. Our consideration of the numbers of MRs that require to be appointed has taken into account these proposed additions to their role. If the original numbers (four) were retained, each MR would be required to deal with five or so detailed cases per week. If, as estimated, around half a day would need to be spent on each case, each MR would have around two days a week remaining for: conducting additional targeted scrutiny; giving more general guidance; and fulfilling an education and training role. The caseload may increase at times and at other times the advice and guidance and education roles may require more time. Furthermore, the additional retrospective scrutiny could take a considerable portion of time leaving little scope for an advice and guidance role. Account must also be taken of sickness, leave commitments and the time each MR will require to devote to continuing professional development, to duties related to appraisal and revalidation and to reports to/liaison with the SMR and the regional MRs.

85. To account for this, the costings allow for six MR posts. This will also provide greater flexibility, more speedy response times and ensure that each MR has a reasonably sized territorial patch. It has been estimated that this number would allow around three days per week for conducting additional focussed scrutiny and the other functions set out above. It would also allow some additional flexibility if the number of ‘interested person reviews’ increased beyond those expected.

86. The number of MRs would not appear in legislation and it is expected that proposed test sites will provide further information about the exact number required. These costs are therefore estimates at present and will ultimately depend on the number of MRs appointed.

87. The associated cost would not necessarily rise linearly with sample size, due to the flexibility between review and training time incorporated into the model, due to non-linear changes in the travel cost and transport charges, and due to possible economies of scale arising from conducting more than the currently assumed number of reviews per week. Each added MR post (including an additional medical assistant) would increase the start-up costs by approximately £2,500 and the annual costs by £151,124, made up of salary and on-costs for the MR and the medical assistant, as well as IT and telephony running costs.
88. The start-up costs (c. £94,500) (see Table 1) will be funded from Scottish Government Health Directorate budgets and are therefore subject to a bid in the next Spending Review expected in autumn 2010.²

89. The costs for the strengthened MR model, based on six MRs and assistants and a SMR, are summarised in Table 1 below (this excludes costings for test sites).

*Table 1 Recurring and Start-up Costs of Medical Reviewer Model (exc Test Sites)*

<table>
<thead>
<tr>
<th></th>
<th>Recurring</th>
<th>Start-up*</th>
<th>TOTAL</th>
</tr>
</thead>
<tbody>
<tr>
<td>Analytical staff</td>
<td>£74,579</td>
<td>£0</td>
<td>£74,579</td>
</tr>
<tr>
<td>Medical staff</td>
<td>£903,345</td>
<td>£0</td>
<td>£903,345</td>
</tr>
<tr>
<td>Support staff</td>
<td>£149,568</td>
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<td>£149,568</td>
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<tr>
<td>SUB TOTAL</td>
<td>£1,127,492</td>
<td>£0</td>
<td>£1,127,492</td>
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<tr>
<td>Total running costs</td>
<td>£61,564</td>
<td>£0</td>
<td>£61,564</td>
</tr>
<tr>
<td>Accommodation</td>
<td>£0</td>
<td>£20,017</td>
<td>£20,017</td>
</tr>
<tr>
<td>IT changes &amp; support</td>
<td>£0</td>
<td>£7,000</td>
<td>£7,000</td>
</tr>
<tr>
<td>GRO promotional costs</td>
<td>£0</td>
<td>£10,000</td>
<td>£10,000</td>
</tr>
<tr>
<td>Development of training module</td>
<td>£0</td>
<td>£57,500</td>
<td>£57,500</td>
</tr>
<tr>
<td>TOTAL</td>
<td>£1,189,056</td>
<td>£94,517</td>
<td>£1,283,573</td>
</tr>
</tbody>
</table>

*Start-up costs currently do not include recruitment costs. These can be non-linear depending on the number of posts advertised (multiple posts announced in one advertisement) and can range anywhere between £2,000 and £20,000.

Analytical Staff

90. The costs for the analytical staff (national statistician and assistant) are based on 2010 Agenda for Change pay scale averages³ for Band 5 and Band 7 (statisticians).

Medical Staff

91. The costs for the medical staff (MRs) are based on an assumption that they are paid at the upper end of a consultant’s salary scale at £100,500, amounting to £603,000 for six MRs (plus on-costs).⁴ The SMR cost is estimated at the top end of a consultant salary plus a management allowance, estimated at a total of £120,000.

Support Staff

92. The costs for the support staff are based on the 2010 Agenda for Change pay scale for a Band 3 officer.⁵ The total annually recurring salary costs associated with this model are therefore based on one national statistician, one statistical assistant, seven MRs (including the SMR) and seven medical administrative assistants, also accounting for 25% on-costs (NI contributions and pension provisions) over and above the salary costs.

² The estimated financial costs are at 2010-11 price levels.
³ http://www.sehd.scot.nhs.uk/pcs/PCS2010(AFC)02.pdf
⁴ ASDHD workforce team estimates.
⁵ http://www.sehd.scot.nhs.uk/pcs/PCS2010(AFC)02.pdf
Provision For On-Costs

93. Total running costs are made up of document transit; travel claims incurred from MRs travelling to and from inspections; and other IT and telephone running costs. Estimates of potential courier costs arising from having to send MCCD forms and medical records between the MRs and the registrars have been derived in consultation with Scottish Government courier contractors. A maximum charge per death of £10.98 has been applied to the sample of 1,000 to give a cost of £10,980 (although this can be expected to be at the upper end of the actual cost, with shorter distances being less costly).

94. To arrive at an estimate for the cost of travel claims submitted by MRs, the sample of 1,000 cases was distributed proportionately across Scottish administrative areas, given the number of deaths in each area in 2009. Each administrative area was divided into either urban and accessible rural or rural (under the Scottish Government’s 6-fold urban rural classification). Average travel distance in urban and accessible rural areas was assumed to be 15 miles per single journey; with 30 miles assumed for rural areas, based on Scottish Transport Statistics. Applying a £0.40 mile compensation figure (Scottish Government mileage rate) to these estimated number of miles claimed per annum gives a total annual cost of approximately £16,984.

95. IT and telephone costs per employee were provided by Scottish Government IT services and are estimated at £2,100 per annum. For 16 employees, the total annual IT and telephone costs are therefore estimated at £33,600.

96. Total running costs, including courier costs, travel claims and IT and telephone costs, are estimated at £61,564 per annum.

Accommodation

97. The two statisticians (the national statistician and statistical assistant) will be based at Information Services Division (ISD), a division of NHS National Services Scotland (NSS). They are expected to be accommodated at ISD within existing premises at no extra cost.

98. The MRs and their assistants will be employed by Healthcare Improvement Scotland (HIS) which was established through the Public Services Reform (Scotland) Act 2010 and will operate from April 2011. The base/location of the MRs is currently under discussion, but it is considered that these posts will be mobile, given the territorial area covered by each MR. It is hoped the MRs can be located within existing premises with no additional costs for buying or leasing out premises, the only costs incurred being running costs such as IT, electricity, furniture, etc. Physical location costs (rent etc.) are therefore not included. Initial start-up accommodation costs (furniture, IT equipment, etc.) have been estimated at £1,251 per full-time employee. For the six MRs plus one SMR, seven assistants and the analytical staff this would amount to £20,017 in Year 1.

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7 http://www.scotland.gov.uk/Topics/Statistics/Browse/Transport-Travel/TablesPublications/ScottishTransportStats
IT Changes And Support

99. Under the new system the format of death certificates (also known as MCCD forms or Form 11) would be changed to incorporate a unique identifier code for each doctor certifying deaths and will include questions on implants and public health. A cost to the General Register Office for Scotland (GROS) is involved in making this change to the forms, and in changing the GROS computer system used by registrars to capture the registration data. There would also potentially be a cost in updating the database at ISD in order to receive and hold the additional information. It is estimated that reprinting the MCCD to take account of any changes would cost GROS about £6,000.

100. In addition, the GROS vital events database, a system used for statistical outputs and analysis and based on the information held on the registration database, would need to be amended to include the unique identifier. It is expected that the cost of this would be in the order of £1,000 bringing the total costs for IT changes and support to £7,000.

Promotional Costs

101. There will be an additional expense to provide for materials to alert doctors and other stakeholders such as funeral directors and the public about the changes. It is expected that these materials will be placed within registrar offices. In a recent Regulatory Impact Assessment on sunbed regulations it was estimated that the issuing and distribution of leaflets and posters cost no more than £10,000. After initial distribution, information materials will be available on designated websites to download.

Training And Development

102. Training needs will vary in different phases of the programme. In the first phase after the inception of this model, the MR posts are likely to be filled by experienced specialists, such as those currently filling the position of medical referees. During this phase only additional training through an e-Learning module (£57,500) will be required to top-up the MRs’ skills set.

103. It is expected that after approximately seven years a second phase will commence. This will coincide with new teaching cycles (with updated modules on the medical reviewer model) for training GPs and other specialists, who would form a pool of second or third generation of designated specialists (MRs) after a few years’ experience of practice. After about 10 years, a third phase is envisaged in which the first group of MRs will begin to be replaced by new doctors, in turn requiring top-up e-Learning training.

104. Initial costs for the introduction of an e-Learning module for MRs will consist of the salary costs of the specialists writing the module and, principally, for the technology development, design and management of the module. Based on the costs of the development of the Department of Health’s e-Learning module for Medical Examiners (the England and Wales equivalent of Medical Reviewers) and past experience in Scotland, such as development of the mental health module and the e-Learning programme for the delivery of services in secure accommodation, this has been costed at around £50,000-£65,000 (a mid-way point of £57,500 is

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8 Public Health etc (Scotland) Act 2008 (Sunbed) Regulations 2009
http://www.scotland.gov.uk/Publications/2009/06/23100211/0
These documents relate to the Certification of Death (Scotland) Bill (SP Bill 58) as introduced in the Scottish Parliament on 7 October 2010

used in the financial model). The recurring cost of training with this module is assumed to be low as there will be no accommodation or teaching costs.

105. The backfill cost associated with GPs (or other doctors) spending time on a training module rather than at work constitutes an opportunity cost of time allocation, which is discussed further in the Cost Benefit Analysis (CBA) but is not incorporated into the financial model. It is estimated that the time requirement will be in the order of two days of a consultant’s time.

106. Over time it is expected that the training programme will produce a number of experienced professionals who could become MRs, probably from the third generation of MRs onwards. In line with the backfill costs, these training programme costs are treated as economic costs and are therefore accounted for in the CBA but not in the financial model. The economic costs which will arise for three years in each 10-year training cycle would consist of GP Registrar salaries and out-of-hours pay and it is assumed that these costs would also arise if the group of GP Registrars in each cohort was trained for any other specialism.

Recouping the Costs Of The New System

107. The initial set-up costs of the new system, estimated at c.£94,500, will be paid by the Scottish Government and subject to a Spending Review bid. However, it is proposed that the annual running costs of operating the new arrangements should be self-funding through the charge of a fee to the public.

Current Fee Arrangements

108. A fee is currently charged to bereaved families (or whoever arranges a funeral) by the doctors signing off certificates authorising cremation of the body. This fee, which goes to two doctors, amounts to £147 per cremation. It is paid as a private financial transaction between the family and the authorising doctors – funeral directors often act as intermediaries by paying the fee to the doctors (which allows them to secure the necessary certificates and proceed with the cremation) and then recoup the fee from the bereaved family when they invoice the relatives for their services.

109. In addition, when a body is cremated a third doctor, the medical referee at the crematorium, performs the final check on the papers. The cremation authority pays the medical referee a fee which is recouped through the cremation fee which is charged by the authority to the nearest relative. This charge appears on the funeral director bill as part of the funeral arrangements. Cremation authorities separately pay the medical referee a fee for their services (this varies, dependent on local decisions).

110. There are currently 26 crematoria, with around 114 medical referees or deputies. Medical referees are regarded as self employed and are approached through their medical practice to become medical referees. The cremation or burial authority will then approach a medical referee from their pool of referees on an ‘as and when’ basis and pay them accordingly.

Proposed Future Fee Arrangements
111. There are two options for financing the recurring annual costs of the new arrangements: by charging a fee per disposal to recover the full costs incurred or by identifying a budget from public funds via the Spending Review process.

112. Whilst the Review Group did not propose that a fee should be charged, economic circumstances have changed since 2005 and the wider financial constraints under which the public sector operates have led Scottish Ministers to conclude that a small, universal fee should be introduced to fund the new death certification system, principally the MRs’ role to carry out the review functions (and related national statisticians’ function).\(^9\)

113. The existing fee is inequitable in so far as it applies to cremations but not to burials, and the current arrangements are not regarded as having resulted in necessary improvements to scrutiny. The new fee would be fairer by applying to all disposals (cremations and burials) and would fund improved scrutiny and improvements in clinical governance related to death certification. This fee is estimated at a much lower rate than the fees currently paid by relatives for cremations. Therefore, for the majority (around 60%) of families in Scotland who currently opt for cremation, there will be a significant saving. The fee will be payable by the personal representatives of the deceased and will be treated as part of the general testamentary and administration expenses of the estate.

114. The fee is estimated at around £22.00, with an additional element to cover the costs of collection (see paragraph 117. below). The fee collection cost is estimated not to exceed £8-£10 per fee and it may be considerably less than this. Under both options the fee level would be set centrally by the Scottish Government and varied according to the number of deaths in the previous year and on longer-term trends. Any increase in estimated running costs would of course also have a direct impact on the proposed level of fee.

115. Indicative fee levels have been calculated assuming 53,856 deaths per annum (based on 2009 deaths in Scotland, GROS 2010). The level of fee will be determined using the principles of full cost recovery; this assumes that no subsidy will be provided against the recurring costs. Year 1 is likely to be 2013-14.

116. As fees will be based on estimated costs, there is a residual risk in any one year that fees collected may not be sufficient to offset the total costs incurred. Any resulting deficit would fall to be met from existing Scottish Government Health budgets. A deficit may arise, for example, if the number of deaths is significantly below projections, if less than 100% of fees is collected or if unanticipated cost pressures emerge during the year. Similarly, a surplus could arise in any given year. If the number of deaths declines, the greater the fee-per-death required to recoup costs. Deaths have been steadily declining – by 10.7% since 1999, in line with a slight decrease in the death rate (from 1.19% of population in 1999 to 1.04% in 2009). The number of deaths in Scotland is currently projected to decline by a further 3.3% until 2017-18 (52,100 deaths) and to then increase again to 59,600 deaths in 2032-33, taking into account projected changes in the

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\(^9\) Including for where MRs will check the necessary paperwork in relation to a death occurring outwith Scotland where the body is to be cremated in Scotland to ensure safe disposal (implants etc).
population size.\textsuperscript{10} To ensure consistent application of the principle of full cost recovery, the level of the fee would be subject to annual review and adjusted through secondary legislation.

117. Administrative options for collection of the fee are currently being developed and the preferred option will require to be detailed in secondary legislation. It is anticipated that it will be necessary to pay those collecting the fee an administration charge to cover the costs of collection. Such charges in other areas are around 10-20\% of the fee incurred.

\textbf{Medical Examiner System In England And Wales}

118. At the time of writing England and Wales are in the early stages of developing options for fee collection for their Medical Examiner system.

\textbf{Transitional Arrangements}

\textit{National Statistician And Assistant}

119. Full implementation of the new system would begin in 2013-14 at the earliest. However, to deliver an immediate improvement in the information available to NHS Boards and the Scottish Government, the national statistician could begin statistical work immediately following the passage of the primary legislation, i.e. from 2011-12. The costs associated with employing the national statistician and an assistant would fall to be met from the Scottish Government’s Health and Wellbeing budget until the full model is implemented.

120. The associated costs would be included in a Spending Review bid as set out in Table 3 below. The budgeted costs of £81,282 per annum on 2010-11 pay scales do not include recruitment costs. HR advice is that these costs vary widely depending on the type of post, the ability to advertise for multiple posts in one announcement, the breadth of media used and any special offers at the time - a broad range of £2,000-£20,000 has therefore been quoted.

\textbf{Test Sites}

121. Provided that primary legislation is completed in the 2010-11 legislative session, secondary legislation may be consulted on and go through the Scottish Parliament in 2011-12. Stakeholders agree that a further transitional period of at least one year would then be required to have small test sites for the new system to trial how the process works in practice. Two test sites in two different areas of the country are anticipated which would offer a comparison between rural and urban populations. Test sites would be expected to run during 2012-13 for six months to allow for evaluation before full implementation in 2013-14. Alternatively, test sites could run in parallel with the development of secondary legislation and guidance.

122. Table 2 below summarises the estimated costs associated with the test.

\textsuperscript{10} ASD calculations based on GROS projected deaths \url{http://www.gro-scotland.gov.uk/statistics/publications-and-data/popproj/projected-population-of-scotland-2008-based/list-of-tables.html}
Table 2 Test Sites Summary Costs 2012-13

<table>
<thead>
<tr>
<th>Cost Description</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Staff costs</td>
<td>£73,462</td>
</tr>
<tr>
<td>Advertising costs</td>
<td>£1,000</td>
</tr>
<tr>
<td>Evaluation costs</td>
<td>£15,000</td>
</tr>
<tr>
<td>Running costs*</td>
<td>£10,712</td>
</tr>
<tr>
<td>Initial accommodation costs</td>
<td>£2,502</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td><strong>£102,676</strong></td>
</tr>
</tbody>
</table>

* Running costs include transport cost; travel expenses; IT and telephone charges for staff.

123. A bid for the test sites would be included in the next Spending Review. The costs of the test sites are approximately made up as follows: staff costs for two part-time (0.5 FTE) MRs and two assistants for six months (£73,462); advertising costs for initially affected registrar offices (£1,000); evaluation (£15,000 - this is based on previous evaluation expenditure); running costs including document transit / transport (up to £5,000), with the remainder being available for incidental costs including administrative and running costs (around £5,700); and accommodation costs. The costs of the test sites would not be recouped through the fee as these are one-off costs and apply to the test sites period only.

124. While GROS will bear the estimated £1,000 cost of printing addendum forms required for the MCCD forms during the test sites phase, there would be an indirect cost to registrars arising from the additional time spent on registering a death as well as general administrative costs, including the testing of desk instructions for registrars in the test sites areas. It is difficult to place a precise estimate on these costs. However, applying the administrative costs of the MR model to the staff requirements for the test sites would give a figure of around £4,200. This estimate may increase to cover any expenses for materials to alert doctors and others (e.g. funeral directors) about the test sites. These ‘promotional’ costs are currently estimated at £1,000.

125. Project management responsibilities for the test sites are expected to be covered within existing staff resources within the Scottish Government.

126. During the test sites a draft e-Learning module would be available and it is expected that the national statistician will have been appointed by that stage. The e-Learning costs make up the predominant share of the start-up costs of the new death certification model, currently assumed to fall in Year 1 of implementation. Since these would not have to be renewed for the actual programme, they would ‘pre-empt’ a large part of the (£94,500) start-up costs.

127. Table 3 below shows when individual costs will occur, with the national statistician costs being incurred first, followed by the costs of the test sites (the running costs comprise of transport and administrative costs), before full introduction from 2013-14. The fee is set to cover the annual costs from 2013-14 onwards - it will not offset any costs incurred during 2011-2013.
These documents relate to the Certification of Death (Scotland) Bill (SP Bill 58) as introduced in the Scottish Parliament on 7 October 2010

Table 3 Year-on-Year Costs of Medical Reviewer Model (inc test sites)

<table>
<thead>
<tr>
<th></th>
<th>2011-12 Inception phase</th>
<th>2012-13 Including Test sites</th>
<th>2013-14 1st year of implementation</th>
<th>2014-15+ 2nd year onwards</th>
</tr>
</thead>
<tbody>
<tr>
<td>Analytical staff (statisticians)</td>
<td>£74,579</td>
<td>£74,579</td>
<td>£74,579</td>
<td>£74,579</td>
</tr>
<tr>
<td>Medical staff</td>
<td>£0</td>
<td>£62,779</td>
<td>£903,345</td>
<td>£903,345</td>
</tr>
<tr>
<td>Support staff</td>
<td>£0</td>
<td>£10,683</td>
<td>£149,568</td>
<td>£149,568</td>
</tr>
<tr>
<td>SUB TOTAL</td>
<td>£74,579</td>
<td>£148,041</td>
<td>£1,127,492</td>
<td>£1,127,492</td>
</tr>
<tr>
<td>Total running costs</td>
<td>£4,200</td>
<td>£14,912</td>
<td>£61,564</td>
<td>£61,564</td>
</tr>
<tr>
<td>Test sites evaluation costs</td>
<td>£0</td>
<td>£15,000</td>
<td>£0</td>
<td>£0</td>
</tr>
<tr>
<td>Initial Accommodation</td>
<td>£2,502</td>
<td>£2,502</td>
<td>£15,013</td>
<td>£0</td>
</tr>
<tr>
<td>IT changes &amp; supports</td>
<td>£0</td>
<td>£0</td>
<td>£7,000</td>
<td>£0</td>
</tr>
<tr>
<td>GRO promotional costs</td>
<td>£0</td>
<td>£1,000</td>
<td>£10,000</td>
<td>£0</td>
</tr>
<tr>
<td>Development of training module</td>
<td>£0</td>
<td>£57,500</td>
<td>£0</td>
<td>£0</td>
</tr>
<tr>
<td>TOTAL</td>
<td>£81,281</td>
<td>£263,955</td>
<td>£1,221,069</td>
<td>£1,189,056</td>
</tr>
</tbody>
</table>

Estimated FEE to cover costs (exc costs of fee collection) £22.08

Table 4 Year-on-Year Costs of Medical Reviewer Model (exc test sites)

<table>
<thead>
<tr>
<th></th>
<th>2011-12 Inception phase</th>
<th>2012-13 Excluding Test sites</th>
<th>2013-14 1st year of implementation</th>
<th>2014-15+ 2nd year onwards</th>
</tr>
</thead>
<tbody>
<tr>
<td>Analytical staff (statisticians)</td>
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<td>£74,579</td>
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<td>£903,345</td>
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</tr>
<tr>
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<td>£0</td>
<td>£149,568</td>
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<td>SUB TOTAL</td>
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<td>£1,127,492</td>
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</tr>
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<td>Development of training module</td>
<td>£0</td>
<td>£57,500</td>
<td>£0</td>
<td>£0</td>
</tr>
<tr>
<td>TOTAL</td>
<td>£81,281</td>
<td>£132,279</td>
<td>£1,221,069</td>
<td>£1,189,056</td>
</tr>
</tbody>
</table>

Estimated FEE to cover costs (exc costs of fee collection) £22.08

128. Table 4 below shows when individual costs will occur, with the national statistician costs being incurred first, without the costs of the test sites. Again, the fee is set to cover the annual costs from 2013-14 onwards - it will not offset any costs incurred during 2011-2013.
COSTS ON LOCAL AUTHORITIES

129. Indirect costs to local authorities comprise of raising staff awareness and training on the new death certification system and the impact of scrutiny on bereaved families. Specifically, desk instructions for registrars will be required as it will be registrars who bereaved relatives will come into contact with first in relation to the new scrutiny system (selection for random sampling, whether they understand and are content with the cause of death on the MCCD form etc.). General material about the new scrutiny system which explains its purpose and where it sits in relation to the death certification process is also required, not least for public reassurance. However, the cost of these materials would be borne by the Scottish Government.

COSTS ON OTHER BODIES, INDIVIDUALS AND BUSINESSES

130. As part of the new system, changes are being considered to the MCCD form to include medical information about surgical implants and the presence of any disease that might pose a risk to public health. Certifying doctors would in future be required to provide this information. This would facilitate the safe handling of the body and ensure the body can be safely cremated (in the case of implants). These changes are likely to be necessary because under the new model the existing cremation documentation (and the associated fees payable to doctors and to medical referees) will be removed. The MCCD is currently completed by hospital doctors and GPs as part of their routine duties free of charge and the proposed changes to the form are not expected to change this.

131. For the new system to work effectively as a deterrent, clinicians and other healthcare practitioners will need to know about the activities and powers of the MRs and national statistician. Effective publicity and awareness raising among the medical and wider health as well as other relevant professionals is therefore crucial and plans to embed these into existing documentation, training and publicity will be developed as the Bill moves through Parliament and beyond. The financial implications are costed through the training elements in the start-up costs as well as this being part of the job description of the MRs and the SMR.

132. Table 5 below summarises the year-on-year costs including the costs of the test sites to the Scottish Government and all others.

<table>
<thead>
<tr>
<th>Year-on-Year Costs of Medical Reviewer Model (inc test sites) to the Scottish Government, Local Authorities and Other Bodies, Individuals and Businesses</th>
</tr>
</thead>
<tbody>
<tr>
<td>Costs to SG</td>
</tr>
<tr>
<td>Costs to LAs, other bodies, individuals and businesses</td>
</tr>
</tbody>
</table>

SAVINGS

133. The Scottish Government does not anticipate any direct savings as a result of implementing a new death certification system.
134. Currently, people opting for cremation pay cremation fees for the statutory forms but these fees are paid to doctors outwith their NHS duties. The forms and fee will be abolished under the new system. In Scotland approximately £4.9m was incurred for cremation fees in 2008, paid by bereaved families. Any reduction in such payments would represent a reduction in opportunity costs to bereaved families, rather than direct savings to the Scottish Government.

135. Indirect savings are expected through a reduction in administrative burden on registrars and certifying doctors as the number of forms required will be reduced and a simplified unified system is introduced. Funeral directors and crematoria directors/managers will no longer have to collect and process fees for the crematoria referees. Equally there will be savings to crematoria authorities who will not need to have medical referees (who perform checks of cremation forms signed by two separate doctors) and their support staff.

DEATHS ABROAD

COSTS ON THE SCOTTISH ADMINISTRATION

136. Under the new system MRs would be empowered to assist persons in arranging a post mortem (including meeting the cost of the examination) in certain cases where a death has occurred abroad, cause of death is not known and disposal is to take place in Scotland. This will support relatives whose family member is repatriated and where currently families have to arrange and pay for post mortems privately.\(^{11}\) This will end the discrepancy between Scotland and England and Wales where Coroners have powers to instruct post mortems in such cases.

137. An estimated annual maximum of 25 deaths abroad do not have a clear cause of death and could therefore potentially fall into this category. The costs would be up to £12,500 annually and this cost would ultimately be borne by the Scottish Government and not recouped through the fee. The assumptions behind the figures are as follows:

138. The current costs of a post mortem for non suspicious deaths, for the purpose of establishing a primary cause of death, is up to £500 at the University of Dundee’s Pathology Department. This £500 figure is an inclusive figure covering minor consumables and other minor technician and secretarial expenses. The University of Dundee is one of the four centres in Scotland providing post mortem services for the PF (the other three centres are Edinburgh, Glasgow and Aberdeen Pathology Departments).

139. The annual figure of 25 deaths abroad which may request a post mortem has been derived from Scottish Government records, which show that 95 overseas cremation cases were dealt with in 2009. The numbers for the previous five years were:

- 2008 - 128 cases
- 2007 - 143 cases

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\(^{11}\) The persons who can make an application to the MR are the same persons who are entitled to authorise a post mortem under sections 30, 32 or 33 of the Human Tissues (Scotland) Act 2006; an application to the MR can only be made for the purpose of providing information about the cause of death where none is available.
• 2006 - 131 cases
• 2005 - 114 cases
• 2004 - 133 cases.

140. These statistics point to an average of around 130 requests a year for cremation authorisations resulting from repatriation of Scots who have died abroad. There are no statistics on the total number of annual repatriations (i.e. burials and cremations) but assuming the 40/60 split between burial and cremation in Scotland applies also to deaths of Scots abroad, one can estimate a total of around 250 deaths per year requiring repatriation for a funeral service. Based on our experience of dealing with those being cremated, in around 10% of these cases the primary cause of death will not have been established. This means that there would be around 22 deaths (rounded up to 25) which would potentially fall into this category.

COSTS ON LOCAL AUTHORITIES

141. There will be no costs on local authorities as a result of this Bill.

COSTS ON OTHER BODIES, INDIVIDUALS AND BUSINESSES

142. There will be no costs on other bodies and businesses – the costs of the post mortems will initially be met by medical reviewers (who are part of HIS) but would ultimately be borne by the Scottish Government.

SAVINGS

143. The Scottish Government does not anticipate any savings to the public purse as a result of implementing these proposals. Bereaved families will benefit as they currently pay for a post mortem in these circumstances.

MARGINS OF UNCERTAINTY

144. Where, appropriate, any margins of uncertainty are set out above in each section where they occur.
EXECUTIVE STATEMENT ON LEGISLATIVE COMPETENCE

145. On 7 October, the Cabinet Secretary for Health and Wellbeing (Nicola Sturgeon MSP) made the following statement:

“In my view, the provisions of the Certification of Death (Scotland) Bill would be within the legislative competence of the Scottish Parliament.”

PRESIDING OFFICER’S STATEMENT ON LEGISLATIVE COMPETENCE

146. On 5 October, the Presiding Officer (Rt Hon Alex Fergusson MSP) made the following statement:

“In my view, the provisions of the Certification of Death (Scotland) Bill would be within the legislative competence of the Scottish Parliament.”
CERTIFICATION OF DEATH (SCOTLAND) BILL

POLICY MEMORANDUM

INTRODUCTION

1. This document relates to the Certification of Death (Scotland) Bill introduced in the Scottish Parliament on 7 October 2010. It has been prepared by the Scottish Government to satisfy Rule 9.3.3(c) of the Parliament’s Standing Orders. The contents are entirely the responsibility of the Scottish Government and have not been endorsed by the Parliament. Explanatory Notes and other accompanying documents are published separately as SP Bill 58–EN.

BACKGROUND

2. In 2005 it was agreed that Scotland’s burial and cremation legislation required updating as much of it was over 100 years old and did not reflect 21st century life. This coincided with a need to examine the processes governing death certification following the inquiry into the case of Dr Harold Shipman. Following the publication of the Shipman Inquiry’s Third Report in June 2003, an independent review group was established in January 2005 by the then Scottish Executive to bring forward recommendations on the law relating to burial, cremation and death certification.

3. The Review Group produced a report in October 2007 which was published in April 2008. The Scottish Government consulted on the report’s recommendations early in 2010. The Scottish Government has given priority to introducing legislation on the aspects of the report relating to death certification, with the remaining aspects related to burial and cremation to be introduced at a later date.

4. The UK Government has also updated its legislation in relation to death certification. Primary legislation has been passed by the Westminster Parliament (the Coroners and Justice Act 2009) and further work, including pilots, is underway. Secondary legislation outlining the detail of the new system to be established in England and Wales is expected to be brought forward next year.

Current Arrangements

5. The following flow chart (Figure 1) and paragraphs set out the current arrangements for death certification in Scotland.
Figure 1 - Current Process

Description of Current Arrangements

6. When a person dies, a doctor will usually certify cause of death and produce a Medical Certificate of Cause of Death (MCCD) form (otherwise known as a Form 11).

7. This MCCD has three purposes:

- The first is the legal requirement to record the fact and cause of death and information on the deceased to enable disposal of the body to take place;
This document relates to the Certification of Death (Scotland) Bill (SP Bill 58) as introduced in the Scottish Parliament on 7 October 2010

- The second is to enable the registration of the death by a Registrar of Births, Deaths and Marriages (hereafter "a registrar"); and
- The third is to provide information on the cause of death which may be used for the purposes of national statistics on mortality.

The Procurator Fiscal

8. In cases where the doctor cannot certify or if the death falls into certain categories of deaths that must be enquired into then the death will be reported to the Procurator Fiscal (PF) for investigation, including a post mortem (or in some cases a type of post mortem referred to as a ‘view and grant’) if required. The PF has a duty to investigate all sudden, suspicious, accidental, unexpected and unexplained deaths and any death occurring in circumstances that give rise to serious public concern. Once the investigation is complete, the body is released with Form E1 which allows for the body to be cremated if that is the chosen method of disposal.

Registration of Death

9. The MCCD can only be completed by a registered medical practitioner. The MCCD must be presented within 7 days of the death to a suitably qualified informant, such as a relative of the deceased. That person has a statutory obligation, within 8 days of the death, to inform a registrar to enable the death to be registered. The registrar will then issue an Extract of an Entry in a Register of Deaths (commonly called a ‘death certificate’). This Extract is legal proof of the death. These arrangements are governed by the Registration of Births, Deaths and Marriages (Scotland) Act 1965 (the 1965 Act). It is a legal requirement to register a death and there are statutory penalties which can be imposed for failure to do so.

10. For deaths in Scotland, it is currently a requirement under the 1965 Act that any registered medical practitioner who was in attendance on the deceased during his/her last illness has a duty to complete the MCCD. Following the move to practice based patient lists with the Primary Medical Services (Scotland) Act 2004 and GP practices withdrawing from the responsibility for out-of-hours arrangements, in most areas it would be expected that a medical practitioner from the patient’s practice would be asked to sign the certificate, although any registered practitioner could, subject to adequate information such as the case notes, make a decision based on best clinical judgement (he/she does not have to view the body). In the event that the GP or registered medical practitioner felt that they had insufficient information at their disposal to complete the declaration on the MCCD, there would be a referral to the PF.

11. The content of the MCCD has to comply with the World Health Organisation’s (WHO) recommendations to ensure comparability for epidemiological purposes. The information recorded on the certificate includes the name of the deceased, the date and place of death, when he/she was last seen alive by the certifying doctor, the cause of death and any contributory factors. The MCCD is prescribed in secondary legislation under section 24 of the 1965 Act (in the Registration of Births, Still-births, Deaths and Marriages (Prescription of Forms) (Scotland) Regulations 1997).

12. The death is registered by the registrar who issues a form (Form 14) confirming the registration of the death. A full Extract of the Entry into the Register of Deaths may also be
provided for a fee. An Abbreviated Extract is provided free of charge. In normal practice it is only after a Form 14 has been issued that a burial may proceed. A cremation may not proceed without the registration of the death, i.e. without a Form 14.

Cremation

13. Additional procedures are required to enable cremation to proceed. An application for cremation (Form A) signed by the executor or next of kin must be completed plus two additional forms (Forms B and C) must be completed by separate doctors who are paid fees totalling around £147. This cost is usually met by a relative. The completion of forms B and C should in theory constitute two separate checks which are totally independent of each other. However, it is recognised that this is not always the case in practice.

14. In addition, when a body is cremated, a third doctor, the medical referee at the crematorium, performs the final check on the papers. The medical referee, who must be of at least 5 years medical standing, can refuse to authorise the cremation if he/she is not satisfied that there has been adequate inquiry by the persons signing certificates or is not satisfied that the fact and cause of death have been definitely ascertained. The cremation authority pays the medical referee a fee which is recouped through the cremation fee which is charged by the authority to the nearest relative.

15. There are currently 26 crematoria in Scotland, with around 114 medical referees or deputies. Medical referees tend to be self-employed and are approached through their medical practice to become medical referees. The cremation authority will approach a referee from its pool of referees on an ‘as and when’ basis and payment will be made accordingly.

POLICY OBJECTIVES AND AIMS OF THE BILL

Aims

16. The Scottish Government has the following overarching policy aims for this Bill:

- To introduce a single system of independent, effective scrutiny applicable to deaths that do not require a PF investigation;
- To improve the quality and accuracy of the medical certificate of cause of death (MCCD) form; and
- To provide improved public health information and strengthened clinical governance in relation to deaths.

17. While the events surrounding the Harold Shipman case were the original driver for change in systems of death certification throughout the UK, no death certification system is able to guarantee that the kind of criminal activities carried out by Shipman could be prevented. Instead, the proposed new system covers only those cases which are not examined by the Procurator Fiscal Service and therefore not within the scope of the criminal justice authorities. As such, it focuses on the aims outlined above, although in doing so it will establish arrangements which should also act as a deterrent to criminal activity or malpractice.
This document relates to the Certification of Death (Scotland) Bill (SP Bill 58) as introduced in the Scottish Parliament on 7 October 2010

18. The Bill seeks to make improvements to the death certification system which are financially sustainable, proportionate and do not impose undue delays on bereaved families arranging a funeral. In addition, the Bill seeks to provide an opportunity to bereaved families whose relatives have died overseas to have a post mortem conducted in Scotland.

Scottish Government Consultation

19. The Scottish Government consulted on the two alternative models of death certification proposed by the Review Group: the Medical Investigator (MI) model and the Medical Examiner (ME) model. In both models it was proposed that a statistician would run regular statistical tests on all death data to identify unusual results and patterns of behaviour over time both nationally and at local NHS Board level. The difference between the two models, as proposed by the Review Group, lay in the level of scrutiny of MCCD forms:

- Under the MI model, Medical Investigators (MIs) would comprehensively scrutinise a 1% random sample of deaths, plus any deaths where concerns had been raised e.g. by a relative or doctor (estimated to account for up to a further 1% of all deaths) and countersign the 2% of MCCDs linked to those deaths; and
- Under the ME model, this comprehensive scrutiny would also take place but, in addition, Medical Examiners (MEs) would undertake a basic level of scrutiny of all other deaths (with much of this work carried out as administrative checks by their assistants) and therefore countersign all MCCDs in Scotland.

Basic Scrutiny

20. Basic scrutiny amounted to the administrative checking of the MCCD form completed by the certifying doctor. It did not extend to looking at medical records or discussions with health professionals or family members.

Comprehensive Scrutiny

21. Comprehensive scrutiny included the basic scrutiny (as above), review of the health care records and taking other evidence including discussing the circumstances surrounding the death with any attending doctor or those responsible for the deceased’s care and, in some cases, talking with relatives.

22. The Review Group did not express a preference for any one model. The Scottish Government expressed an initial preference for the MI model in its consultation.

23. The consultation attracted 102 responses. Of these, 56 respondents commented on the models and a small majority (52%) of these were in favour of the Scottish Government’s preferred option, the MI model, while just over a third favoured the ME model. Seven respondents wanted neither model, either because they were content with the existing system or because they wanted an alternative, such as the model being developed in England and Wales. An analysis of the consultation is available on the Scottish Government’s website at: http://www.scotland.gov.uk/Publications/2010/07/12161026/0.
24. Following the consultation, further work has been undertaken to address and take into account points made by consultees. A range of stakeholder meetings has been conducted to examine key issues and to explain to stakeholders the Government’s proposals and the rationale which underpins them. These engagements have clearly demonstrated a need to improve the clinical standards applied to death certification through enhanced education and training.

**Strengthened Model: The Medical Reviewer Model**

25. Following further consideration in light of the consultation responses and discussion with key stakeholders, the Scottish Government has developed a strengthened version of the MI model proposed by the Review Group and this is the model that has been set out in the Bill. The following paragraphs explain this model, which is described here and in the Bill as the Medical Reviewer (MR) model.

26. Under this model, a Senior Medical Reviewer (SMR) and potentially up to six regionally based Medical Reviewers (MRs), all medically qualified, will be employed by Healthcare Improvement Scotland (HIS). Each MR and the SMR will be supported by an administrative assistant. In addition, there will be a statistician (a non statutory role) located with, and employed by, NHS National Services Scotland (NHS NSS) (within Information Services Division) who will produce both national and local statistics for further consideration by the MRs. The statistician will also be supported by an assistant.

27. The Bill sets out the obligation for HIS to appoint the MRs and SMR to carry out the functions set out in the Bill. As part of HIS, the MRs and SMR will be accountable to the HIS Board, but will have a high degree of operational independence in the exercise of their functions. Employment of the SMR and MRs by HIS fits with its purpose as a national organisation and is seen as advantageous in terms of ensuring an appropriate degree of independence from territorial NHS Boards.

28. The exact number of MRs required will be decided following test site work on the operation of the new system. The Financial Memorandum outlines in more detail the cost of employment of up to six MRs, an SMR, one statistician and statistical and medical support staff and the workload this would entail. The proposals for six regionally based MRs and an SMR take into account the additional duties to be performed under the strengthened model which are set out below.

29. The scrutiny (review) to be conducted by MRs will involve the following:

- Comprehensive checks of all (relevant) paperwork associated with the death including the MCCD, appropriate medical records and the results of any medical investigations;
- A discussion with the certifying doctor and other relevant clinical and healthcare staff, as required;
- A discussion with the family of the deceased or an informal carer, as required; and
- Consideration of any other relevant evidence, such as (arranging to) view the body, if necessary (rarely).
30. The MR will be required to consider whether to approve the MCCD for every death subject to scrutiny (unless referred to the PF); approval is likely to take the form of a countersignature and the MCCD forms will be updated to allow for this. All other MCCDs not subject to scrutiny will feature the signature of the certifying doctor only.

31. A doctor signing an MCCD has a professional responsibility to undertake this role to the best of his/her ability and to record information and cause of death according to their professional opinion; in order to respect that professional opinion, the Bill does not seek to force certifying doctors to, for example, record a different cause of death to that stated on the original MCCD. Accordingly, where there is disagreement between the MR and the certifying doctor regarding the information provided on the MCCD, the Bill sets out a procedure which gives the certifying doctor an opportunity to issue a replacement certificate following discussion with the MR.

32. However, whilst it is expected that agreement between the certifying doctor and the MR will be reached in the majority of cases, the Bill recognises that this may not always be the case. Provision is therefore made to allow for a second opinion to be sought from the SMR and, if necessary, a further opportunity given to the certifying doctor to issue a replacement certificate. In most cases, it is likely that the changes required to the MCCD will be linked to issues of quality and standards rather than concerns about the cause or manner of death. However, where a disagreement does occur concerning the cause of death and this cannot be resolved, the SMR can refer the case to the PF for investigation into the cause of death.

33. Any scrutiny/discussions undertaken by the MR will be documented in order to provide a record of the discussions undertaken.

34. Where the review of an MCCD gives rise to any suspicions of criminality, the MR or the SMR must report the matter to the PF.

Deaths Subject to Review

Randomly Selected Cases

35. The scrutiny system to be carried out by the MRs will review around 500 randomly selected cases annually. This is a similar level to the 1% recommended by the Review Group. Further information on this is provided at paragraphs 55-61 below. The Registrar General (RG) for Scotland, through his office, the General Register Office for Scotland (GROS), records and retains the records of all deaths that occur in Scotland. Computer systems at GROS will be utilised to call up a random sample of cases for scrutiny at the point when an individual comes to register the death at a local registrar’s office. The GROS computer system will alert the local registrar that the case has been selected for review under the Act and that registration of the death should not be completed until the review is complete.

Interested Person Reviews

36. In addition, as also proposed by the Review Group, there is power for “interested persons” to make an application where they wish a review to be conducted by an MR. This is
expected to add a further 500 deaths annually to the cases scrutinised. The numbers referred by interested persons will of course be flexible.

37. Interested persons able to refer cases to the MRs are as follows:

- anyone classed as an “informant” under the 1965 Act i.e.:
  - any relative;
  - any person present at the death;
  - executor or legal representative of the deceased;
  - occupier at time of death of any premises where death took place; and
  - any other person who has knowledge of the particulars to be registered in the absence of those people named above;

- and the following:
  - a health professional or other carer involved with the deceased’s care prior to death;
  - the funeral director;
  - persons in charge of the place of disposal of the deceased; and
  - any other persons specified by Scottish Ministers by order.

38. In both the randomly selected cases and interested person applications, the MR will, in the carrying out the review, have the power to examine health records of the deceased person, seek the views of the doctor who completed the MCCD, and consider other evidence or documents which he/she thinks will assist them (in pre-registration cases, this could potentially include viewing the body, although the circumstances in which this will be necessary are very limited).

39. The following flow charts (Figures 2 and 3) set out how the new system of reviews (scrutiny) will operate:
This document relates to the Certification of Death (Scotland) Bill (SP Bill 58) as introduced in the Scottish Parliament on 7 October 2010

Figure 2 - Random Review

Death occurs

Certifying doctor completes MCCD and gives it to informant to take to the registrar to register the death

Informant attends registration office to register and is informed that the death has been chosen for random scrutiny and registration cannot be completed until scrutiny has been concluded

MR alerted that a case has been selected for scrutiny and arrangements made to pass the MCCD to MR

MR undertakes review

Changes required to MCCD but MR and certifying doctor cannot agree - MCCD referred to SMR for second opinion

Changes required to MCCD – MR and certifying doctor agree changes; an amended MCCD is returned to MR to approve

SMR agrees with certifying doctor and approves MCCD

SMR agrees with MR. Certifying doctor agrees to amend MCCD approved by SMR

Funeral takes place

Funeral takes place

Funeral takes place

SMR agrees to approve MCCD or signifies that review is complete

MR approves MCCD

Case is referred by SMR to PF. PF reviews cause of death

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Figure 3 - Interested Person Review

Informant contacts MR and requests a review of MCCD

MR considers circumstances on receipt of application

MR initiates review process

MR asks RG to flag up to anyone registering the death

Registrar either does not issue disposal form, or tells MR that disposal has already taken place

MR undertakes review, contacts certifying doctor

MR decides whether MCCD is in order; ‘second opinion’ process may apply, if required

Case is referred by SMR to PF, if required; PF reviews case

MR/SMR decides MCCD is in order, approves form or otherwise completes review; MR notifies all interested parties

PF carries out investigation, (including post mortem by pathologist, if body

Funeral takes place

Confirmation of registration issued by registrar, if pre-registration case

Cause of death confirmed

Pathologist signs new MCCD form (previous form goes to GROS); interested parties notified

Additional Retrospective and Prospective Scrutiny

MRs may also decide that, following consideration of national and local statistics, there is a need for further checks to be carried out in a particular area (e.g. a particular geographic area), hospital, practice or in respect of a particular individual. The MR could then ask the statistician to carry out additional sampling retrospectively for whatever period is deemed appropriate. The statistician would gather information to allow the MR to conduct the additional checks. These additional retrospective checks could be carried out on records of deaths already available from GROS and by accessing MCCDs and medical records previously linked to those deaths. Retrospective checks could be authorised for a specified period of time, such as the previous 6 months, but could go back further as MRs will not be subject to the three-year time limit applicable in interested person applications.
41. The only limitation on retrospective reviews is that the formal review procedure (which results in MRs approving MCCDs etc.) only applies to MCCDs completed from commencement of the Act; however, this will not prevent MRs from requesting sight of MCCDs completed prior to the coming into force of the Act on an administrative basis and following up any general issues of concern through clinical governance routes.

42. Equally, MRs will have a power to conduct additional pre-registration scrutiny in such cases as they consider appropriate. This power is likely to be used rarely - if there was a serious issue with a practice etc. requiring that level of additional scrutiny then the NHS Board should already have been approached with a view to taking action to deal with the issue. Again, the power available to the MR to instruct this further work underlines the robustness of the proposed new system and allows additional scrutiny (over and above the random sample and interested person scrutiny proposed) to be carried out where the MR decides that it is appropriate to do so. Hospitals or practices whose records are subject to these additional checks will be informed of the process as will the relevant NHS Board(s).

43. In these cases, the review process will follow the same steps as set out in Figure 3 above, from the point at which the MR undertakes the review.

Referral by District Registrars

44. In addition to the above, district registrars will have the power to refer MCCDs for review where they consider it appropriate to do so.

45. In these cases, the review process will follow the same steps as set out in figure 3 above, from the point at which the MR undertakes the review.

Links to Clinical Governance

46. The relationship between the MRs and NHS Boards is a key part of this new scrutiny system. MRs will be responsible for conducting scrutiny and also considering the statistical outputs provided to them by the statistician. MRs may at any time wish to highlight to NHS Boards issues linked to an individual scrutiny case or to the statistics provided by the statistician. It would be the responsibility of NHS Boards, and in particular, Medical Directors, as part of their duty of clinical governance, to take cognisance of the information provided by the MR and to take whatever action they consider to be appropriate. The Bill places a duty on NHS Boards to co-operate with the MRs and SMR. In carrying out their duties, NHS Boards may wish to conduct further investigation of an individual, practice or hospital, for example, and could also compare the information provided by the MR to other information held by Boards such as prescribing patterns, complaints and annual appraisal reports. Although in some cases MRs may be flagging up the need for NHS Boards to investigate further the behaviour or practices of a particular individual, practice or hospital, in other cases the MRs may draw Boards’ attention to general issues that simply require additional training or guidance.

47. It is the correlation of the accurate information and strong links under the new scrutiny system with well established clinical governance systems in NHS Boards that helps to ensure that it will be robust.
Other Activities

48. The MRs will also require to have close and effective working relationships with certifying doctors, registrars and the local PF. Additional elements are included in the MR model to help support those relationships. In particular, both certifying doctors and registrars will be able to call the local regional MR by phone to request assistance on any aspect of the scrutiny system, or where they have concerns regarding the completion of an MCCD. This additional support will ensure that a source of advice is available to certifying doctors and registrars which is not currently available.

49. The MRs (including the SMR) will have a training and education role in relation to death certification, in respect of doctors and other healthcare professionals. This might involve, for example, giving presentations about their role and the certification of death generally to medical students, providing input for guidance on the certification of death and the provision of training for doctors’ continuing professional development.

50. In relation to the PF, the Bill does not in any way seek to change the existing powers and duties of the Lord Advocate or PFs. Where criminality is suspected in any case, the MR or the SMR must report their suspicions to the PF and thereafter follow the directions of the PF.

Summary of Medical Reviewer Role

51. The following bullet points summarise the role of the MRs:

- to undertake comprehensive scrutiny of a sample of around 500 deaths annually and to consider any interested person cases reported to them (estimated to amount to an additional 500 deaths annually);
- to consider reports from the statistician and make available and discuss those reports with the relevant NHS Board Medical Directors for further investigation or action;
- to perform additional checks where he or she believes further scrutiny is required e.g. at regional, hospital, practice or individual level, in the light of information gathered by the statistician (up to 100% of deaths if required);
- to directly support certifying doctors in making effective decisions in relation to death certification through, for example, phone support;
- to directly support and guide registrars where information provided on MCCDs is inaccurate, incomplete or requires further inquiry;
- to potentially offer ‘on-the-job’ and ‘off-the-job’ education and training of doctors and other healthcare professionals, for example through speaking about their role and through continuing professional development; and
- to liaise closely with PFs.

The Senior Medical Reviewer

52. The role of the SMR will be to provide leadership for the new system and, particularly, he or she will have responsibility for leading a change in culture in the NHS in terms of the attitude and priority given to the certification of death. This can be done in a number of ways. Strong links should be developed with NHS Boards, consultant networks and doctors, including
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general practitioners. A form of education and training can be offered, for example, through talking at events and to groups of doctors, and there should be close liaison with the appropriate Royal Colleges and with NHS National Education for Scotland (NES) on training. The SMR will be responsible for managing the MR service and the team of staff and will be accountable for this through the HIS Board. He or she will be a primary source of expert advice on the certification of death.

53. In addition, where there is a disagreement between an MR and a certifying doctor over an MCCD under review, the SMR has a statutory role in the process which provides an opportunity for a ‘second opinion’; in such a case, the SMR may conduct a review of the MCCD and the associated health records etc. (as described above).

**Reporting Requirements**

54. The SMR will be required to provide a report to Scottish Ministers for each financial year on the activities of the SMR and MRs and produce other information reasonably requested by Scottish Ministers. These reports will also be published.

55. The following bullet points summarise the role of the SMR:

- strategic leadership and the promotion of improved and consistent high quality standards nationally in relation to death certification;
- provision of professional leadership and peer support to MRs, including support for aspects such as continuing professional development and medical revalidation;
- input to development of medical education and training in relation to death certification, linking in with NHS Education for Scotland (NES) and the Royal Colleges;
- delivery of a proportion of education and training at national level by giving seminars, conference talks, local sessions etc;
- management of MRs and their staff and reporting to the HIS Board;
- provision of ‘second opinion’ where there is disagreement between an MR and a certifying doctor, and, where necessary, carrying out a full review of the case; and
- liaison with the Chief Medical Officer and Scottish Government officials, the Scottish Association of Medical Directors and COPFS and other appropriate persons (such as counterparts in other parts of the UK).

**Further Information Regarding the Sampling Process**

56. Following consideration of available research evidence, costs and practicalities, the Burial and Cremation Review Group considered that a 1% random sample should be proposed. The Review Group considered the following published research on mortality monitoring at the time and fixed sampling systems used for NHS fraud detection:

• “Using hospital mortality rates to judge hospital performance: a bad idea that just won’t go away” by Lilford and Pronovost (2010); in: British Medical Journal, 20 April, 340: c2016;
• “Can mortality monitoring in general practice be made to work?” by Guthrie (2005), in: British Journal of General Practice, September 1, 55(518): 660-662;
• Early results from: “Routine mortality monitoring for detecting mass murder in UK General Practice” by Guthrie and others (2008); in: British Journal of General Practice, May, 58:311-317.

57. The work conducted by Professor Lilford and Dr Peter Pronovost, though based on the use of hospital mortality rates, concludes that: “Deeper understanding will depend not on statistical or organisational studies carried out in isolation but on synthesis of both subjects…”. They also argue for “…use of (hospital mortality rates) … not as the basis for judgement leading to sanction or reward, but as a signal to identify where further investigation is necessary”.

58. The studies carried out by Bruce Guthrie and others concluded that “at best mortality monitoring can act as a backstop to detect a particularly prolific serial killer when other means of detection have failed. Policy should focus on changes likely to improve detection of individual murders such as reform of death certification …”.

59. The Review Group’s approach reflected their consideration of costs and benefits. They considered that comprehensive scrutiny of a 1% random sample would be sufficient as a deterrent, recognising that no system can guarantee to detect crime. Anything greater than this was considered to create significant resource problems. The scope for additional referral of cases by interested persons was considered to form an important additional element of the scrutiny system and meant that, overall, an estimated 2% of cases annually would be comprehensively reviewed. This, coupled with the wider statistical analysis was considered to provide safeguards and allow trends to be detected over time.

60. The Scottish Government agrees with the Review Group that no system can guarantee to detect criminality or malpractice and believes the most effective way to address current concerns related to the processes and outcomes concerning death certification is to improve quality standards and clinical governance in this area of NHS activity, while also providing a deterrent against malpractice. The system proposed by the Bill therefore emphasises the importance of establishing a system which improves education and training in this area and which will result in adherence to higher standards by clinicians in delivering on this function. In line with this, the Scottish Government’s view is that random sampling of around 500 cases per year should form part of an audit cycle of activity with the results from the sample considered, analysed and acted on as set out above. The level of the random sample may be expected to vary and the Bill is therefore deliberately silent on the size of the sample to allow for future variances in the sample level if required. It is considered that sampling should be based on a number of cases rather than a percentage, although the sample size which has been determined as appropriate (around 500 cases) is in line with the Review Group’s approach (in 2009 there were 53,856 deaths in Scotland, GROS, 2010).

61. However, the value of the Bill’s review (scrutiny) system, and its role in providing a deterrent against malpractice, should be considered as an entire package comprising the random
sample activity and audit cycle, interested person / district registrar reviews and the opportunity for additional retrospective and prospective checks to be undertaken by MRs. This latter element will allow efforts to be more focussed on individuals or areas where likely problems have been identified and can be carried out at a level of up to 100% of cases for the area, practice or hospital in question.

62. It is also important to recognise the potential for important links between the work of the statistician looking at death certification and existing work on hospital standardised mortality ratios undertaken by NHS NSS. This work currently considers probabilities of death for all patients compared to actual deaths, but does not examine the recorded cause of death. However, data files will be available which would allow more detailed analysis to be done on causes of death in e.g. particular localities, and comparisons made to original diagnosis. It is expected that the NHS NSS statisticians will collaborate on the links between the two data sets.

The Impact of Scrutiny on Timetabling of Funerals

63. The additional checks required for those deaths selected for scrutiny pre-registration will introduce an extra step to be completed before a body can be released for a funeral.

64. When the Review Group considered these issues a few years ago, the average time lag between a death and the funeral was around 3-4 days.

65. From some informal research of recent online family newspaper announcements (which contain both date of death and date of funeral) it is our impression that the average wait for a funeral was close to 7 days in most cases.

66. It is anticipated that this aspect of the system will be examined and tested as part of the operational test of the new system, with a view to ensuring that scrutiny will, as a norm, be completed immediately following death (i.e. within a day or two of the death) and therefore have no perceptible impact for bereaved families on the scheduling of funerals.

67. There may however be exceptional circumstances where selection for scrutiny impacts on the scheduling of funerals because the scrutiny of an individual’s records takes longer than normal (for example, where records may need to be retrieved from rural and remote locations or where public holidays constrain the swift retrieval of records).

68. In addition, it is recognised that there may be circumstances in which the delays inherent in a scrutiny system, even when they are fairly short, might create difficulties for particular bereaved families. This is perhaps especially true in randomly selected cases where the family of the deceased will only learn that the MCCD relating to the deceased is to be reviewed at the point at which they seek to register the death.

69. Accordingly, in cases randomly selected for review, families will be able to request that registration takes place in parallel with the review process to allow the funeral to proceed as soon as possible after the registration requirements have been met. Where timing difficulties are raised with the registrar as an issue, at the point where the case has been flagged for scrutiny, the
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registrar will be in a position to discuss this with the family member and will refer the question to the MR for a decision on whether registration may proceed in parallel with scrutiny. Guidance will be provided to the public and to registrars on this aspect of the review process.

70. The following bullet points summarise how this aspect of the system will work:

- New system will include guidance for families, registrars and others on scrutiny;
- MCCD is completed by certifying doctor;
- Informant presents MCCD to registrar and case flagged for review;
- Registrar provides information to informant about review and informant can indicate if he/she wishes registration to take place in parallel with the review, and the reasons justifying this;
- Registrar refers the matter to the MR to seek approval for registration to take place straight away (MCCD may be faxed to MR);
- MR considers whether there is a good cause to justify this and whether there is likely to be a need to retain the body to allow a referral to the PF e.g. where he/she has a valid concern about the cause of death on the MCCD. In some cases this may require a telephone call to the certifying doctor before a decision can be taken;
- The registrar is notified of the decision and notifies the informant;
- If the MR considers that use can be made of this expedited procedure, the registrar may allow the death to be registered and the funeral may take place according to the family’s requirements; and
- Scrutiny proceeds in parallel with family kept informed of outcome as usual.

71. In most cases the above process would take place within office hours and would not require any out-of-hours working. However, there are currently circumstances in which registrars open their offices in an emergency e.g. at a weekend and there may therefore be circumstances in which out of hours working by a MR would be required. These issues will be considered further during the consideration of guidance and contracts for the MRs.

72. This alternative and expedited process will be fully consulted on and additional details set out in guidance. However, circumstances in which it may be appropriate to make use of the expedited procedure include the following:

- Where a funeral is taking place outwith Scotland;
- Where a child has died;
- For reasons of faith where it is a strict requirement of that faith that a funeral takes place very quickly e.g. within 24 hours; and
- Where the body is being donated to medical research and has to be preserved quickly.

73. This expedited procedure is only available in cases which are randomly selected for review.
Resourcing

74. The Financial Memorandum sets out in detail the anticipated costs of the new system.

75. A modest fee may be charged in respect of the functions of medical reviewers (but not their functions relating to post-mortems in cases where the death occurs outwith Scotland) including those relating to the national statistician.

Other Changes

Medical Referees

76. The role of medical referees (and deputies) at crematoriums will be abolished. The responsibilities they currently have for checking that bodies are safe for cremation e.g. by checking whether a pacemaker or other implant require to be removed, will be carried out in future by certifying doctors.

77. This would be done by including a requirement to conduct checks of medical records and record such information on the revised MCCD. Any subsequent required physical removal of, for example, a pacemaker or implant would be carried out either by funeral directors (if an easy to remove pacemaker) or (in the case of implants, which can be more difficult to remove) a medical practitioner. In the case of a death occurring abroad (and potentially other cases from outwith Scotland, depending on legislative developments in the rest of the UK), MRs would carry out the necessary paperwork checks to ensure bodies are safe for cremation.

Deaths Outside Scotland

78. Currently Scottish Ministers have a role under the Cremation (Scotland) Regulations 1935 in giving authority for cremation in Scotland where a death has occurred abroad and there is sufficient certification equivalent to the certificates required under those Regulations (this does not apply to burials of those who have died abroad, where Scottish Ministers have no involvement).

79. The administrative element is undertaken on behalf of Scottish Ministers by civil servants and Senior Medical Officers who check the paperwork and the cause of death. The paperwork is then passed to the relevant medical referee to sign off with Form F (authority to cremate) and the cremation can proceed.

80. These overseas deaths have already been certified by a doctor abroad and the deaths have been registered before the remains come back to Scotland. In such cases, the authorities in the country in which the person died will have completed their investigations (if any) into the circumstances of the death, and will have released the remains for disposal.

81. Where the current checks by the Scottish Government fail to establish a satisfactory cause of death, current administrative practice is to refuse to authorise a cremation. This can be distressing for families who then either have to arrange a private post mortem in an attempt to establish cause of death or have to opt instead for burial. This is discussed further below.
82. The Scottish Government handles an average of 130 requests a year for cremation authorisations resulting from repatriation of Scots who have died abroad. There are no statistics on the total number of annual repatriations (i.e., burials and cremations) but assuming the 40/60 split between burial and cremation in Scotland applies also to deaths of Scots abroad one can estimate a total of around 250 deaths per year requiring repatriation for a funeral service. It is estimated that in around 10% of these cases the cause of death will not have been established.

Disposal Requirements Applying to Deaths Occurring Outside Scotland

83. Under the new system, there will be a duty on persons having charge of a place of interment or cremation to ensure that the disposal is authorised by the correct certification (which for deaths outside Scotland is likely to be certification equivalent to the MCCD and the certificate of registration of death). In addition, where a person has died outside Scotland and it is intended that he or she be cremated in Scotland, the case will be referred to an MR, who will examine the paperwork to determine whether it is safe for the body to be cremated, such as checking for information about whether the deceased had a pacemaker or other implant that might be hazardous during the cremation process.

Proposals Regarding Post Mortems of Deaths Abroad

84. With the exception of certain powers in relation to service personnel who die abroad, the Lord Advocate does not have jurisdiction to investigate deaths occurring outside Scotland, nor any power to instruct post mortems of such deaths. This is in contrast to the position in England and Wales where Coroners hold such powers. There was a high level of agreement amongst those who responded to the Scottish Government consultation (just over 40%) that when the death of a person who is normally resident in Scotland occurs abroad, a government body in Scotland should be able to assist in the arranging of a post mortem to seek to establish the cause of death if this is unknown.

85. There was a high level of agreement (just over 40%) among those who responded to the consultation question included in the recent SG consultation paper: “When death of a person who is normally resident in Scotland occurs abroad should a Government body be able to arrange a post mortem to establish the cause of death if this is unknown?”

86. Agreement has been reached with the Crown Office & Procurator Fiscal Service that a power should be given to allow MRs to assist in the arranging of a post mortem (including providing financial assistance) to help support relatives whose family member is returned to Scotland for disposal and no cause of death is available. This power will be used in limited circumstances (to be set out in guidance) where it is deemed appropriate on compassionate grounds to address a need that a bereaved family may have to establish the cause of death. This might be, for example, to establish whether a hereditary medical condition may have existed. Extensive experience of dealing with bereaved families in this situation has demonstrated that a post mortem can help them through their bereavement, but that the inability of Government to help arrange such a post mortem leaves them with no option but to carry out the procedure privately, the cost of which is prohibitive for some. This compares poorly with the position in England and Wales where post mortems of deaths abroad can be instructed by the coronial authorities.
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87. This limited power would not be made available where a cause of death is already available (so, for example, it will not be available as a means of settling disputes over the cause of death) and will not amount to an investigation into the wider circumstances surrounding the death (such wider investigation functions are exclusively held by the Lord Advocate in Scotland, but those functions do not, in any event, extend outwith Scotland).

88. It is estimated that, annually, a maximum of 25 deaths abroad do not have a clear cause of death and could therefore potentially fall into this category, warranting a post mortem on compassionate grounds. At a cost of £500 per post mortem (based on current figures) this would cost a modest amount (£12,500 per annum) which would be borne by Healthcare Improvement Scotland (out of funding provided by the Scottish Government). There would be no separate or additional charge to the families affected.

Stillbirths

89. There are already procedures in place to try and identify the cause of death in most stillbirth cases as all stillbirths are already investigated by maternity units with post mortems offered and currently undertaken in around half of cases. There are also policy changes already underway, due to come into effect in 2011, which require cause of death to be specified according to new stated categories which will reduce the high proportion of categorised ‘unexplained’ causes of deaths for stillbirths. In addition an increased use of post mortems is encouraged (two thirds of stillbirths used to have a post mortem in 1998). In the light of this, additional scrutiny of stillbirth certificates by MRs is regarded as unnecessary.

90. Nevertheless, there are other activities proposed which are aimed at improving the quality and accuracy of stillbirth certificates. The following paragraphs set out Scottish Ministers’ (largely non-legislative) proposals in this area.

91. It is proposed to add improved guidance at the beginning of the Stillbirth Certificate (Form 6) about the importance of providing complete and accurate information. This is to try and avoid any situation where registrars may have to ask potentially distressing questions of parents when they register a stillbirth because the information on the certificate is incomplete or inaccurate; or to avoid unnecessary referral to the PF.

92. An additional way to improve the quality and accuracy of stillbirth certificates would be through education and training of midwives and doctors. It is therefore planned to incorporate this as part of on-the-job training for other healthcare professionals and within the e-Learning modules and guidance for doctors as is being developed for the new death certification system.

93. It is also intended to ensure that stillbirths are considered in any guidance on clinical governance, particularly in cases where a midwife or a doctor persistently makes mistakes.

94. Since the posts of medical referees will be abolished under the new system, it will also be necessary for persons in charge of crematoria/cemeteries to check that the stillbirth certificate and confirmation of registration have been produced prior to disposal (similar to the proposals with regards to other deaths).
95. Furthermore, it has been agreed with COPFS that, in future, where no doctor or midwife is present at a stillbirth, such cases should be referred directly to the PF. It is therefore proposed to repeal the existing provision in the 1965 Act which enables a stillbirth declaration to be made by a non-clinician (i.e. Form 7, *Declaration as to Still-Birth*, would be withdrawn as it would no longer serve a function). In such cases, the PF will, if satisfied, issue an authorisation which will allow burial or cremation to proceed.

96. Finally, it is planned to record additional relevant information on Form 6, in line with proposed changes to the MCCD form, including additional questions about public health.

**Dealing with Pandemics and/or Severe Epidemics**

97. Clearly, in a situation of a severe epidemic or pandemic (such as pandemic flu), which would be expected to continue over a period of some months, it would be difficult for a scrutiny system to run effectively. This is because the volume of deaths taking place may be significantly higher than usual, placing additional pressure on systems; certifying doctors would have very little time to provide additional information to an MR; it may be more difficult for hospitals to find and transmit non-electronic patient records; because funerals may need to take place straight away to prevent the development of backlogs; and because of the distress this could cause. In addition, certifying doctors, registrars and PFs may fall ill and MRs themselves, as doctors, might also find themselves being redeployed to provide frontline assistance as required.

98. The Bill therefore provides a power for Scottish Ministers to suspend, by order, the scrutiny system in an epidemic situation (or, where necessary, to prevent the spread of disease).

**Unexplained Deaths**

99. This is an area where there appears to be a considerable amount of confusion about current requirements and inconsistency in how the current system operates around the country. It is intended that (non-legislative) steps are taken to improve the future handling of this issue.

100. In future, it is proposed that where a death occurs and the cause of death is unknown or undetermined it will be referred to the PF for investigation. Where a death has occurred in hospital, a post mortem can already be undertaken to try and establish what caused the death before a PF referral takes place. Where a case is referred to the PF, he/she will take a view on the need for further investigation and a post mortem (such as a view and grant). Thereafter, there may be a number of different outcomes and the PF will take the decision on the appropriate type of disposal in these cases.

**Testing and Implementing the New System**

101. Full implementation would be no earlier than 2013-14. However, to deliver an immediate improvement in the information available to NHS Boards and the Scottish Government, the new NHS NSS national statistician could begin work immediately following the passage of the primary legislation, i.e. from 2011-12.
102. Provided that primary legislation is completed in the 2010-11 legislative session, secondary legislation could be consulted on and go through the Scottish Parliament in 2011-12. Stakeholders agree that a further transitional period of at least one year would then be required to run small test sites to test how the process would operate in practice. Two test sites in two different areas of the country, for example, one rural and one urban area are anticipated. Test sites would be expected to take place during 2012-13 and run for at least six months to allow for evaluation before full implementation in 2013-14. Alternatively, work on secondary legislation could take place in parallel with the test sites. A full implementation plan will be drawn up in due course. The overarching aim of testing the system will be to ensure that the system is as efficient as possible and to allow individual elements of the system to be tested and adapted as a result of the information gained from the test sites.

103. The Financial Memorandum sets out more detail on the anticipated mechanics and costs of the test sites.

104. The test sites will be run largely on an administrative basis.

105. In addition to secondary legislation, there would need to be a comprehensive assessment of the guidance, training and information required for key groups. This would include the following:

- Members of the public, who will require general information about the new system and how it might affect them; specific advice will be required if their relative is randomly selected for scrutiny; guidance will be required on contact with the MRs and information on how to refer a case (as an interested person) to the MRs;
- Registrars, who will require guidance and training on the new system, including the interface with members of the public who will be affected by scrutiny;
- Certifying doctors and pathologists, who will require additional guidance and training on the new system and how to engage with the MRs; and
- Funeral directors, who will require information about the new system and the impact on funeral arrangements.

106. Key stakeholders will be involved in further development of all of the above, including NHS Education for Scotland (NES) and the Royal Colleges on training issues. In addition, close working with Crown Office is anticipated.

ALTERNATIVE APPROACHES

107. England and Wales are set to introduce a Medical Examiner (ME) system and primary legislation for this is included in the Coroners and Justice Act 2009. Under this system, every death that does not require a Coroner's post mortem or inquest will be scrutinised and countersigned by the ME. The UK Government envisages recruiting 240 FTE MEs (up to 1,000 part-time posts) plus the same number of assistants and a National Medical Examiner. The ME will give advice to attending doctors, Coroners and their staff, talk to relatives, view the body if necessary, and check medical records before giving authorisation and releasing the body for registration and disposal.
108. Many of the details are yet to be confirmed as pilots are still underway and to be evaluated but the proposed changes are intended to provide a simpler process for bereaved families and provide increased scrutiny and transparency. Certifying doctors will have access to MEs to discuss cause of death to improve the quality of registration. Funeral directors will benefit from simplified forms and better data to help meet health and hygiene requirements. Registrars will benefit from improved certification processes with fewer requirements on them to understand and seek to interpret medical information on MCCD forms.

109. The legislation includes a power to raise public fees, although the details on who and how to collect have still to be specified in regulations. Because of the significant investment required to recruit a relatively high number of doctors, any public fee is likely to be close to the level of the current cremation fee in England (slightly higher than the existing £147 fee in Scotland). The UK Government has undertaken to ensure that the new system costs no more than the existing system (£45 million a year).

110. Northern Ireland is also considering the review of their system of death certification though no public consultation has yet taken place.

111. In terms of practical issues arising from different systems, it is not considered that these will necessarily present any insurmountable problems. Close working with relevant parties to work up generic guidance (or a protocol) has been agreed with counterparts in England and Wales, with the aim of ensuring that there is clarity around the arrangements for transferring remains from and to Scotland.

112. The Scottish Government believes that the model set out in the draft Bill is the right model for Scotland. This follows consideration of the original Review Group recommendations, a formal consultation exercise, consideration of the England and Wales model and many discussions with stakeholders.

113. The Scottish Government believes any scrutiny system should build on the existing structure and established processes of the NHS, as well as on the professionalism and high standards of health professionals in Scotland.

114. According to Scottish Ministers’ view, the approach taken in England and Wales of requiring the actions of a certifying doctor to be double checked in every single case is not an efficient, required or desirable use of resources. Under the current system up to three doctors can be involved in providing certification for cremation, including additional scrutiny from the crematorium referee. Practice has shown that such checking tends to be perfunctory. It is neither necessary nor proportionate as a means of ensuring that an effective level of monitoring and governance is in place. Rather than requiring costly and unnecessary checks of the actions of every single doctor in certifying every single death in Scotland, focus should be on building on existing systems of clinical governance, seeking to drive up standards and quality throughout the process and introducing a level of deterrence. Fundamentally, therefore, this can be achieved through a scrutiny system that checks a (flexible) sample of cases supplemented by the ability of certain interested parties to refer cases and the power of the MRs to conduct additional checks where they feel this is of value. This system should seek and lead to improvements over time.
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and can then also adapt to those improvements. In this way it can be adapted and made responsive to needs as they change over time.

115. Discussions have been taking place with Medical Directors of NHS Boards to ensure that the most is made of links with systems of clinical governance in NHS Boards. Earlier sections of this Memorandum highlight the practicalities of this. It will mean that the clinical governance committee of an NHS Board will be in a strong position to evaluate and take action on the information provided by the MRs. They will be able to assess it alongside other key information including appraisals and revalidation processes, complaints, prescribing patterns and surgical mortality rates to obtain a clear picture of potential problems and the need to take action to address those problems. This applies both to serious or potentially criminal issues around the actions of a particular doctor and to other issues such as a gap in training.

116. In addition to the role performed by the MRs themselves, Scotland’s system will benefit from its unique capacity to produce a single national set of statistics which can be broken down in any number of ways. Those national statistics will clearly be able to show changes and trends over a period of time.

117. The MR (formerly MI) model has been strengthened in response to specific stakeholder concerns by:

- Acknowledging that there should be room for flexibility in the numbers of cases chosen for random sampling;
- Introducing the concept of additional (up to 100%) scrutiny where considered necessary by the MR;
- Leaving the final numbers of MRs flexible;
- Placing a greater emphasis on training and education;
- Placing greater emphasis on the need for strong leadership of change through the role of the SMR; and
- Allowing more scope in the system for specific support to be given on a daily basis to both doctors and registrars.

118. It is clear that the importance of death certification has to be reinforced and achieving this will require the strong leadership role of the SMR in particular and close relationships with the Royal Colleges but also, importantly, with NHS Boards and practitioners.

CONSULTATION

119. The Scottish Government undertook a consultation on Death Certification, Burial and Cremation which ran from 27 January 2010 to 21 April 2010. This exercise attracted 102 responses, from a range of stakeholders such as local authorities, the funeral industry, health boards and individuals.

120. The consultation was split into four sections:

- When a death occurs;
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- Death certification;
- Burial and cremation; and
- Alternative methods of disposal.

121. The consultation document, published responses and the independent analysis of responses can be accessed at the Scottish Government’s publication website through the following links:

- [http://www.scotland.gov.uk/Publications/2010/01/26131024/0](http://www.scotland.gov.uk/Publications/2010/01/26131024/0);
- [http://www.scotland.gov.uk/Publications/2010/06/01155027/0](http://www.scotland.gov.uk/Publications/2010/06/01155027/0); and

122. The Bill only deals with the death certification part of the consultation. Other issues contained in the consultation will be dealt with at a later date.

EFFECTS ON EQUAL OPPORTUNITIES, HUMAN RIGHTS, ISLAND COMMUNITIES, LOCAL GOVERNMENT, SUSTAINABLE DEVELOPMENT

Equal Opportunities

123. The Bill’s provisions are not discriminatory on the basis of age, gender, race, disability, marital status, religion or sexual orientation. The new system will bring in a common method of certification and review regardless of the method chosen for disposal (i.e. burial or cremation) and will remove the differential treatment of burials (which do not currently attract a fee) compared to cremations (which do attract a fee). People who have traditionally paid for cremation forms to be signed will no longer be charged this levy (currently around £147 payable by the family). Instead a standard fee will be charged for the certification required for all types of disposal, whether burials or cremations. Therefore, anyone who opts for burial will be asked for a small charge which they have not previously been asked to pay. There is currently a split of 40/60 for burial and cremation in Scotland and the majority of bereaved families in Scotland will therefore benefit financially from the new arrangements.

124. An EQIA was undertaken on the policies expected to be included in the Bill to consider the possible impact of these proposals on people according to their age, disability, race, religion and beliefs, general and sexual orientation. Religion and beliefs are important considerations in death certification, in particular the release of bodies for burial and cremation as swiftly as possible.

125. The issue of the delay that may occur if a death (upon registration) is chosen for random review has therefore been an important consideration.

126. As outlined earlier in the Memorandum, in most cases it is estimated funerals will take place within the average timescales expected despite the additional scrutiny step.

127. The arrangements made to ensure that a very quick process can be made available in certain defined circumstances are set out above. This expedited process will be available to all...
persons provided sufficient justification can be made and there are no circumstances present which would make this unsuitable. In these limited cases, review would take place in parallel to the funeral arrangements.

Human Rights

128. The Scottish Government is satisfied that the provisions of the Bill are compatible with the European Convention on Human Rights. In particular, the view is taken that any delays inherent in the certification process, and the nature of them, are proportionate to the legitimate aims pursued by the Bill.

129. Despite adopting this view, careful consideration has been given to the possibility that a short delay may occur if a death is chosen for the random review at the point of registration (this was an issue which particularly concerned those whose religious beliefs call for the body of the deceased to be disposed of quickly). Accordingly, Scottish Ministers’ proposals, as described above in the Policy Memorandum, include the potential for an expedited review process to be made available in randomly selected cases where this is considered appropriate. This will be set out fully in guidance in due course.

130. Access to the expedited review process is available on a non-discriminatory basis to all persons, provided sufficient justification can be shown.

Island Communities

131. Traditionally in the more rural parts of Scotland burial has been the preferred option and this trend is expected to prevail. There may therefore be a disproportionate impact on rural communities in relation to the introduction of fees for burials.

132. There is also more likely to be a delay in retrieving papers required for scrutinising deaths in rural communities, which could affect the timetabling of a greater proportion of funerals. This will be considered further during test sites and as part of the preparation for the implementation of a new system.

Local Government

133. Under the new proposals, local authority registrars will play a fuller role at the point of registration. It is anticipated that at the point of registration the registrar will be responsible for informing the family that the death has been chosen for random scrutiny and that registration will not be completed until the scrutiny has been undertaken. This builds on the experience which registrars already have as the public facing end of death certification. Guidance will be produced to support registrars in this enhanced role.

Sustainable Development

134. There are no specific issues applicable to death certification.
CERTIFICATION OF DEATH (SCOTLAND) BILL

DELEGATED POWERS MEMORANDUM

PURPOSE

1. This memorandum has been prepared by the Scottish Government in accordance with Rule 9.4A of the Parliament’s Standing Orders, in relation to the Certification of Death (Scotland) Bill. It describes the purpose of each of the subordinate legislation provisions in the Bill and outlines the reasons for seeking the proposed powers. This memorandum should be read in conjunction with the Explanatory Notes and Policy Memorandum for the Bill.

General Background

2. The Bill introduces independent scrutiny of medical certificates of cause of death in cases of deaths that do not require a procurator fiscal investigation. The provisions create the role of medical reviewers, and a senior medical reviewer whose functions are to conduct reviews of medical certificates of cause of death. They also have a role in providing training, guidance and support to doctors who certify the cause of death and they will liaise with other persons and bodies with a view to improving the accuracy of these certificates.

3. Medical certificates of cause of death will also provide additional information, for example, whether the body contains a pacemaker which it would be hazardous to cremate.

4. In the case of deaths outwith the UK where the body is brought to Scotland, medical reviewers will be able to instruct a post-mortem examination to try to determine the cause of death for the benefit of the family, if this is not available, and to certify whether it is safe to cremate the body.

Rationale for subordinate legislation

5. The Scottish Ministers have carefully considered the requirement for subordinate legislation in connection with this Bill. The provisions that provide for subordinate legislation can be divided into two groups. One group consists of provisions to prescribe the form and content of documents such as application forms and certificates and to specify administrative processes. These need to be prescribed for the purposes of consistency and efficiency, but it is not necessary to set them out at length on the face of the Bill. These are matters of detail clearly within the scope and policy intentions of the Bill and required to operate the provisions in the Bill. Setting them out in full would greatly add to the length of the Bill. It would be
unnecessary and time-consuming to subject them to the procedure required for primary legislation.

6. The other group consists of provisions which offer the flexibility necessary to bed in a new system and to react over time to change. This group, for example, allows fees to be specified, the qualifications of medical reviewers to be added to or amended over time or consequential provisions to be made when necessary and expedient. This group of provisions cannot be set out once and for all in the Bill, as their content will depend on reaction to changing circumstances. Subordinate legislation can usefully be employed in this case so that this range of provisions can be adapted and updated within the basic structure and principles of the Bill, without the need for further primary legislation and the corresponding parliamentary time.

Delegated powers

7. Delegated powers provisions are listed below with a short explanation of what each power allows, why the power has been taken in the Bill and why the selected form of Parliamentary procedure has been considered appropriate.

Section 2: Power of Scottish Ministers to give directions to the Registrar General

Power conferred on: the Scottish Ministers
Power exercisable by: Direction
Parliamentary procedure: None

Provision

8. Section 2 inserts Section 24A into the Registration of Births, Deaths and Marriages (Scotland) Act 1965 (“the 1965 Act”). Section 24A(2) requires the Registrar General to refer a random selection of certificates of cause of death for review under section 8 of the Bill. Section 24A(5) and (6) permit the Scottish Ministers to give directions to the Registrar General, in particular about the minimum number of certificates of cause of death to be selected and the method of selection.

Reason for taking power

9. It is expected that the numbers of certificates of cause of death required for random review will vary from time to time for statistical reasons, to ensure that a significant sample is achieved. It is important therefore, that at any given time an appropriate number of certificates is referred. Computer software used by the Registrar General will be available to generate certificates at random, however, methods of selection may change and be refined over time and are likely to be the subject of consultation with the Registrar General and with professional statisticians. The power is therefore taken to ensure that adjustments can speedily be made to ensure that a suitable number of certificates are selected by appropriate means when this is required for statistical or other reasons.

Choice of procedure

10. The detailed adjustment of numbers and methods of selection will require technical and professional expertise and close liaison between Government Departments. Given the technical
This document relates to the Certification of Death (Scotland) Bill (SP Bill 58) as introduced in the Scottish Parliament on 7 October 2010

and detailed nature of the content and the possible need to make adjustments rapidly, this is more easily and flexibly achieved by the use of a direction making power.

Section 2: Suspension of referral of certificates for review during emergencies

Power conferred on: the Scottish Ministers
Power exercisable by: Order made by statutory instrument
Parliamentary procedure: Negative resolution of the Scottish Parliament

Provision

11. Section 2 inserts section 24A(7) into the 1965 Act. This allows the Scottish Ministers to suspend the referral to medical reviewers of medical certificates of cause of death during an epidemic or when it is considered on reasonable grounds that it is necessary to do so to prevent, or to prevent the spread of, infectious diseases or contamination.

Reason for taking power

12. It may be necessary to suspend the referral of the certificates to medical reviewers during an epidemic or a situation where an infectious disease or contamination is spreading rapidly, if there are large numbers of deaths. A marked increase in the number of deaths could place a significant burden on the registration system, leading to backlogs. Doctors in hospital and general practice are likely to be under considerable pressure. This may, in turn, slow down the disposal of bodies. In some circumstances, funerals may need to take place straightaway to prevent the development of a danger to public health, if there is a risk of infection or contamination. In addition, certifying doctors and medical reviewers may need to be redeployed to provide frontline assistance. This power will allow these rare but extreme circumstances to be catered for.

Choice of procedure

13. Negative procedure has been chosen as this power will be required in emergency situations where there is a serious risk to public health that has to be addressed urgently. Negative procedure will allow such an order to be brought into force almost immediately, whereas if the emergency took place at the beginning of a long parliamentary recess, it would be impossible for the order to be made quickly enough to deal with the situation using affirmative procedure.
This document relates to the Certification of Death (Scotland) Bill (SP Bill 58) as introduced in the Scottish Parliament on 7 October 2010

Section 4(5)(e): Specification of additional interested persons

Power conferred on: the Scottish Ministers
Power exercisable by: Order made by statutory instrument
Parliamentary procedure: Negative resolution of the Scottish Parliament

Provision

14. Section 4(5)(e) allows the Scottish Ministers to specify additional “interested persons”. An interested person is one who may, under section 4, apply to a medical reviewer for a review of a medical certificate of cause of death. Section 4(5) lists interested persons comprising relatives and others who are qualified to register the death under the 1965 Act, healthcare professionals, funeral directors and persons having charge of a place of disposal of the body. These are persons who have a personal interest in the accuracy of the medical certificate of cause of death or who are in a position to have informed concerns about its accuracy.

Reason for taking power

15. A wide range of “interested persons” is already listed in the primary legislation. It is, however, possible that when the system is in operation, it will become apparent that other categories of person have a legitimate close interest in the accuracy of the medical certificate of cause of death or are liable to be in possession of information which might lead them to query the certificate and to apply for a review. The reason for taking the power is to allow such persons to be added to this list.

Choice of procedure

16. Negative procedure has been chosen because of the narrow limits of the power to supply additional cases to an established list. Prescribing additional opportunities for certificates to be reviewed by adding to this list is unlikely to raise any significant issues of concern.

Section 4(7): Suspension of applications under section 4 during emergencies

Power conferred on: the Scottish Ministers
Power exercisable by: Order made by statutory instrument
Parliamentary procedure: Negative resolution of the Scottish Parliament

Provision

17. Section 4(7) contains a power to suspend applications under section 4, just as section 24A(7) of the 1965 Act, introduced by section 2, contains a power to suspend the referral of certificates under that section, that is during an epidemic or when it is necessary to do so to prevent the spread of infectious diseases or contamination.

Reason for taking power

18. This power is taken for the same reasons as are given for the power taken under section 24A(7) of the 1965 Act as inserted by section 2.
Choice of procedure
19. The procedure has been chosen for the same reasons given for the choice of procedure for section 24A(7) of the 1965 Act as inserted by section 2.

Section 4(8): Applications for review

Power conferred on: the Scottish Ministers
Power exercisable by: Regulations made by statutory instrument
Parliamentary procedure: Negative resolution of the Scottish Parliament

Provision
20. Section 4(8) permits the Scottish Ministers to make regulations about applications for reviews by interested persons under section 4. Regulations may provide for the procedure for making applications and their form and content as well as the action to be taken by medical reviewers in respect of applications.

Reason for taking power
21. The power is necessary to ensure a consistent process across the country for making and dealing with applications. Setting out the form and content of applications and the administrative processes for dealing with them in the primary legislation, would add to the size of the Bill and demand a disproportionate amount of parliamentary time.

Choice of procedure
22. Regulations made under this power will deal with the detail of the content of application forms and administrative processes. Negative resolution procedure has been chosen given the narrow confines of the power, which deals with procedural measures.

Section 8(5): Conduct of review

Power conferred on: the Scottish Ministers
Power exercisable by: Regulations made by statutory instrument
Parliamentary procedure: Negative resolution of the Scottish Parliament

Provision
23. Section 8 describes the steps to be taken by a medical reviewer when reviewing a medical certificate of cause of death. Section 8(5) allows the Scottish Ministers to make further provision about such reviews including action to be taken by medical reviewers when conducting a review.

Reason for taking power
24. It may become necessary at some point to add some actions to those that the medical reviewer is required to undertake during a review. This may be, for example, as a consequence of changes to other processes. The review system is closely connected with the systems for
certifying cause of death, the registration of deaths and the investigation of deaths by the procurator fiscal.

Choice of procedure
25. Regulations made under this power will be used to make any further provision necessary to facilitate the review. Negative procedure has been chosen as appropriate for the level of technical detail regarding procedural measures which such regulations would contain.

Section 17(4): Form and content of application and authorisation

Power conferred on: the Scottish Ministers
Power exercisable by: Regulations made by statutory instrument
Parliamentary procedure: Negative resolution of the Scottish Parliament

Provision
26. Section 17 requires medical reviewers to determine whether or not it is safe to cremate the body of a person who has died outwith Scotland. A body may, for example, contain implants such as a pacemaker, making it dangerous to cremate. An application must be made for a certificate to authorise cremation. Subsection (4) permits the Scottish Ministers to make regulations about the form and content of the application and the certificate of authorisation and the procedure to be followed by medical reviewers when deciding whether to authorise cremation.

Reason for taking power
27. It is desirable to have a standard form of application and process of authorisation for these purposes and it is appropriate to put this level of detail in subordinate legislation rather than taking up a disproportionate amount of parliamentary time considering such administrative detail as part of primary legislation.

Choice of procedure
28. Negative procedure has been chosen as suitable for the level of procedural detail required in this instance and the narrow range of the power.

Section 18(4): Application for post-mortem examination

Power conferred on: the Scottish Ministers
Power exercisable by: Regulations made by statutory instrument
Parliamentary procedure: Negative resolution of the Scottish Parliament

Provision
29. Section 18 allows certain persons to apply for a post-mortem examination of a person who has died outwith the UK where no cause of death is available. Subsection (4) allows the Scottish Ministers to make provision about the form and content of such applications.
Reason for taking power

30. It is desirable to have a standard form of application in this case and it is suitable to put the detail of this in subordinate legislation to save parliamentary time over matters of administrative detail.

Choice of procedure

31. Negative procedure has been chosen as suitable for the level of procedural detail required in this instance and the narrow range of the power.

Section 22(3): Annual report

Power conferred on: the Scottish Ministers
Power exercisable by: Regulations made by statutory instrument
Parliamentary procedure: Negative resolution of the Scottish Parliament

Provision

32. Section 22 provides for an annual report to be prepared by the senior medical reviewer. Subsection (3) allows the Scottish Ministers to make further provision about the content, the frequency and the recipients of copies of the report.

Reason for taking power

33. It is expected that the annual report will provide useful information on the new system of scrutinising medical certificates of cause of death set up by the Bill. It is possible, once the system is up and running, that it could become apparent that it would be helpful to specify particular information to be contained in the report, to require more frequent reports or to ensure that copies are made available to particular persons. This power is intended to deal with those eventualities.

Choice of procedure

34. The negative procedure has been chosen as suitable for supplying additional detail to the reporting activity already established by the Bill.

Section 23(3): Fees

Power conferred on: the Scottish Ministers
Power exercisable by: Regulations made by statutory instrument
Parliamentary procedure: Affirmative resolution of the Scottish Parliament

Provision

35. Section 23 permits the Scottish Ministers to charge a fee in respect of the review functions of medical reviewers and to charge a fee for an application to cremate a person who has died outwith Scotland.
36. Subsection (3) allows the Scottish Ministers to make provisions by regulation, about the charging of fees, including the amount of such fee, arrangements for collection and any circumstances in which no fee is payable. In setting a fee, the Scottish Ministers are obliged to have regard to the cost of the exercise of the functions for which the fee is to be charged and must consult such persons as they consider appropriate.

Reason for taking power
37. Section 23 provides for fees payable for the review functions and for an application under section 17(2) (medical reviewers to authorise cremation). The fees are intended to cover the expenses of providing the system of scrutiny of medical certificates of cause of death and applications for cremation where the body has come from outwith Scotland. It is therefore expected that the fees will require to be altered from time to time. It is more flexible to do this in subordinate legislation than to amend primary legislation. With regard to fee collection, the precise mechanisms of the collection of the fee are likely to be of a technical nature and as such are best suited to regulations in the interests of efficient use of parliamentary time.

Choice of procedure
38. Affirmative procedure has been chosen for the setting of a fee, or its modification, allowing for greater parliamentary scrutiny.

Section 24: Documentation for disposal of a body

Power conferred on: the Scottish Ministers  
Power exercisable by: Regulations made by statutory instrument  
Parliamentary procedure: Negative resolution of the Scottish Parliament

Provision
39. Section 24 inserts a new section 27A into the 1965 Act creating the offence of disposing of a body without authorisation. The Scottish Ministers are given the power to specify the certificates or other documentation required for disposal of a body. In the case of a person who died in Scotland, this is likely to be a certificate of registration of death in the form prescribed under the 1965 Act. However, there will also be a need to prescribe the documentation required in other situations such as cases where persons have died abroad, where a child has been still-born, or where bodies or body parts have been used for anatomical examinations. The Scottish Ministers are also given the power to provide for the form and content of certificates, other than those prescribed by the Registrar General.

Reason for taking power
40. The offence requires a detailed list of all of the types of documentation necessary in a variety of different circumstances. Forms and certificates often require adjustment from time to time and subordinate legislation can deal with this more flexibly.

Choice of procedure
41. Negative procedure has been chosen as suitable to the level of technical detail required in setting out the various circumstances which may apply.
Section 25: Prescribed content of still-birth certificates

Power conferred on: the Registrar General
Power exercisable by: Regulations made by statutory instrument
Parliamentary procedure: None

Provision
42. Section 25 amends section 21(2)(a) of the 1965 Act. This section provides for the information to be contained in the still-birth certificate form to be prescribed by the Registrar General. Although the power already exists for the Registrar General to prescribe the form, the prescribed content may change as a result of these amendments.

Reason for taking power
43. No new power is being taken. This is an amendment of an existing power which is necessary so that more information can be added to the prescribed form in question. The intention is to add information on whether the body is an infection risk.

Choice of procedure
44. The prescription of forms by the Registrar General under the 1965 Act is not subject to any parliamentary procedure.

Section 25: Prescribed content of medical certificate of cause of death

Power conferred on: the Registrar General
Power exercisable by: Regulations made by statutory instrument
Parliamentary procedure: None

Provision
45. Section 25 also amends section 24(1) of the 1965 Act. This section provides for the information to be contained in medical certificates of cause of death forms to be prescribed by the Registrar General. Although the power already exists for the Registrar General to prescribe such forms, the prescribed content may change as a result of these amendments.

Reason for taking power
46. No new power is being taken. This is an amendment of an existing power which is necessary so that more information can be added to the prescribed MCCD forms in question. The intention is to add information on whether the body is an infection risk and whether the body has an implant that could be hazardous if the body were to be cremated.

Choice of procedure
47. The prescription of forms by the Registrar General under the 1965 Act is not subject to any parliamentary procedure.
Section 27: Consequential amendments etc.

**Power conferred on:** the Scottish Ministers  
**Power exercisable by:** Order made by statutory instrument  
**Parliamentary procedure:** Affirmative resolution of the Scottish Parliament where the order contains provisions which add to, omit or replace any part of the text of an act and negative resolution of the Scottish Parliament for orders which do not contain such provisions

**Provision**

48. Section 27 allows the Scottish Ministers, by order, to make supplementary, incidental, consequential, transitional, transitory or saving provisions as they consider necessary or expedient for the purposes of, in consequence of, or for the purposes of giving full effect to any provision of the Bill, including the power to modify any enactment, instrument or document.

**Reason for taking power**

49. The new procedures for scrutiny of medical certificates of cause of death have to interface with the established systems for the provision of medical certificates of cause of death, for the registration of deaths and for the investigation of deaths by the procurator fiscal. There may need to be supplementary, incidental, consequential, transitional, transitory or saving provisions to ensure that procedures in each system dovetail properly and there is the possibility that a supplementary provision could be required to ensure the smooth working of the system. This power is necessary to provide for the transition from the current law to the new system. If any requirements for adjustment come to light, they can be more speedily addressed through subordinate legislation than by making amendments to primary legislation. The power is limited to anything that is necessary or expedient in consequence of, or for the purposes of, giving full effect to the Bill.

**Choice of procedure**

50. As is usual, where the text of primary legislation is to be altered, affirmative procedure has been chosen to provide the higher level of scrutiny appropriate to the nature of the provisions. Otherwise, negative procedure has been chosen as appropriate for provisions which make adjustments within the scope and policy intentions of the Bill.

Section 31(3): Commencement

**Power conferred on:** the Scottish Ministers  
**Power exercisable by:** Order made by statutory instrument  
**Parliamentary procedure:** No procedure

**Provision**

51. Section 31(3) permits the Scottish Ministers to appoint a day for the majority of the provisions to come into force, including power to make transitional, transitory or saving provision, and to make different provision for different purposes (including different areas). It is intended to conduct site tests of the new procedures and the ability to make different provision
This document relates to the Certification of Death (Scotland) Bill (SP Bill 58) as introduced in the Scottish Parliament on 7 October 2010

for different areas will allow, for example, sample certificates from a particular registration area to be referred for consideration as part of this process.

Reason for taking power

52. This power is required to commence the provisions of the Bill at an appropriate time, together with any transitional, transitory or saving provisions as are necessary or expedient for commencement of the new system.

Choice of procedure

53. As is usual with commencement orders, no provision is made for laying the order in Parliament. The Subordinate Legislation Committee will, in terms of its remit, have the opportunity to consider the order.

Schedule 1: Qualifications of medical reviewers

Power conferred on: the Scottish Ministers;
Power exercisable by: Regulations made by statutory instrument;
Parliamentary procedure: Negative resolution of the Scottish Parliament

Provision

54. Schedule 1 inserts a new paragraph 7A into Schedule 5A to the National Health Service (Scotland) Act 1978 which sets out the functions of Healthcare Improvement Scotland. Paragraph 7A deals with the appointment of medical reviewers and, in particular, paragraph 7A(3)(c) requires medical reviewers or the senior medical reviewer to have such qualifications, training and experience as may be specified by regulations.

Reason for taking power

55. This is a provision which deals with the detail of qualifications, training and experience of medically qualified persons. As it deals with matters which may be subject to change over time, for example as medical qualifications change, it is more appropriate to put this in subordinate legislation where it can more readily be amended, as circumstances require.

Choice of procedure

56. Negative resolution procedure has been chosen as consistent with other powers under the 1978 Act and suitable to deal with the detailed and technical nature of any such regulations and the narrow limits of the power.
Health and Sport Committee

1st Report, 2011 (Session 3)

The Certification of Death (Scotland) Bill at Stage 1

Published by the Scottish Parliament on 21 January 2011
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Health and Sport Committee

Remit and membership

Remit:

To consider and report on (a) health policy and the NHS in Scotland and other matters falling within the responsibility of the Cabinet Secretary for Health and Wellbeing and (b) matters relating to sport falling within the responsibility of the Minister for Public Health and Sport.

Membership:

Helen Eadie
Ross Finnie (Deputy Convener)
Christine Grahame (Convener)
Rhoda Grant
Michael Matheson
Ian McKee
Mary Scanlon
Dr Richard Simpson

Committee Clerking Team:

Clerk to the Committee
Douglas Wands

Senior Assistant Clerk
Douglas Thornton

Assistant Clerk
Seán Wixted

Committee Assistant
Andrew Howlett
INTRODUCTION

Procedure

1. The Certification of Death (Scotland) Bill (“the Bill”) was introduced by Nicola Sturgeon MSP, Deputy First Minister and Cabinet Secretary for Health and Wellbeing (“the Cabinet Secretary”), on 7 October 2010. The Bill was accompanied by Explanatory Notes (SP Bill 58–EN), which include a Financial Memorandum, and a Policy Memorandum (SP Bill 58-PM), as required by the Parliament’s Standing Orders. The Health and Sport Committee was subsequently designated lead committee on the Bill. Under Rule 9.6 of the Parliament’s Standing Orders, it is for the lead committee to report to the Parliament on the general principles of the Bill.

Purpose of the Bill

2. The Bill, if passed, would introduce a new system of scrutiny of death certificates, which are formally called medical certificates of cause of death (“MCCDs”). It would create the posts of medical reviewer and senior medical reviewer whose functions would be to review for accuracy the MCCDs referred to them from a variety of sources, including random referrals by district registrars. The Registrar General would be responsible for ensuring the referral of MCCDs in accordance with the chosen selection scheme. Persons with some connection to the deceased would be able to apply for a review and medical reviewers themselves would also be able to select MCCDs for scrutiny.¹

3. Medical reviewers would be involved in the training of doctors in the completion of MCCDs. Information derived from reviews would feed directly into that training.²

4. The Bill provides for the form of MCCDs to be amended to show additional relevant medical information. This could include, for example, an indication that it is safe to dispose of the body by cremation. The Bill also provides for the form of still-birth certificates to be amended to show additional relevant medical information to indicate any risk to public health presented by the body.³

5. Where a person dies outwith Scotland and the body is to be cremated in Scotland, medical reviewers would determine whether it is safe to cremate the body. They would also in such cases be able to assist persons to make arrangements for a post-mortem examination (including meeting the cost of the examination) for deaths outwith the UK where no cause of death is available.⁴

6. A fee could be charged to pay for the review system and in cases requiring authority to cremate a body from outwith Scotland.⁵

7. It would be an offence to dispose of a body or body parts without authorisation.⁶

Pre-legislative scrutiny

Independent review of existing legislation in the light of the Shipman Inquiry

8. An independent review group (“the Review Group”) was established in January 2005 by the former administration to make recommendations on the law relating to burial, cremation and death certification, much of which was over 100 years old and was not felt to reflect 21st century life. There was also a need to examine the processes governing death certification following the independent public inquiry into the issues arising from the case of Harold Frederick Shipman (“the Shipman case”). The Review Group published a report, A review of the Burial and Cremation legislation in Scotland⁷, in April 2008.

Scottish Government consultation

9. The Scottish Government consulted on the report’s recommendations early in 2010. It has given priority to introducing legislation on the aspects of the report relating to death certification, with the remaining aspects relating to burial and cremation to be introduced at a later date.⁸

10. The Scottish Government consulted on the alternative models of death certification proposed by the Review Group: the Medical Investigator (“MI”) model

² Explanatory Notes.
³ Explanatory Notes.
⁴ Explanatory Notes.
⁵ Explanatory Notes.
⁶ Explanatory Notes.
and the Medical Examiner (“ME”) model. In both models it was proposed that a statistician would run regular statistical tests on all death data to identify unusual results and patterns of behaviour over time both nationally and at local NHS board level. The difference between the two models, as proposed by the Review Group, lay in the level of scrutiny of MCCD forms—

- Under the MI model, medical investigators were to scrutinise comprehensively a 1 per cent random sample of deaths, plus any deaths where concerns had been raised e.g. by a relative or doctor (estimated to account for up to a further 1 per cent of all deaths) and countersign the 2 per cent of MCCDs linked to those deaths;
- Under the ME model, in addition to the comprehensive scrutiny proposed for the MI model, medical examiners were to undertake a basic level of scrutiny of all other deaths (with much of this work carried out as administrative checks by their assistants) and therefore countersign all MCCDs in Scotland.  

11. In its consultation, the Scottish Government expressed an initial preference for the MI model.  

12. The consultation attracted 102 responses. Of these, 56 respondents commented on the models and a small majority (52 per cent) of these were in favour of the Scottish Government’s preferred option, the MI model, while just over a third favoured the ME model. Seven respondents wanted neither model, either because they were content with the existing system or because they wanted an alternative, such as the model being developed in England and Wales. An analysis of the consultation is available on the Scottish Government’s website.  

13. Following the consultation, further work was undertaken to address and take into account points made by respondents to the consultation. A range of stakeholder meetings was conducted to examine key issues and to explain to stakeholders the Government’s proposals and the rationale underpinning them.  

Other UK legislation

14. Primary legislation reforming the system for England and Wales has been passed by the UK Parliament and further work, including pilots, is underway. Secondary legislation outlining the detail of the new system to be established in England and Wales is expected to be brought forward in 2011.  

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9 Policy Memorandum.  
10 Policy Memorandum.  
12 Policy Memorandum.  
14 Policy Memorandum.
Committee consideration

15. The Committee records its thanks to those who gave evidence to, or otherwise participated in, its inquiry into the general principles of the Bill.

Formal evidence

16. The Committee issued a call for written evidence on 8 October 2010, with a closing date of 18 November 2010. 39 written submissions were received in response to the call for evidence. The Committee also took oral evidence from—

Mike Palmer, Deputy Director for Public Health, Frauke Sinclair, Bill Team Leader, Certification of Death (Scotland) Bill, Jacqueline Campbell, Head of Health Protection Team, and Edythe Murie, Scottish Government Legal Directorate, Scottish Government;

Professor Stewart Fleming, Professor of Cellular and Molecular Pathology, University of Dundee;

Dr Colin Fischbacher, Consultant in Public Health, Information Services Division, NHS National Services Scotland;

Ishbel Gall, Mortuary Manager and Vice-Chair, Association of Anatomical Pathology Technology;

Dr Jeremy Thomas, Consultant Pathologist and Clinical Lead, Scottish Pathology Network;

Jim Nickerson, Chairman of the Scottish Sub Committee, Federation of Burial and Cremation Authorities;

Gerard Boyle, Immediate Past President, National Association of Funeral Directors;

Elizabeth Allan, President of the Association of Registrars of Scotland and Chief Registrar, City of Edinburgh Council;

Leah Granat, Deputy Director, Scottish Council of Jewish Communities;

Dr Salah Beltagui, Convenor, Muslim Council of Scotland;

Shona Robison MSP, Minister for Public Health and Sport, Mike Palmer, Deputy Director for Public Health, Dr Mini Mishra, Senior Medical Officer, and Frauke Sinclair, Bill Team Leader, Certification of Death (Scotland) Bill, Scottish Government.

17. Extracts from the minutes of all meetings at which the Bill was considered may be found in Annexe A. Where written submissions were made in support of oral evidence, they are reproduced, together with the extracts from the Official Report of each of the relevant meetings, in Annexe B. All other written submissions are reproduced in Annexe C.
Consideration by other committees
18. A letter of 1 December 2010 from the Finance Committee, about the Financial Memorandum, is attached at Annexe D. The letter is taken into account in the section entitled ‘Financial implications of the Bill’ below.

19. The provisions within the Bill for making subordinate legislation were considered by the Subordinate Legislation Committee; its report to the Committee is attached at Annexe E. The report is taken into account under the heading ‘Subordinate Legislation’ below.

THE PURPOSE OF DEATH CERTIFICATION

Background

Principles of the death certification process
20. Professor Stuart Fleming of the University of Dundee submitted that death certification served to fulfil three aims—

- to allow the detection and investigation of unnatural death;
- to confirm as accurately as possible the cause of death for input into health care planning;
- to confirm the fact of death.\textsuperscript{15}

Scottish Government approach
21. Scottish Government officials explained that the Government’s approach was to propose the implementation of a set of arrangements for a sample of scrutiny on a random basis. Mike Palmer, Deputy Director for Public Health, stated—

“... any interested person who was connected to the death would be able to request scrutiny by the team of medical reviewers. We also propose that the medical reviewers would be at liberty to scrutinise up to 100 per cent of cases in any geographical area or any practice where there might be a concern and they believed it was appropriate to go in and implement more intensive scrutiny.”\textsuperscript{16}

22. Mike Palmer recognised concerns that random scrutiny was proposed for “only about 500 cases a year”, which, he said, appeared to be “significantly lower than the scrutiny in 100 per cent of cases” proposed in England and Wales. He emphasised, however, that random scrutiny was “only one small element” of the package of measures proposed.\textsuperscript{17} He explained—

“On the ethos that underpins our proposals, we are seeking to drive up the standard of completion of death certificates at source. In England and Wales, the proposal is to institute a check on every single certifying doctor’s medical certificates. Essentially, the assumption that lies behind that is that it is


necessary to check every single doctor’s work, and that that is the only way to institute an effective and robust system around death certification.

“We approach the issue from a different perspective. The goal that we are aiming at is to drive up standards at source so that we do not need to worry about having to check every single doctor’s completion of a death certificate. We aim to drive up the attention and priority that are given to that particular function, which we feel is a Cinderella function to an extent in some parts of the national health service. We also aim to drive up the priority and attention that are given to the standards of completion of the certificate, and to change the culture and practice so that certifying doctors complete certificates to a much higher level of accuracy at source. We do not believe that the heavy education and training element in our proposals is as prominent in the English proposals. Almost half of the remit for the medical reviewers will be to do with education and training to drive up standards at source.”

Detection and investigation of unnatural death

Detecting criminal activity

23. Asked whether the proposed new system would have the public’s confidence in the context of preventing another case like the Shipman case, Dr Colin Fischbacher of NHS National Services Scotland replied—

“No. Allowing interested parties to raise concerns about a death, sampling or the collection of other information might have a small deterrent effect, but no absolute assurance can be given that someone like Shipman would be detected. Indeed, as research carried out by Bruce Guthrie and colleagues in my organisation indicates, it is not feasible simply to rely on statistical methods to detect criminal activity and the response to the Shipman case depends not only on changes in death certification but a range of actions including better clinical governance, the revalidation of doctors and the reform of opiate prescribing. The short answer, therefore, is no.”

24. Professor Stewart Fleming of the University of Dundee and Dr Jeremy Thomas of the Scottish Pathology Network agreed. Professor Fleming stated that deaths such as those in the Shipman case occurred so rarely compared with other unnatural deaths such as industrial disease, suicide, road traffic accidents and so on that they could not be detected by statistical methods.

25. Dr Colin Fischbacher went on to explain that, if a statistical approach were to be employed in detecting murderers, “the number of false alarms would far exceed the number of true signals”. He stated that such an approach could not feasibly be taken and that other approaches were “more appropriate”. He added—

“Moreover, because of the way in which patients in Scotland are registered, we can monitor mortality in general practice only at practice level, not at individual doctor level. Murderers are clever. Dr Shipman moved practice


during his career, perhaps deliberately to avoid detection, and we cannot be sure that that will not happen again. This is just a distraction from the real purposes of statistical monitoring.”

26. Dr Fischbacher went on to state that it was possible that the Bill might have some effect but stressed that the impacts would be “relatively minor” and “certainly would not offer any reassurance” that such criminal activity would be detected. He believed that it was “fair” to state that the unlikely event of another Shipman would be made “marginally less likely” if all the measures proposed in the Bill were enacted. Professor Fleming put it more strongly—

“I think that the proposed measures make it much less likely that a Shipman-type case would be picked up, compared with the current system.”

27. Asked to develop the point, he stated—

“Under the current system, 62 per cent of deaths have three doctors reviewing them, two of whom are not part of the professional practice of the first doctor. Under the bill’s proposals, a doctor looking after a patient will sign a death certificate. That means much less scrutiny. Sampling will not pick up cases like Shipman; statistical analysis will not pick them up; but scrutiny by a second and third doctor, as occurs at the moment for cremation papers, is more likely to pick them up. They might not all be picked up, but it is more likely under those arrangements. If we do away with those arrangements, it will be less likely that we will pick up such cases.”

28. Dr Jeremy Thomas stated—

“The real concern relates to the size of the sample, which is set at around 1 per cent. The Royal College of Pathologists has experience of concerns about pathologists who make diagnostic errors, and there have been cases where pathologists have been reviewed to see whether their practice is up to scratch.

“From the samples that we have to take of a pathologist’s practice and his annual workload, we know that a 1 per cent sample will not detect those errors at all. We probably need to get up to around the 10 per cent level to have a realistic chance of picking up errors. You must remember that there will be a lot of noise but not a lot of signal, because the errors that we will see in death certification will be relatively minor. Picking through all that noise to find the signal will be difficult, particularly on a 1 per cent sample.”

29. Dr Colin Fischbacher agreed—

“We are not saying that there is nothing that can be done about cases like Shipman, far from it. We are just saying that statistical methods are not the way to go, and that there are better approaches, including those that I

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mentioned: better clinical governance, the regulation of opiate prescribing and the revalidation of doctors. Those measures would be more appropriate.”

30. Professor Stewart Fleming added that this concern was wider than “detecting or deterring a Shipman”. He stated—

“... many unnatural causes of death are picked up only at the confirmatory medical certificate on the cremation form. Somewhere in the region of 30 cases a year are picked up at that point. Some of them are road traffic accidents. An old lady dies of bronchial pneumonia and it is only when the doctor who is filling in part C enquires into the circumstances and mode of death that it becomes apparent that she was in hospital because she was knocked down by a car and was dying as a long-term or later consequence of a road traffic accident. Many unnatural deaths are picked up only because a second doctor scrutinises the cremation certificate.”

31. The confirmatory checks were also felt to be important by funeral directors. Gerard Boyle of the National Association of Funeral Directors stated—

“The funeral directors’ issue with the bill is that the system it would introduce is not as robust as the current one. We welcome any improvement to the medical certification for statistical analysis, but we feel that, for cremation, going from a two-doctor system plus a medical referee at the crematorium down to one doctor is, as was said in the previous session, a bit of a backward step ... Although we welcome any changes to the medical cause of death certification, the proposed system is definitely not as robust as the current one.”

32. Asked what difference the signing of the MCCD and authorising of the cremation by one medical practitioner rather than two would make if the purpose of the Bill was not to prevent, for example, a determined, cunning murderer, Gerard Boyle explained—

“It primarily comes down to safeguards and the fact that it is in the public interest that proper checks are done for everybody who is to be cremated. At the moment, only one doctor signs a certificate for a burial, but the system is different for cremation. Fortunately, we have not had any incidents like Harold Shipman—I do not think that we can legislate for that sort of occurrence anyway. If people set out to carry out that sort of crime, legislation will not prevent them from doing so, but we are moving from something that is quite robust to something that is not.”

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33. Jim Nickerson of the Federation of Burial and Cremation Authorities went on to explain further the importance of confirmatory checks—

“What happens now with the cremation papers is that they come into the cremation office and the office staff check that they are consistent. They will check that the name is right, the address is right, the age is right, the date of death is right and that all questions are filled in. The start of form B states that it is a statutory form and that all questions must be answered. That is the form that asks who was present at the time of death, what the cause of death is and so on. In about 20 per cent of cases not all the questions are answered. What concerns us is the accuracy of the MCCD. If the existing system, which is not entirely accurate, is swept away, how accurate will the replacement system be?”

Preserving evidence

34. It was put to witnesses that the Bill would result in burials and cremations being treated in the same way but that, in practice, there was a reason for paying more attention in cremation cases: cremation destroyed any evidence recoverable from the body whereas, in burial cases, the body could be exhumed and further tests could be performed. Ishbel Gall of the Association of Anatomical Pathology Technology agreed, stating that once a body had been cremated, there was very little that could be gleaned from the ashes. She argued in favour of double treatment—

“If the bill is passed, the body will not have to be examined by even one doctor before the medical certificate of cause of death is issued. That is rather worrying.”

35. Dr Jeremy Thomas described the proposals as a “dangerous move”, stating—

“The concern is that the whole system is being dumbed down. At the moment, the system requires two signatories to safeguard against the concerns that have been raised by Dr McKee. We are moving away from that, and that appears to me to be a backward step.”

36. Professor Stuart Fleming suggested that the Bill’s approach went the wrong way—

“I support the move to a single process for both burial and cremation, but I would move to one that is similar to the process for cremation rather than, as the bill suggests, one that is similar to the process for burial.”

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Stillbirths

37. Asked about current arrangements for stillbirths in the absence of a doctor or midwife, Ishbel Gall of the Association of Anatomical Pathology Technology responded—

“Depending on the circumstances, certain changes happen in a baby that can help to determine whether it died in the womb prior to its birth or died during birth—I do not want to get too technical. In many cases, the mother and baby will present at the maternity hospital, where qualified staff decide whether what has happened is a stillbirth with no suspicious circumstances or whether there might be merit in reporting it to the procurator fiscal. At the moment, it is determined on a case-by-case interpretation of the circumstances.”

38. Asked about the proposal to make a referral to procurators fiscal in all cases where no doctor or midwife is present at a stillbirth, Ishbel Gall stated—

“In certain cases it is obvious that what has happened is a stillbirth with no suspicious circumstances. If, for example, maceration is quite well developed, there will be no need for an inquiry. Moreover, in most cases, the parents will authorise a hospital post mortem to establish what has happened.”

Scottish Government

39. In oral evidence to the Committee, the Minister recognised the concerns raised in other evidence that the proposals might not act as a sufficient deterrent to wrongdoing nor involve sufficient scrutiny. She went on to announce “significant enhancements” that she believed would help to address those concerns—

“First, I propose to double the number of cases in the random sample, which is designed to provide a benchmark for measuring annual quality improvement, from 500 to 1,000 a year. When that is added to the proposed number of targeted and interested person reviews, it will amount to around 2,000 comprehensive—or level 2—reviews a year.

“Secondly, I propose to add to that a larger programme of independent level 1 reviews that are to be applied randomly to around 25 per cent of all deaths. That will capture around 13,500 deaths a year. Level 1 reviews will be conducted by medical reviewers, who will check the medical certificate of the cause of death and discuss it with the certifying doctors before sign-off. If a medical reviewer found cause for concern, a level 2 review could follow.

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“Furthermore, the legislation has been designed to require an annual report to Parliament on the activities and performance of the reviewers. I would be happy to agree that a report should come back to the committee on the workings of the new system after a suitable period, to review how the system is working before further roll-out. That would take account of stakeholder input, which will feed into the monitoring and evaluation plans that will be developed in due course.

“I believe that the package provides robust enough deterrence and reassurance to the public through widespread independent scrutiny of MCCDs, while harnessing the benefits of a targeted quality improvement approach that is proportionate and keeps the financial burden on bereaved families and the Government at a reasonable level.”

40. Asked whether the decision to double the number of cases to be scrutinised from 500 to 1,000 and to increase the proportion of level 1 reviews to 25 per cent had been made on a statistical basis or on a reasonableness basis, the Minister responded—

“A reasonableness test has been applied, with the recognition that, when the test sites have been in operation for a year, that should begin to give us some ability to judge whether there are any concerns about the new system. That is why the test sites are so important. As the figure of 25 per cent will be under ministerial direction to the registrar, it can be changed upwards or downwards in light of the evidence that we gather from the practice of the new system.

“What is proposed is a reasonable compromise, and it is proportionate cost-wise. The proposed system is affordable and it will increase the Government’s contribution by around £600,000. I feel strongly that I do not want to increase the level of fee to be paid by members of the public; I want to hold that at the £30 that we have proposed. We therefore propose that Government expenditure will cover the additional cost of having level 1 reviews in 25 per cent of cases.

“That is the rationale, and it can be tested during the test site period.”

41. She added that the doubling of the number of comprehensive reviews from 500 to 1,000 was a “significant step” in itself—

“After all, those level 2 reviews will be fairly in-depth and will involve checking not only the paperwork associated with the death but the appropriate medical records and the results of any medical investigations; discussions with the certifying doctor, other relevant staff and the deceased’s family or informal carers; and consideration of any other evidence including, if necessary, arranging to view the body.

“The test sites will allow us to reflect on whether the system is working not just with regard to level 1 and level 2 reviews but in a number of areas. For

example, communication with families will be important and we will be able to find out whether we need to do more in any area in response to feedback from stakeholders on the test sites. I regard that as very important, and I want to involve the committee in this work. Indeed, I have committed to reporting back to you on what stakeholders are saying and reflecting on whether any changes need to be made before the new model is rolled out.”

42. In response to a question asking how often, on average, each doctor would have a review, it was stated that it would really depend on the number of certificates that a doctor signed—

“It is difficult to make an average because a doctor in a remote area might sign few certificates, whereas a doctor who looks after a care home might sign many. We can categorically say that one certificate in four will be reviewed, but the link between the certificate and the doctor is quite tenuous.”

43. In relation to the removal of confirmatory checks, the Minister was asked whether the public would be convinced that the system had been improved when, instead of, in 60 per cent of deaths, the first doctor being interrogated by a doctor with no financial or professional interest in the workings of the first doctor and the relatives or people nursing the deceased also being questioned, 25 per cent of death certifications would require a telephone conversation between a central doctor and the doctor signing the certificate. She replied—

“The question is really about the purpose of what we are trying to achieve. The review group, which debated those issues for two years, concluded that there was little to be gained for the public purse or for public reassurance from the current system. That is why we are sitting here debating a new system to replace it. The old system was seen as out of date and unnecessary ... and it was extremely costly to the bereaved family. We could not continue to justify the ash cash issue, which has caught the public’s attention, and times and understanding have moved on from when that system was established medical practice.”

44. In response to a question about the proposal to make referral to a procurator fiscal mandatory when a child is stillborn and no medical practitioner or midwife was present, it was stated—

“It is applicable in less than 1 per cent of cases; it hardly ever applies. We are not really changing many circumstances here. The number of stillbirths in Scotland in 2009 was 317, so we are talking about a couple of cases. Referral of stillbirths to a procurator fiscal is very rare.”

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45. It was then asked whether it was necessary to do this in cases where there were no suspicious circumstances—

“Any doctor who is asked to certify a stillbirth will always say, if they were not present at the death, that it was a sudden death. On that basis, they would refer the stillbirth. If it was a death in utero, the mother would in most cases deliver in a hospital setting. In that case, somebody would be present at the birth. What we are really looking at is sudden deaths where a young girl delivers a baby—a concealed pregnancy or whatever—and the baby is found dead. In those circumstances I think that the doctor would be required to refer to the procurator fiscal, because the cause of death is uncertain.”

46. In addition, the Royal College of Midwives, the Royal College of Obstetricians and Gynaecologists and the Crown Office and Procurator Fiscal Service (“COPFS”) had been consulted and all had been content with the proposals. The Minister agreed to reflect further and subsequently wrote to the Committee on the matter—

“COPFS currently requires all sudden and unexplained deaths to be reported to the procurator fiscal (PF). While a sudden or unexplained death may not be suspicious, there is a requirement to report it, just as suspicious deaths have to be reported to the PF. If a baby has died in utero and is diagnosed, then the delivery will usually occur in a hospital, where clinical staff will be available at delivery. If a baby dies during birth, and a midwife or a doctor is present, they may be able to establish a cause of death and sign a stillbirth certificate. If the cause of death is not known or death is sudden or unexpected, the doctor or midwife cannot offer a cause of death if they have not witnessed the event, i.e. delivery, or examined the body. The COPFS currently expect the doctor or midwife to discuss the case with the PF. There will be no change to this practice as a result of this Bill.

“In investigating non-criminal deaths all PFs are expected to act with sensitivity in dealing with nearest relatives. Where the deceased is a child (perhaps a sudden unexpected death in infancy) or where stillbirth has occurred this duty of sensitivity is particularly acute. It is paramount that parents are informed that the involvement of a PF is not an indication of wrongdoing but rather that the PF is exercising his/her "other" role as deaths investigator. The only change being made by the Bill is to remove the current requirement in section 21(2)(b) of the Registration of Births, Deaths and Marriages (Scotland) Act 1965; this requires a qualified informant (usually a family member) seeking to register the stillbirth to complete a declaration to the effect that the child was not born alive and that there was no doctor or midwife present at the birth. As the PF will, in practice, be involved in such cases, this requirement is unnecessary.”

Conclusion
47. The Committee has concerns about the Bill as introduced. Whilst the Committee accepts that no system can eliminate the possibility of criminal activity by, for example, a serial killer, the initial proposals were for a level of

44 Scottish Government, written submission.
scrutiny and review of MCCDs that was much less rigorous than the existing arrangements. In particular, the Committee notes that a sample size of 10 per cent was said to be necessary to have a “realistic chance”\(^\text{45}\) of identifying errors.

48. The Committee welcomes the increasing of the random sample size and the planned addition of an extra tier of review, as announced by the Minister. However, the Committee notes that the sample size would be increased only to 4 per cent and remains concerned as to why this figure has been selected.

49. The Committee notes the intention to report to the Parliament on the outcome of the pilot in the test sites. In the meantime, the Committee will seek views on the Minister’s new proposals from witnesses who were critical of the Bill.

50. The Committee remains concerned, however, about the removal of the requirement for approval from a second and a third doctor from cremation cases. The Committee notes the argument that the procedures for burials and cremations should be aligned but believes that, owing to the finality of cremation, any alignment should have taken as its benchmark the rigour of the current cremation procedures.

51. The Committee notes the Minister’s further explanation regarding proposals relating to stillbirths, given in correspondence\(^\text{46}\) following her oral evidence.

**Accurate recording of the cause of death**

*Background*

52. Dr Colin Fischbacher acknowledged that there were weaknesses in the current system—

> “Two important weaknesses of the current system are that there is no systematic method of feeding back the problems that are detected by the form C doctor or others in the process, and my understanding is that there has been little or no improvement in the accuracy of death certification in Scotland in the past 10 years. The present system is therefore not delivering any improvement and it is not completing the feedback loop.”\(^\text{47}\)

*Analysis of the proposals*

53. Asked whether the Bill would result in more thorough or more accurate information on the death certificate, Professor Fleming stated that he did not believe so—

> “At the moment, in 62 per cent of deaths, the disposal of the body is by cremation. There is a separate cremation form, a second doctor and a confirmatory medical certificate. We know from our local experience and the


\(^{46}\) Scottish Government, written submission

nationwide crematoria experience that in about 15 per cent of cases—the figure is somewhere in that ballpark—there is a fine tuning or even an alteration of the diagnosis by the confirmatory medical certificate. That involves someone standing back, looking at the bigger picture and inquiring into the circumstances and mode of death. A system that does away with that will be inherently less accurate.”

54. Witnesses were asked about the Scottish Government’s view that the signing of a confirmatory certificate by a second and a third doctor in cremation cases – around 60 per cent of all cases – was conducted “in a relatively perfunctory manner” and did not deliver a “robust check” and that secondary checks should therefore be removed entirely. Professor Fleming responded that this view did not reflect his professional experience—

“The doctor who completes the confirmatory certificate has to speak to the doctor who has filled in the first part and to other individuals who are named on the certificate, such as nursing staff, family members, or other doctors involved in the person’s care, and then they have to complete the certificate. In hospitals such as Ninewells and those in Fife, a relatively small number of individuals carry out that task.

“I have already said that on approximately 15 per cent of occasions the diagnosis is fine-tuned or changed. In Scotland as a whole, between 20 and 30 cases a year end up with a full procurator fiscal investigation for an unnatural death. Some of those cases are suicides and some are industrial diseases, and they have just slipped through the net; no malice is intended. A 15 per cent improvement in accuracy and picking up on dozens of unnatural deaths does not seem to me to be perfunctory.

“I would much rather that the approach had been to look for the flaws in the system and to improve it, rather than do away with it completely.”

55. Ishbel Gall of the Association of Anatomical Pathology Technology agreed that the confirmatory certificate was “far from perfunctory”, stating that it picked up “quite a few anomalies” that were usually ironed out before the cremation papers went to the medical referee at the crematorium.

56. Dr Jeremy Thomas stated that he accepted the Scottish Government’s assertion that the quality of the current system was patchy but argued that the principles were sound. He also made a point about the seniority of the two practitioners who are involved in the signatory process—

“It is proposed that an FY2, which is a doctor who has been qualified for just one year, will be the person in hospitals who will normally sign the only certificate to allow a burial or cremation to proceed. The current system requires a second doctor who has been registered for five years.”

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57. It was suggested to witnesses that it was in some cases impossible to be accurate unless a post mortem was requested and that another doctor reviewing the first certificate could not give any more accurate a guess than the first doctor. Professor Fleming acknowledged that this was correct, explaining that research-based studies had shown that, in cases in which a post mortem had been performed after the completion of a death certificate, the inaccuracy rate was about 20 to 30 per cent. He added, however—

"... there are some circumstances in which a second doctor who has come to a case fresh and who reviews it from more of a distance and inquires into the circumstances and the mode of the death may suggest an altered diagnosis. That is what happens with the confirmatory medical certificates at the moment.

"I fully agree that we will not get anywhere near 100 per cent accuracy with death certificates, but I think that we can improve on the present accuracy rate. I am concerned that the bill’s proposals will make it less likely that we improve accuracy."

58. Ishbel Gall echoed this view—

“A post mortem is the ultimate audit, but it is probably not possible or feasible, given the number of pathologists we have in the country at the moment, to go back to the number of post mortems that we carried out 20 or 30 years ago.

“I do think that having a second doctor from a hospital setting, who is usually more qualified, adds something to death certification, because of their depth and breadth of experience. When they read through the case notes, they quite often pick up on something that a more junior, newly qualified doctor did not pick up on.”

59. Dr Jeremy Thomas added—

“In my experience of the process of carrying out a post mortem, scrutiny of the case notes usually takes you a long way towards the correct diagnosis. If a second doctor reviews the case notes carefully, he can usually get a long way towards the correct diagnosis. The post mortem does not usually throw up that many surprises. I believe that taking a little bit of time to review the medical records—that does not have to be done by a pathologist; a senior practitioner could do it—can do an awful lot to improve the accuracy of death certification.”

60. Gerard Boyle of the National Association of Funeral Directors also spoke of the advantages of the checks by further doctors—

“There have occasionally been marks or bruises on bodies that cannot be explained from the doctor’s first signing of the form. The doctor who signed

the death certificate might not have been aware that the person had had a
fall in the previous weeks, and the second doctor might find unexplained
bruising on the body. The second doctor will examine the remains if they
want to do so.”

61. He added—

“… I cannot think of any case in which a funeral director or an embalmer who
was preparing the deceased noticed something that both the first and second
doctor had missed, although I can think of occasions when the second doctor
has seen something.”

Scottish Government

62. Asked about reservations expressed in other evidence to the Committee on
whether the proposals would improve quality, the Minister explained that the
“whole raison d’être of the review system, including both level 1 reviews and level
2 reviews” was to “drive up the quality of MCCDs in general”. She stated that a
“very important part of the new system” was that, “unlike in too many cases at the
moment”, every certifying doctor was to ensure that the quality improved—

“The issue is not just how many certificates each doctor might end up having
scrutinised; it is more about driving up the general quality of those certificates
across the board.”

63. She went on to state—

“In addition, it will be possible to take an in-depth look at practice in certain
areas of Scotland—for example, groups of care homes, GPs or hospitals—and
consider whether there are statistical anomalies that require to be further
investigated. Furthermore, there is an education and training element, in
which medical reviewers will play an important part.

“Looking at the package, quality improvement comes through all that. The
quality of the completion of the certificates should improve—I very much
believe that it will—because of all the elements of the system.”

64. In relation to the issue of false certification in error relative to underlying
causes of death, it was put to the Minister that such cases would not be detected
by the systems proposed. Asked whether the information would be more accurate
under the proposals, the Minister responded that she believed that it would—

“… quality will be driven up. Unfortunately, at the moment some death
certificates still say that a person died of old age. That is completely
unacceptable in this day and age.”

65. The Minister and the Senior Medical Officer, Dr Mini Mishra, later acknowledged that, in some circumstances, it was “acceptable under the current guidance to specify "old age" in people above the age of 80”.61

66. The Minister added that the current system did not detect issues such as erroneous false certification and reiterated that the aim of the proposals was to “drive up quality”. She stated—

“The nub of … [the] question is whether there is any system that we could put in place that would detect some of the issues that have been mentioned. That would be a difficult task. Unless a post mortem is conducted and a toxicology report is produced for every one of the 50,000-plus deaths in Scotland each year, we will not necessarily be able to get at some of the issues that she raised. However, we can have the best and most proportionate system that includes a sufficient level of deterrence … The best that we can do is ensure that the level of deterrence is strong enough, that any statistical issues that arise are detected—the national statistician has a hugely important role—and that the quality of completion of death certificates improves. I believe that the system that we propose will do that. That is the best and most proportionate approach—affordability is an issue. The bill establishes the best system for doing all the things that we want to do.”62

67. Asked to give an example of how the position would be strengthened, the Minister responded—

“Under the new system, families will be able to raise with the medical reviewer concerns about the cause of death, which is not the case at the moment ... At the moment, families have no mechanism to say in an easy way that they are concerned that something about the cause of death has been omitted from a death certificate. Under the new proposals, a family will be able easily to contact the medical reviewer to say that they are not happy, which will allow the reviewer to look into the case. At the moment, that mechanism does not exist, but it will be part of the medical reviewer’s role. That is an important additional element for families that will enable them to raise their concerns.”63

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68. A question was asked about whether any consideration had been given to specifying a level of experience and training required of doctors before being eligible to sign an MCCD, given that, currently, MCCDs in cremation cases could not be signed other than by doctors who had a specified minimum number of years of experience and who had completed a module of training. In response, it was stated that the question had been considered—

“Any registered doctor who is beyond F1—that is, who is in F2 onwards—can certify death. If we are restricted to people who have more than a certain amount of experience, two issues arise. One is that doctors in training do not get that training, and the other is that we will not have enough doctors to do the certification, which would lead to delays and other problems.

“We spoke to educationists, who feel strongly that junior doctors should have a role in certifying deaths, but that they should be supervised by their seniors, which is what is meant to happen. That is also relevant to general practice, where GP registrars should be supervised by their trainers.

“That is the way that deaneries would like us to go. They would like us to emphasise the educational supervisors’ role in death certification, just as in other activities, such as operations.”

Conclusion

69. The Committee considers that the new proposals increasing the level of scrutiny, announced by the Minister during oral evidence to the Committee, take a step towards addressing the main concerns about quality and confidence in the system.

70. The Committee remains concerned that no level of experience is specified as a pre-requisite for a doctor to be eligible to sign MCCDs in a professional culture where supervision can be very variable – with, for example, junior doctors sometimes being left responsible for death certification at weekends without consultants being present. The Committee believes that, if the aim is genuinely to drive up quality, there must either be an experience qualification or junior doctors should not be allowed to sign a death certificate unless they have been signed off by the deanery as having undertaken a module.

71. The Committee also believes that accuracy could be improved with appropriate use of technology. This is discussed later in the report under the heading ‘Use of technology’.

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65 There are four postgraduate deaneries in Scotland, each an integral part of NHS Education for Scotland. NES and its postgraduate deans are accountable for managing the delivery of postgraduate training to standards required by the General Medical Council. They share this responsibility with NHS Boards for the trainees within their employment and with universities for the first year of postgraduate training.
Confirming the fact of death

72. Ishbel Gall of the Association of Anatomical Pathology Technology explained that it was currently legal for a registered medical practitioner to issue a death certificate without examining the deceased but that, in cremation cases, at least two doctors had to examine the body of the deceased. She argued that the Bill’s removing of the confirmatory signatures of a second and a third doctor was therefore problematic—

“In the bill, there is no plan to insist that the registered medical practitioner must view and examine the deceased before issuing the certificate. It is therefore perfectly possible that somebody could be cremated without having been examined by a registered medical practitioner. That is definitely a retrograde step, because currently at least two people examine the body.”  

73. She said that a situation where a GP who knew a terminally-ill patient very well presented the sort of circumstances that gave rise to a risk—

“If somebody has been very ill at home for a long time, rather than just taking somebody’s word that life is extinct—that the person has died—it would be prudent to insist that a medical practitioner examine the body before issuing a certificate.”

Conclusion

74. The Committee is concerned that it might still be possible for a medical practitioner to sign an MCCD without examining the deceased. The Committee draws this point to the Minister’s attention and requests that she respond to it in the Scottish Government’s formal response to this report.

OPERATION OF THE SYSTEM PROPOSED

Background

75. According to the Policy Memorandum, under the model proposed by the Bill, a senior medical reviewer (“SMR”) and up to six regionally based medical reviewers (“MRs”), all medically qualified, would be employed by Healthcare Improvement Scotland (“HIS”). The SMR and each MR would be supported by an administrative assistant. In addition, there would be a statistician located within, and employed by, NHS National Services Scotland who would produce both national and local statistics for further consideration by MRs. The statistician, a non-statutory role, would also be supported by an assistant. The Policy Memorandum states that the SMR and MRs would be accountable to the HIS board but would “have a high degree of operational independence in the exercise of their functions”. 

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68 Policy Memorandum.
76. The Policy Memorandum also states that the exact number of MRs required would be decided following test site work on the operation of the new system and that the work to be conducted by MRs would involve the following—

- comprehensive checking of all relevant paperwork associated with the death including the MCCD, appropriate medical records and the results of any medical investigations;
- discussions with the certifying doctor and other relevant clinical and healthcare staff, as required;
- discussions with the family of the deceased or an informal carer, as required;
- consideration of any other relevant evidence, including viewing the body, if necessary.\(^{69}\)

77. MRs would be required to consider whether to approve the MCCD for every death subject to scrutiny, unless the case is referred to a procurator fiscal; approval is likely to take the form of a countersignature and MCCD forms would be updated to allow for this. All MCCDs not subject to scrutiny will feature the signature of the certifying doctor only.\(^{70}\)

78. In cases of disagreement between an MR and the certifying doctor regarding the information provided on the MCCD, the certifying doctor would have an opportunity to issue a replacement certificate following discussion with the MR. Where agreement between the certifying doctor and the MR cannot be reached, a second opinion could be sought from the SMR and, if necessary, a further opportunity given to the certifying doctor to issue a replacement certificate. In cases of irresolvable disagreement over the cause of death, the SMR could refer the case to a procurator fiscal for investigation into the cause of death.\(^{71}\)

79. Any discussions entered into by MRs would be documented in order to provide a record of the discussions undertaken. Where the review of an MCCD gave rise to any suspicions of criminality, an MR or the SMR would have to report the matter to a procurator fiscal.\(^{72}\)

80. The Policy Memorandum summarises the role of MRs as being—

- to undertake comprehensive scrutiny of a sample of around 500 deaths annually and to consider any interested person cases reported to them (estimated to amount to an additional 500 deaths annually);
- to consider reports from the statistician and make available and discuss those reports with the relevant NHS board medical directors for further investigation or action;
- to perform additional checks where required e.g. at regional, hospital, practice or individual level, in the light of information gathered by the statistician (up to 100 per cent of deaths if required);
- to support certifying doctors directly in making effective decisions in relation to death certification through, for example, phone support;

\(^{69}\) Policy Memorandum.  
\(^{70}\) Policy Memorandum.  
\(^{71}\) Policy Memorandum.  
\(^{72}\) Policy Memorandum.
• to support and guide registrars directly in respect of information provided on MCCDs that is inaccurate, incomplete or requires further inquiry;
• to offer, potentially, ‘on-the-job’ and ‘off-the-job’ education and training of doctors and other healthcare professionals, for example through speaking about their role and through continuing professional development;
• to liaise closely with procurators fiscal.  

81. The Policy Memorandum summarises the role of the SMR as involving—

• strategic leadership and the promotion of improved and consistent high quality standards nationally in relation to death certification;
• provision of professional leadership and peer support to MRs, including support for aspects such as continuing professional development and medical revalidation;
• input to development of medical education and training in relation to death certification, linking in with NHS Education for Scotland (NES) and the royal colleges;
• delivery of a proportion of education and training at national level by giving seminars, conference talks, local sessions, etc;
• management of MRs and their staff and reporting to the HIS board;
• provision of second opinions in cases of disagreement between an MR and a certifying doctor and, where necessary, carrying out a full review of the case; and
• liaison with the Chief Medical Officer and Scottish Government officials, the Scottish Association of Medical Directors, the Crown Office and Procurator Fiscal Service and other appropriate persons (such as counterparts in other parts of the UK).  

Workload

82. Witnesses were asked how realistic it was to expect MRs to fulfil their educational functions in respect of training, guidance and support to persons required to complete medical certificates of cause of death, given that that function would be performed by at least 5,000 general practitioners alone, as well as by many other medical practitioners. According to Professor Stuart Fleming of the University of Dundee, it was “clear” that six medical reviewers would “not be able to deliver an education programme to around 12,000 doctors and 1,000 new graduates every year”. Commenting that neither the Bill nor the associated documentation contained any detail on how it would be done, he suggested that that work would “have to be outsourced, probably through the medical schools”.  

Scottish Government

83. The Scottish Government informed the Committee that there were 19,224 licensed doctors with a registered address in Scotland, anyone of whom would be eligible to sign a death certificate.   

73 Policy Memorandum.
74 Policy Memorandum.
doctors for a small number of MRs, with other functions to fulfil, was raised with the Minister. Asked how she envisaged that MRs would fulfil their education function, she responded—

“The medical reviewers will have the opportunity of some strong local links with the professionals in their areas. I envisage that they will take the opportunity, particularly in the early stages of the new system, to hold educational sessions locally. However, the most important aspect will be the on-going relationship. The medical reviewer should develop a relationship with the doctors in their area so that they can lift the phone, for example, should anything require to be clarified, particularly in the early stages of the new system. Some of the work might indeed involve formal input—obviously, that will have to be manageable time-wise—but some of it might be more informal, such as doctors checking on the phone with the MR that they understand the system correctly.”

84. It was also stated that the Scottish Government did not expect that MRs would personally undertake the training of nearly 20,000 certifying doctors—

“That would not be feasible. We have had initial talks with educational bodies and, for example, the postgraduate deans. Their view is that the education supervisors have a responsibility to ensure that there is quality in this area.

“The medical reviewers will carry out their education and training functions in a number of ways. We will particularly look for the senior medical reviewer to take a leading role in the area. For example, they will be expected to contribute to training through seminars, making links with the deans and talking to boards. The regional medical reviewers will have one day a week, not half their time, in which to carry out their training and education role. They will mainly focus on the scrutiny and review role.”

Conclusion
85. The Committee notes the explanation that MRs’ training and education role would be primarily supervisory whereas the responsibility for providing training and education would fall on doctors’ educational supervisors. The Committee has reservations that, with a remit to advise, to train and, now, to carry out 25 per cent level 1 scrutiny, which is likely to lead to an increase also in level 2 review, the proposed workforce may still be inadequate.

86. The Committee also draws the Parliament’s attention to paragraph 3 of Schedule 1, which states that any function conferred on MRs may not be delegated by Healthcare Improvement Scotland, and requests that the Scottish Government clarify whether it will be possible, in the context of this provision, for the educational and training role of MRs to be exercised by third parties as was suggested in oral evidence to the Committee.

76 Scottish Government, written submission.
Use of technology

87. Given the policy objective to improve accuracy, it was put to witnesses that electronic submission of death certification would be desirable as it could restrict the data entered to pre-determined formats.

88. In response, Dr Colin Fischbacher of NHS National Services Scotland stated that he understood the value of such an approach but was reserved about its feasibility. Professor Stuart Fleming of the University of Dundee, however, stated that he “strongly” supported it—

“We have a number of front-end systems like that. In my clinical job, I am a renal and transplant pathologist. We have a Scottish renal biopsy registry where we register diagnoses. There are subtle wording differences for describing things, and there are prompts to qualify the answer if it does not match the coding system. The software is available, but obviously quite a bit of work would need to be done. However, I strongly support the principle of the suggestion.”

Scottish Government

89. It was confirmed in oral evidence that there were no plans for electronic underpinning of the new system of death certification. The Minister stated, however, that it had been considered and could be introduced in the future—

“I reassure you that nothing in the bill confines practice to a paper-based system. My only note of caution is that introducing new information technology systems is costly.

We will certainly continue to consider the suggestion. I suspect that it might be difficult to have a system up and running for the test sites, but we would always consider where IT solutions could help. On your main point, I reassure you that nothing in the bill requires the system to be paper based, so it is future proof.”

Conclusion

90. The Committee notes the Minister’s comments that the Bill would not confine practice to a paper-based system. The Committee is surprised, however, that an electronic system was not specified from the outset, given the evident advantages: an electronic system could provide prompts and help to those completing MCCDs, as well as ensuring that non-compliant MCCDs were impossible to submit. The need for repeated data entry, which is another source of possible error, would also be removed from the process. Using an electronic system would also establish a chain of evidence and would do much to clarify matters. The Committee notes that it would now be difficult to devise and implement such a system in time for the beginning of the test sites but, if this proves impossible to achieve, strongly

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urges the Scottish Government to do so as soon as possible and, in any case, before the eventual roll-out of the new system nationwide.

Timescales

Background

91. The Policy Memorandum states that the additional checks required for those deaths selected for scrutiny pre-registration would introduce an extra step to be completed before a body could be released for a funeral. The Policy Memorandum also states that the average wait for a funeral is, “in most cases”, close to 7 days, based on “informal research of recent online family newspaper announcements”. It is anticipated that this aspect of the system would be examined and tested as part of the operational test of the new system, with a view to ensuring that scrutiny would, as a norm, be completed immediately following death (i.e. within a day or two of the death) with, therefore, no perceptible impact for bereaved families on the scheduling of funerals.  

92. It is conceded, however, that, in exceptional circumstances, selection for scrutiny could have an impact on the scheduling of funerals – for example, where records need to be retrieved from rural and remote locations or where public holidays constrain the swift retrieval of records. It is further recognised that there may be circumstances in which the delays inherent in a scrutiny system, even when they are fairly short, might create difficulties for particular bereaved families. The Policy Memorandum states that, accordingly, in cases randomly selected for review only, families would be able to request that registration take place in parallel with the review process. The registrar would refer the request to the MR for a decision on whether registration may proceed in parallel with scrutiny. It would then be for the MR to consider whether there was a good cause to justify this and whether there was likely to be a need to retain the body to allow a referral to a procurator fiscal, for example where the MR had a valid concern about the cause of death on the MCCD. Where the MR approves use of this expedited procedure, the registrar would allow the death to be registered, the funeral could take place according to the family’s requirements and scrutiny would proceed in parallel with family kept informed of the outcome as usual.

93. The Policy Memorandum envisages that, in most cases, the above process would take place within office hours and would not require any out-of-hours working. However, there are currently circumstances in which registrars open their offices in an emergency – for example, at the weekend – and there could, therefore, be circumstances in which out-of-hours working by a MR would be required. These issues would be considered further during the consideration of guidance and contracts for MRs.

94. The Policy Memorandum suggested that the expedited procedure would be used in circumstances such as—

- funerals taking place outwith Scotland;
- death of a child;

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83 Policy Memorandum.
84 Policy Memorandum.
Organ donation
95. Ishbel Gall of the Association of Anatomical Pathology Technology was asked whether the Bill would make it more complex for medical practitioners to consider tissue and organ donation. In response, she explained that, currently, a procurator fiscal was involved in many such cases because they typically resulted from some sort of traumatic event—

“If there is a chance that the death certificate may have to be reviewed, many people would feel uncomfortable going ahead and retrieving tissue. In much the same way as we need permission from the procurator fiscal, we would expect to have permission from the medical reviewer to proceed. Unfortunately the medical reviewer will not be a 24/7 operation, so we may have difficulty getting that tissue and therefore lose some of the valuable donations that we currently get.”85

96. She went on to confirm more specifically that the presence of the medical reviewer “could make it more difficult to retrieve, or could delay, potential organ or tissue donations” and illustrated the point with a practical example—

“… if the death occurs, say, on a Friday, we might not be able to contact the medical reviewer or get the death registered until the Monday morning. At the moment, if we have an adequate cause of death and there is no procurator fiscal involvement, we go ahead with the retrieval.”86

Remote communities
97. Witnesses were asked about the logistics of matters such as moving bodies and storing them for long periods in the context of the proposals. In particular, it was asked whether any problems were anticipated, despite the provision allowing for an expedited procedure. Ishbel Gall of the Association of Anatomical Pathology Technology believed that there were—

“I have spoken to quite a lot of the funeral directors in my area and, although they are based in Aberdeen, they deal with a lot of deaths from Aberdeenshire, the Highlands and Islands and Orkney and Shetland. Most of the undertakers in those areas do not have refrigerated accommodation, which is part of the reason why burials in those areas go ahead quickly—in many cases, they take place within two or three days of death.

“The funeral directors to whom I spoke said that they would do nothing until the family had successfully registered the death, which is different from the way in which things happen at the moment. Often, in the case of deaths that are some distance from Aberdeen, the funeral director will collect the deceased and will also pick up any personal effects and the certificate of cause of death, which he will convey to the family to save them having to travel to pick up the certificate themselves. However, they have stated that, now, they would definitely not be going to collect the deceased and the death

certificate, because they would then be responsible for the deceased until such time as the funeral arrangements were made, and they just do not have the facilities. In this kind of weather, it is not such a problem but, in summer, storage of the deceased is often a problem.”

98. Ishbel Gall went on to explain that, typically, the deceased was taken to funeral directors’ premises, put in a coffin and then taken to the family’s home before, on the night before the funeral, being moved to the church—

“That process takes two to three days. Under the proposals, therefore, the undertakers would be expecting that the deceased would stay with us for an extra two to three days, in most cases, which would cause major problems for us at certain times of the year, especially if the medical reviewer were working 9 to 5, Monday to Friday, and taking all the public holidays.”

99. Asked whether mortuaries would have the capacity to manage the extensions that she had cited in her examples, Ishbel Gall responded—

“Currently, the mortuary at Foresterhill hospital in Aberdeen is the busiest by ratio of space to the number of people passing through it. We see ourselves as being relatively efficient because we have quite a lot of burials and people spend as little time as possible in the hospital mortuary. We also have a duty of co-operation under the Public Health etc (Scotland) Act 2008 to work with the local authority on its body storage, which is also woefully inadequate. My concern is that the proposals will be a major issue not just in our area. We already have a problem in that there are no out-of-hours GPs and most of the services are run by an out-of-hours service, which is not particularly good at issuing certificates out of hours because the circumstances surrounding the death are not always known. It is common for the deceased to be moved to the public mortuary because no certificate is forthcoming until such time as a GP can be contacted. If the death occurs on a Friday night, that might happen on Monday morning and, if there is a public holiday, it might take even longer. We already have pressures on the available space and the proposed review would exacerbate the problem.”

Impact on faith-based practices

100. In its written submission, the Scottish Council of Jewish Communities stated that it supported the principle of effective scrutiny but suggested that accuracy “should not be an overriding consideration” if no “significant issues” depended upon it, “such as legal proceedings”. Asked whether this concern was about burials being delayed only to ensure a more accurate diagnosis for statistical purposes, Leah Granat of the Scottish Council of Jewish Communities stated in oral evidence that there needed to be a balance between, on one hand, the need for accuracy and information to plan appropriate medical provision and, on the other hand, the need for communities and people who are bereaved to be able to begin grieving, which she described as the “overriding factor”. She added—

“In the Jewish community, the seven-day shivah period—in other words, the formal grieving process—begins only after burial. There has been a lot of research in this area and, according to psychologists, when grieving is delayed it becomes a much longer and much more difficult process for the bereaved.”

101. She went on to state that the proposal to subject 1 per cent of deaths to more rigorous scrutiny involving a medical reviewer travelling various distances, looking at notes, interviewing the doctor and relatives for the sake of accuracy and so on would cause problems for religious communities—

“In the Jewish community, there is a very strong imperative for speedy burial. At the moment, the vast majority of Jewish burials in Scotland take place either on the same day or early the following day and if a review had to be carried out before burial could go ahead it would cause delays and a great deal of distress to a lot of people.”

102. Dr Salah Beltagui of the Muslim Council of Scotland stated that the experience of burial was also important in Islam and was supposed to take place on the day of death or the next day, unless there was some necessary delay. He spoke further about the issues that could be caused by a delay—

“If the bereaved see no reason for it, it becomes a cause of anxiety for them. It is important to make the point that the burial provides a kind of closure for the bereaved; the recovery process starts after that. If the burial is delayed, it is like starting again after a week. That is the main reason for having the burial take place on the same day.”

103. Leah Granat commented on how wide the impact could be—

“The issue does not affect only the Jewish and Muslim communities or even only ethnic minority communities. Delay to burial is distressing generally. If we establish that there is no reason why registration and disposal—certainly

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by means of burial—cannot go ahead in parallel with review, that will be of
benefit widely across the community.”\(^{93}\)

Relationship between review and registration
104. Gerard Boyle of the National Association of Funeral Directors expressed a
concern that delays under the Bill could affect funerals more widely than only
those relating to cases selected for review—

“From the funeral directors’ point of view, it is important that the certification
is right before we carry on with any funeral arrangements. The bill proposes a
1 or 2 per cent review of cases with six medical reviewers. Our concern is
that that would add undue delay to all funerals.”\(^{94}\)

105. Professor Stuart Fleming of the University of Dundee questioned whether
delays to registration were at all necessary—

“If, as is probably the case, the primary purpose of the review is to
benchmark the error rate rather than anything else, it is not clear ... why that
cannot be done as a post-registration event. It is not there to pick up flaws
that would block registration, so why block registration?”\(^{95}\).

106. This suggestion was supported by Leah Granat of the Scottish Government
Council of Jewish Communities—

“... the committee has received evidence that it is unlikely that review would
involve post-mortem examination of the body ... In that case, why should not
registration and subsequent disposal of the body simply go ahead? The
review could take place in parallel and continue afterwards. Where the
disposal is by means of burial, it will still be available in the extremely rare
circumstances in which the body needs to be examined.”\(^{96}\)

107. Dr Salah Beltagui of the Muslim Council of Scotland added—

“The delay that will be caused by the review, which is a paper exercise, could
continue after the burial. Muslims do not practise cremation. As Leah Granat
indicated, because the body still exists, there is a chance of getting it back, if
necessary.”\(^{97}\)

108. Leah Granat went on to point out that, whilst the Bill provided for “parallel
registration and review”, it did not refer to parallel disposal and review—

“In earlier evidence ... [it was] said fairly explicitly that the Scottish
Government view is that in this case “disposal” and “registration” mean
exactly the same thing. We would certainly appreciate reassurance that that
is the case. Perhaps—thinking about the drafting of the bill—if it means
parallel disposal and review, the bill should refer to that rather than simply to

registration, which might imply that registration can go ahead but the burial cannot until the review is concluded.”

109. She added that the Bill would give Scottish Ministers regulation-making powers to prescribe the types of documentation required before disposal could go ahead and questioned whether one of the required documents would be a confirmation that any review had ended—

“… that would put a stay on burial. It would be problematic if registration had gone ahead but disposal could not.”

110. Dr Salah Beltagui made the point that the first point in the summary of recommendations in the Review Group’s report was—

“The procedure for certifying deaths should be sensitive to the many different faiths and beliefs in Scotland and ensure as short a delay as possible between death and disposal.”

111. He called for the word “faith” and consideration of faith to be included in the Bill not just for Muslim and Jewish interests but for the future. Leah Granat followed up on this point—

“In the equality impact assessment, there is discussion about the bill being fair because there will be a uniform process for everybody. I just want to emphasise that fairness is not the same as uniformity.”

Scottish Government
112. The Scottish Government wrote to the Committee about organ and tissue donations, stating that “early discussions with relevant stakeholders” had taken place with a view to ensuring that the new system would not adversely impact on organ and tissue donation—

“Specifically, we have spoken to the Tissue and Cells Medical Director at the Scottish National Blood Transfusion Service and concluded scrutiny would not affect organ and tissue donation because by the point at which scrutiny is flagged up (when the MCCD is presented to the registrar) tissues or organs would already have been removed. Equally, it would be of no concern for the purposes of scrutiny that some parts of the body had been removed.”

113. The letter also stated that consideration had been given to whether scrutiny would cause any delays that would affect whether bequests of bodies donated for medical research could be accepted—

“We have had early discussions with university anatomy departments and will be continuing these to consider the need to develop guidance. In the meantime, we have noted that these cases would be justifiable reasons for
the expedited procedure (section 6 of the Bill) to prevent any delay and deterioration of the body.”

114. The availability of the expedited procedure to facilitate prompt burials – for example, in the observance of faith-based practices – was raised in oral evidence. The Minister stated—

“We need to reassure faith communities that there would not be a delay, because that is a significant issue for them. The main thing to understand is that the review can happen concurrently with the registration at the discretion of the medical reviewer. We want to ensure that that happens. We would also highlight to the General Register Office for Scotland the need to ensure that there are no delays in the system. The test sites will be important because they will give us an opportunity to monitor and, if required, to make adjustments at that stage, before further roll-out. We recognise the sensitivities and we would certainly not want to create difficulties for our faith communities.”

115. In response to a question about the definition of registration compared with that of disposal, it was confirmed that registration and disposal would not be the same and that disposal could not take place whilst a review was taking place. The procedure envisaged was explained as follows—

“In the expedited procedure, when somebody makes an application, the MR, apart from screening out the vexatious requests, will communicate with the registrar after cursory, superficial scrutiny to say that, in his view, there will be no need to retain the body and that registration and disposal can go ahead while he deals with the more detailed aspects of the certification process. Another point that was made was that the disposal documents might require an MCCD and that that could tie in while the funeral arrangements are being made in the expedited procedure, bearing it in mind that getting the notes and doing about a three-hour review should all tie into an expedited burial as well. In the expedited scenario, there is provision for the MR to say that registration and disposal can go ahead while they carry out a concurrent review.”

116. The Minister went on to clarify that disposal would only go ahead at the stage where the medical reviewer was satisfied that there were no outstanding issues—

“It would not happen automatically but would have to be at the say-so of the medical reviewer. In effect, it would be a judgment made by the medical reviewer. If the committee is uncomfortable with that, we can certainly explore it further. We felt that it was important for the discretion to be kept.”

117. She added that it was planned to address the issue in guidance but that the Scottish Government could “certainly consider” the matter further if the Committee

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103 Scottish Government, written submission.
felt that more than that was necessary.\textsuperscript{107} She subsequently wrote to the Committee about this matter—

“Under the expedited procedure it will be possible to proceed to dispose of the body before the review is complete. When a case is selected for review, an application may be made directly to the medical reviewer who will confirm to the registrar as soon as possible whether the expedited procedure can be used.

“Where a case proceeds using the expedited procedure, registrars will be able to register the death right away and will not need to wait until the review has been completed. Registrars will be able to issue a Form 14 certificate there and then, confirming that the death has been registered. In such cases, this confirmation certificate is all that will be required to dispose of the body (this will be set out in regulations to be made under the new section 27A of the Registration of Births, Deaths and Marriages Act 1965, inserted by section 24 of the Bill). Accordingly, families will be able to proceed directly to funeral, whilst the review is ongoing.”\textsuperscript{108}

Conclusion

118. The Committee believes it is important to respect the position of different faith groups in relation to the Bill’s provisions, particularly the Jewish and Muslim faiths. The Committee considers that the system should not unduly delay disposal of the body and this should be clear in the Bill. In the light of the Scottish Government’s evidence on this point, the Committee is not confident the Bill is entirely clear on this point and believes the expedited process should reflect the faith needs of certain groups in society. The Committee welcomes, therefore, the clarity brought by the Minister’s explanation given in correspondence but believes the Bill should be amended in order that the position be similarly clear in the legislation itself.

119. Concerns were also raised with respect to particular difficulties for remote and island communities, relating to potential delays in both initial certification and review.

120. The Committee notes the important concerns raised in relation to organ donation, which appear to conflict with the Scottish Government’s position on the matter. The Committee looks to the Government’s response for further clarity on this issue.

121. The Committee also notes the need for expedited procedures where bodies were being donated for medical research and notes the Minister’s response that this would be dealt with in guidance.


\textsuperscript{108} Scottish Government, written submission.
Deaths abroad

Background
122. The Policy Memorandum explains that, currently, Scottish Ministers have a role under the Cremation (Scotland) Regulations 1935 in giving authority for cremation in Scotland where a death has occurred abroad and there is adequate documentation equivalent to the certificates required under those regulations. It is added that this does not apply to burials of those who have died abroad, where Scottish Ministers have no involvement. The administrative element is undertaken on behalf of Scottish Ministers by civil servants and senior medical officers who check the paperwork and the cause of death. The paperwork is then passed to the relevant medical referee to sign off with the authority to cremate (“Form F”) and the cremation can proceed.\textsuperscript{109}

123. According to the Policy Memorandum, where current checks by the Scottish Government fail to establish a satisfactory cause of death, current administrative practice is to refuse to authorise a cremation. Families then have either to arrange a private post mortem in an attempt to establish cause of death or to opt for burial.\textsuperscript{110}

124. The Scottish Government handles an average of 130 requests a year for cremation authorisations resulting from repatriation of Scots who have died abroad. There are no statistics on the total number of annual repatriations (i.e. burials and cremations) but the Policy Memorandum assumes that the 40/60 split between burial and cremation in Scotland applies also to deaths of Scots abroad and estimates a total of around 250 deaths per year requiring repatriation for a funeral service. It also estimates that in around 10 per cent of these cases the cause of death will not have been established.\textsuperscript{111}

125. The Bill would impose a duty on persons having charge of a place of interment or cremation to ensure that the disposal is authorised by the correct certification (which, for deaths outside Scotland, is likely to be certification equivalent to the MCCD and the certificate of registration of death). In addition, where a person has died outside Scotland and it is intended that he or she be cremated in Scotland, the case will be referred to an MR, who will examine the paperwork to determine whether it is safe for the body to be cremated, such as checking for information about whether the deceased had a pacemaker or other implant that might be hazardous during the cremation process.\textsuperscript{112}

126. With the exception of certain powers in relation to service personnel who die abroad, the Lord Advocate does not have jurisdiction to investigate deaths occurring outside Scotland, nor any power to instruct post mortems of such deaths. This is in contrast to the position in England and Wales where coroners hold such powers. The Policy Memorandum states there was a high level of agreement amongst those who responded to the Scottish Government consultation (just over 40 per cent) that, when the death of a person who is normally resident in Scotland occurs abroad, a government body in Scotland

\textsuperscript{109} Policy Memorandum.
\textsuperscript{110} Policy Memorandum.
\textsuperscript{111} Policy Memorandum.
\textsuperscript{112} Policy Memorandum.
should be able to assist in the arranging of a post mortem to seek to establish the cause of death if this is unknown.\footnote{Policy Memorandum.}

127. It is proposed that a power be given to allow MRs to assist in the arranging of a post mortem (including providing financial assistance) to help support relatives whose family member is returned to Scotland for disposal and no cause of death is available. This power would be used in limited circumstances (to be set out in guidance) where it is deemed appropriate on compassionate grounds to address a need that a bereaved family may have to establish the cause of death. This might be, for example, to establish whether a hereditary medical condition may have existed. The Policy Memorandum points out that post mortems can help families through their bereavement but that they currently have no option but to carry out the procedure privately, the cost of which is prohibitive for some. The Policy Memorandum draws a comparison with the position in England and Wales, where post mortems of deaths abroad can be instructed by the coronial authorities.\footnote{Policy Memorandum.}

Responsibility for judging the validity of foreign certification

128. The Institute of Cemetery and Crematorium Management’s written submission argued that it was “inappropriate” for the responsibility for registration to fall on the person having charge of the cemetery or crematorium – a medically-unqualified member of staff – bearing in mind the penalties to be introduced for disposing of a body without authorisation.\footnote{Institute of Cemetery and Crematorium Management. Written submission to the Health and Sport Committee.} Commenting on this point, Jim Nickerson of Federation of Burial and Cremation Authorities stated—

“The Government envisages that the medical reviewer will review the medical notes from Britain to determine whether the person had an implant or something else that is likely to explode or be hazardous when it cremates. If there is not, they will say to the crematorium, "It is safe to cremate." However, that system would rely on the crematorium staff ensuring that they have the equivalent of the death certificate and the registration of death from whatever country the person died in. We would have totally unqualified people making decisions on whether a document is a death certificate.”\footnote{Scottish Parliament Health and Sport Committee. \textit{Official Report, 1 December 2010}, Col 3765.}

129. He went on to speak from his experience of running two crematoria, which, between them had handled 12 to 15 deaths from abroad in the past year—

“In only one case out of the last three was there a proper registration of death from the country where the death occurred—Spain. The death certificate stated in Spanish at the top that it was a death certificate, and the registration of death also stated what it was in Spanish at the top, so that was okay.

“One of the others was in Malta—it was somebody who died on a cruise ship. We got permission from the Government to go ahead, and the paperwork that came to us consisted of an unheaded note that looked as if it had come from the ship, saying what the person died from. It had been stamped at the bottom by a police sergeant in Malta. Presumably, that is a registration.
“The other one concerned somebody who died in Turkey. The local consul had done a translation of the death certificate, but there was nothing about registration.”\(^{117}\)

130. He added that, whilst the current system “might be vague”, but “at least someone in the Scottish Government” had the authority to make a decision—

“In future, it would be somebody in a crematorium or cemetery. There are many cemeteries in Scotland, some of which do only one or two burials a year. The people at those places might come across such paperwork only once every 10 years and they would have to make a decision on the matter. A part-time elder, for example, would have to decide whether the paperwork was correct.”\(^{118}\)

131. He went on to describe the scale of this potential problem—

“The paperwork is to be distributed throughout the whole of Scotland and it is to be kept, but there is to be no review of it whatever. As far as I know there is no such review now, but at least all the paperwork is held by the Scottish Government so that if somebody wishes to do a review of how many people have died on a particular cruise ship, or in Turkey, for instance, the paperwork is available for that review to be carried out. The proposal is for the paperwork to be dispersed throughout the whole of Scotland, and unqualified people—hundreds of them—are to be asked to make the necessary decisions.”\(^{119}\)

**Conclusion**

132. The Committee considers that the responsibility for assessing the validity of documentation in cases of repatriation of the deceased for burial or cremation should be exercised centrally.

**FINANCIAL IMPLICATIONS OF THE BILL**

**Background**

_Estimated cost of the new system_

133. The Financial Memorandum states that its costings are based on assumed likely workload and tasks initially agreed by an independent Review Group which met between 2005 and 2007. It assumes that 500 cases would be sampled and a further 500 referred for investigation. This would mean that around 1,000 deaths would be scrutinised annually, around 19-20 cases per week. It is estimated that reviewing a single case would take an MR around half a working day. The Financial Memorandum recognises that the number of cases referred would vary and states that there is some spare capacity within the model, which would also cover additional scrutiny initiated by MRs.


134. Costings shown in the Financial Memorandum allow for six MR posts. This is intended to provide flexibility and speedy response times and to ensure that each MR has a reasonably sized territory to cover. It is estimated that this would allow (a) around three days per week for conducting additional focussed scrutiny and other functions and (b) additional flexibility if the number of interested person reviews exceeded expectations. The Financial Memorandum points out that the number of MRs would not appear in legislation and, as the proposed test sites are expected to inform the exact number of MRs required, the costings shown are estimated.

135. The Financial Memorandum explains that associated costs would not necessarily rise linearly with sample size, owing to factors such as flexibility between review and training time incorporated into the model, non-linear changes in travel cost and transport charges and possible economies of scale arising from conducting more than the currently assumed number of reviews per week. Each added MR post (including an additional medical assistant) would increase start-up costs by about £2,500 and annual costs by £151,124, composed of salary and on-costs for the MR and the medical assistant, as well as IT and telephony.

136. The recurring and start-up costs (excluding those relating to the test sites and recruitment costs, which would depend on whether posts were advertised together or separately and could range from £2,000 to £20,000) are summarised in the Financial Memorandum as follows—

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<thead>
<tr>
<th></th>
<th>Recurring</th>
<th>Start-up</th>
<th>TOTAL</th>
</tr>
</thead>
<tbody>
<tr>
<td>Analytical staff</td>
<td>£74,579</td>
<td>£0</td>
<td>£74,579</td>
</tr>
<tr>
<td>Medical staff</td>
<td>£903,345</td>
<td>£0</td>
<td>£903,345</td>
</tr>
<tr>
<td>Support staff</td>
<td>£149,568</td>
<td>£0</td>
<td>£149,568</td>
</tr>
<tr>
<td>SUB TOTAL</td>
<td>£1,127,492</td>
<td>£0</td>
<td>£1,127,492</td>
</tr>
<tr>
<td>Total running costs</td>
<td>£61,564</td>
<td>£0</td>
<td>£61,564</td>
</tr>
<tr>
<td>Accommodation</td>
<td>£0</td>
<td>£20,017</td>
<td>£20,017</td>
</tr>
<tr>
<td>IT changes &amp; support</td>
<td>£0</td>
<td>£7,000</td>
<td>£7,000</td>
</tr>
<tr>
<td>GRO promotional costs</td>
<td>£0</td>
<td>£10,000</td>
<td>£10,000</td>
</tr>
<tr>
<td>Development of training module</td>
<td>£0</td>
<td>£57,500</td>
<td>£57,500</td>
</tr>
<tr>
<td>TOTAL</td>
<td>£1,189,056</td>
<td>£94,517</td>
<td>£1,283,573</td>
</tr>
</tbody>
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137. Under the new system, the format of MCCDs would be changed to incorporate a unique identifier code for each doctor certifying deaths and to include questions on implants and public health. The Financial Memorandum sets out a cost to the General Register Office for Scotland (GROS) arising from making this change to the forms and from changing the GROS computer system used by registrars to capture the registration data. There would also potentially be a cost in updating the database at the Information Services Division in order to receive and hold the additional information. It is estimated that reprinting the MCCD to take account of any changes would cost GROS about £6,000.

138. In addition, the GROS vital events database, a system used for statistical outputs and analysis and based on the information held on the registration database, would need to be amended to include the unique identifier. It is
expected that the cost of this would be in the order of £1,000 bringing the total costs for IT changes and support to £7,000.

139. There would be an additional expense to provide for materials to alert doctors and other stakeholders such as funeral directors and the public about the changes. It is expected that these materials would be placed within registrar offices. The Financial Memorandum states that, in a recent regulatory impact assessment on sunbed regulations, it was estimated that the issuing and distribution of leaflets and posters cost no more than £10,000. After initial distribution, information materials would be available on designated websites to download.

140. Training needs would vary in different phases of the programme. In the first phase after the inception of this model, the MR posts are likely to be filled by experienced specialists, such as those currently filling the position of medical referees. During this phase, only additional training through an e-Learning module at an estimated cost of £57,500 would be required to top-up the MRs’ skills set. The Financial Memorandum outlines an expectation that, after approximately seven years, a second phase would commence. This would coincide with new teaching cycles (with updated modules on the medical reviewer model) for training GPs and other specialists, who would form a pool of second or third generation of MRs after a few years’ experience of practice. After about 10 years, a third phase is envisaged in which the first group of MRs will begin to be replaced by new doctors, in turn requiring top-up e-Learning training. The recurring cost of training with this module is assumed to be low as there would be no accommodation or teaching costs.

Recouping the costs of the new system
141. The Financial Memorandum states that the initial set-up costs of the new system, estimated at around £94,500, would be paid by the Scottish Government and subject to a Spending Review bid. However, it is proposed that the annual running costs of operating the new arrangements would be self-funding through the charge of a fee to the public.

142. Currently, a fee is charged to bereaved families (or whoever arranges a funeral) by the doctors signing off certificates authorising cremation of the body. This fee, which goes to two doctors, amounts to £147 per cremation. It is paid as a private financial transaction between the family and the authorising doctors and is often handled by funeral directors acting as intermediaries. In addition, when a body is cremated, the medical referee at the crematorium performs the final check on the papers. The cremation authority pays the medical referee a fee which is recouped through the fee charged by the authority to the nearest relative as part of the funeral arrangements. The Financial Memorandum points out that the existing fee is inequitable insofar as it applies to cremations only and that the current arrangements are not regarded as having resulted in necessary improvements to scrutiny.

143. In future, the Scottish Government proposes that a universal fee should be introduced to fund the new death certification system, principally the role of MRs to carry out the review functions (and related national statisticians’ function). The new fee would apply to both cremations and burials; would fund improvements in
scrutiny and clinical governance related to death certification, and is estimated at around £22, with an additional fee of £8 to £10 to recover the costs of collection. The Financial Memorandum concludes that for around 60 per cent of families, there would be a saving. The fee would be payable by the personal representatives of the deceased and would be treated as part of the general testamentary and administration expenses of the estate.

Costs relating to deaths abroad
144. The Financial Memorandum estimates an annual maximum of 25 deaths abroad with no clear cause of death, which could, therefore, be eligible under the Bill for MR assistance arranging a post mortem (including meeting the cost of the examination). The costs would be up to £12,500 annually and would be borne by the Scottish Government and not recouped through the fee.

Consideration by the Finance Committee
145. As is the case with all bills, the financial implications of the Bill were considered by the Finance Committee. In relation to the Bill, the Finance Committee sought written evidence from organisations financially affected using a standard questionnaire. The Finance Committee’s letter to the Committee, enclosing the one response received, can be found in Annexe D.

Collection of the new fee
146. Asked about the proposal that registrars collect the new fee for registering a death, Elizabeth Allan of the Association of Registrars of Scotland and Chief Registrar, City of Edinburgh Council, stated that there was currently no fee for registering a death, unless a choice is made to buy a certificate—

“If the procedure of registrars taking a fee is introduced, it might be perceived as a fee for registering a death, and that might deter people from coming in. That could cause problems for people who are not relative and who might not benefit from the estate of the person.”

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147. She went on to explain the basis for her statement—

“... I make it on the basis of registering deaths for 33 years. I have seen people come in and I have seen how upset they have been. People do not understand what they are being told—it must be broken into bite-sized chunks for them. People have also complained about having to pay £8 or £9 for a death certificate. That has been when they have been physically given something. If we have to say to them that they will be liable to pay a fee, they will say, "What’s that for?" It would have to be explained to them when their relative has just died that they will be liable to pay it so that they can get a better service from the national health service. That will not be easy to sell to the public.”

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148. She added—

“We are more for keeping the status quo, whereby the funeral directors collect it.”

149. Gerard Boyle of the National Association of Funeral Directors disagreed—

“If there is to be a fee for issuing a death certificate, it will be a statutory fee. Where funeral directors currently collect fees for doctors for cremation certificates, most funeral directors will have entered into a contract or agreement with the doctors to supply those certificates. We would pay the fees for that. We do not enter into contracts for doctors at hospitals to sign death certificates. There were recommendations in the "Burial and Cremation Review Group: Report and Recommendations" that suggested that funeral directors were best placed to collect the money because we seem to collect money for everything else, but we do not think that we should be responsible for collecting a statutory fee. It was nice that the report said that we could charge an administration fee, but again we disagree with that. Why should we charge a fee for collecting a fee that is not ours? Registrars are the constant in everything. Not every family has to use a funeral director.

“On accountability and the management of the funds that are collected, it seems to me that every death must be registered. If a person does not register a death—I understand why they might have difficulties doing that—that is an offence. The law of the land is that a death must be registered within eight days. If it is not, the person must have a pretty good reason for not doing so.

“We have said that all deaths have to be registered anyway. The funeral directors thought that if the fee is not to be collected at the time of death from the hospital on the production of the certificate for the family, it should not be our responsibility to collect the fee on the Government’s behalf.”

Scottish Government

150. In oral evidence, the Minister confirmed that revised financial information would be provided in light of the “significant enhancements” that she had announced. This information was provided in correspondence on 13 January 2011.

151. She went on to state that she did not believe it to be fair that families opting for cremation paid at least £147 to doctors for that service—

“There is a real inequity in that—it has been described as the ash-cash issue. The proposed new charge will deal with that, as everyone will pay £30. For the vast majority who currently pay £147, it will be a vast improvement. You also have to consider the cost of some of the alternative systems. For
example, in the English medical examiner model, the cost will be £100 plus £70 to £80 for the inspection of the body, so bereaved families in England face a bill of £170 to £180. You have to put the matter in context.”\textsuperscript{125}

152. She went on to comment on the question of who should collect the fee—

“The truth of the matter is that representations have been made on behalf of registrars that they do not want to collect the fee, for a number of reasons, and, similarly, the funeral directors have said that they do not want to collect it. Nobody is exactly falling over themselves to volunteer, so a choice has to be made and we need to look at the arguments for and against. I will not go to the wall on this one; the judgment is for the committee. There are a number of reasons why our preference is for the registrar. All deaths have to be registered. Registrars are used to dealing with the bereaved. There are registrars in all 32 local authorities, so there is a system in place. It is not necessary to use a funeral director to arrange a funeral, so there will always be some cases that fall outwith the funeral director. It also seems odd that a statutory fee for a public service should be collected by a commercial organisation. Funeral directors do not want to collect an admin charge for a service that they are not providing—I am sure that they have expressed that view strongly. There is also the danger of significant additional bureaucracy. Hundreds of funeral homes across Scotland would have to be registered and brought into some kind of monitoring and audit scheme. We would probably have to legislate to force them to collect the fee.

“Having heard all the disadvantages, I was put into the position of having to choose between two reluctant fee collectors. In the end, I came down on the side of the registrars. The list of disadvantages for a system where funeral directors are the collectors is longer than the list of disadvantages for registrars doing that.”\textsuperscript{126}

153. The Minister was asked what effect the doubling of the random sample size would have on the number of medical reviewers to be appointed. She told the Committee—

“We estimate that the number of medical reviewers will rise to 10. That is not set in stone, so we can make adjustments if required, but we estimate that there will be 10 full-time equivalents—there might be some part-time people. However, they will have administrative assistance to help with some of the paperwork, so it is not as if they will have to do all the paperwork themselves. We believe that that will be adequate but, again, we will be able to find out for sure through the test-site model.”\textsuperscript{127}

Conclusion

154. The Committee welcomes the Minister’s comments relating to the setting of the fee and the comparison with the expected fee in England.

155. The Committee also welcomes the abolishing of the higher fee relating to cremation only, until now paid in 62 per cent of cases, in favour of a lower and universal fee. The Committee supports the original intention for the new system to be self-funding. The Committee notes the rationale for giving the responsibility for collecting the fee to registrars but acknowledges the concerns raised by representatives of registrars.

SUBORDINATE LEGISLATION

Background

156. Under Rule 9.6.2 of Standing Orders, where a bill contains provisions conferring powers to make subordinate legislation, the Subordinate Legislation Committee (“SLC”) must consider and report to the lead committee on those provisions. The SLC may also consider and report to the lead committee on any provision in such a bill conferring other delegated powers.

Delegated powers provisions in the Bill

157. The SLC’s report is attached at annexe F. In it, the SLC reported that it considered each of the delegated powers provisions in the Bill and that it determined that it did not need to draw the attention of the Parliament to the delegated powers in sections 2 (Power of Scottish Ministers to give directions to the Registrar General), 4(5)(e), 4(8), 8(5), 17(4), 18(4), 22(3), 24, 25(1), 25(2), 27 and 31(3) nor to the power to be inserted in paragraph 7A of Schedule 5A to the National Health Service (Scotland) Act 1978 by paragraph 2 of schedule 1 to the Bill.

Conclusion

158. The Committee notes the Subordinate Legislation Committee’s report.

CONCLUSIONS

Summary of conclusions

Detection and investigation of unnatural death

159. The Committee has concerns about the Bill as introduced. Whilst the Committee accepts that no system can eliminate the possibility of criminal activity by, for example, a serial killer, the initial proposals were for a level of scrutiny and review of MCCDs that was much less rigorous than the existing arrangements. In particular, the Committee notes that a sample size of 10 per cent was said to be necessary to have a “realistic chance” of identifying errors.

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160. The Committee welcomes the increasing of the random sample size and the planned addition of an extra tier of review, as announced by the Minister. However, the Committee notes that the sample size would be increased only to 4 per cent and remains concerned as to why this figure has been selected.

161. The Committee notes the intention to report to the Parliament on the outcome of the pilot in the test sites. In the meantime, the Committee will seek views on the Minister’s new proposals from witnesses who were critical of the Bill.

162. The Committee remains concerned, however, about the removal of the requirement for approval from a second and a third doctor from cremation cases. The Committee notes the argument that the procedures for burials and cremations should be aligned but believes that, owing to the finality of cremation, any alignment should have taken as its benchmark the rigour of the current cremation procedures.

163. The Committee notes the further explanation regarding proposals relating to stillbirths, given by the Minister in correspondence\textsuperscript{129} following her oral evidence.

\textbf{Accurate recording of the cause of death}

164. The Committee considers that the new proposals increasing the level of scrutiny, announced by the Minister during oral evidence to the Committee, take a step towards addressing the main concerns about quality and confidence in the system.

165. The Committee remains concerned that no level of experience is specified as a pre-requisite for eligibility to sign MCCDs in a professional culture where supervision can be very variable – with, for example, junior doctors sometimes being left responsible for death certification at weekends without consultants being present. The Committee believes that, if the aim is genuinely to drive up quality, there must either be an experience qualification or junior doctors should not be allowed to sign a death certificate unless they have been signed off by the deanery\textsuperscript{130} as having undertaken a module.

166. The Committee also believes that accuracy in the completion of MCCDs could be improved with appropriate use of technology. This is discussed later in the report under the heading ‘Use of technology’.

\textbf{Confirming the fact of death}

167. The Committee is concerned that it might still be possible for a medical practitioner to sign an MCCD without examining the deceased. The Committee draws this point to the Minister’s attention and requests that she respond to it in the Scottish Government’s formal response to this report.

\textsuperscript{129} Scottish Government, written submission

\textsuperscript{130} There are four postgraduate deaneries in Scotland, each an integral part of NHS Education for Scotland. NES and its postgraduate deans are accountable for managing the delivery of postgraduate training to standards required by the General Medical Council. They share this responsibility with NHS Boards for the trainees within their employment and with universities for the first year of postgraduate training.
Medical reviewers’ workload
168. The Committee notes the explanation that MRs’ training and education role would be primarily supervisory whereas the responsibility for providing training and education would fall on doctors’ educational supervisors. The Committee has reservations that, with a remit to advise, to train and, now, to carry out 25 per cent level 1 scrutiny, which is likely to lead to an increase also in level 2 review, the proposed workforce may still be inadequate.

169. The Committee also draws the Parliament’s attention to paragraph 3 of Schedule 1, which states that any function conferred on MRs may not be delegated by Healthcare Improvement Scotland, and requests that the Scottish Government clarify whether it will be possible, in the context of this provision, for the educational and training role of MRs to be exercised by third parties as was suggested in oral evidence to the Committee.

Use of technology
170. The Committee notes the Minister’s comments that the Bill would not confine practice to a paper-based system. The Committee is surprised, however, that an electronic system was not specified from the outset, given the evident advantages: an electronic system could provide prompts and help to those completing MCCDs, as well as ensuring that non-compliant MCCDs were impossible to submit. The need for repeated data entry, which is another source of possible error, would also be removed from the process. Using an electronic system would also establish a chain of evidence and would do much to clarify matters. The Committee notes that it would now be difficult to devise and implement such a system in time for the beginning of the test sites but, if this proves impossible to achieve, strongly urges the Scottish Government to do so as soon as possible and, in any case, before the eventual roll-out of the new system nationwide.

Timescales
171. The Committee believes it is important to respect the position of different faith groups in relation to the Bill’s provisions, particularly the Jewish and Muslim faiths. The Committee considers that the system should not unduly delay disposal of the body and this should be clear in the Bill. In the light of the Scottish Government’s evidence on this point, the Committee is not confident the Bill is entirely clear on this point and believes the expedited process should reflect the faith needs of certain groups in society. The Committee welcomes, therefore, the clarity brought by the Minister’s explanation given in correspondence but believes the Bill should be amended in order that the position be similarly clear in the legislation itself.

172. Concerns were also raised with respect to particular difficulties for remote and island communities, relating to potential delays in both initial certification and review.

173. The Committee notes the important concerns raised in relation to organ donation, which appear to conflict with the Scottish Government’s position on the matter. The Committee looks to the Government’s response for further clarity on this issue.
174. The Committee also notes the need for expedited procedures where bodies were being donated for medical research and notes the Minister’s response that this would be dealt with in guidance.

Deaths abroad
175. The Committee considers that the responsibility for assessing the validity of documentation in cases of repatriation of the deceased for burial or cremation should be exercised centrally.

Collection of the new fee
176. The Committee welcomes the Minister’s comments relating to the setting of the fee and the comparison with the expected fee in England.

177. The Committee also welcomes the abolishing of the higher fee relating to cremation only, until now paid in 62 per cent of cases, in favour of a lower and universal fee. The Committee supports the original intention for the new system to be self-funding. The Committee notes the rationale for giving the responsibility for collecting the fee to registrars but acknowledges the concerns raised by representatives of registrars.

Delegated powers
178. The Committee notes the Subordinate Legislation Committee’s report.

Overall conclusion and recommendation

179. The Committee invites the Scottish Government to consider the conclusions of this report and looks forward to the Government’s response

180. The Committee draws its conclusions to the attention of the Parliament and recommends that the general principles of the Certification of Death (Scotland) Bill be agreed.
ANNEXE A: EXTRACTS FROM THE MINUTES

34th Meeting, 2010 (Session 3)
Wednesday 24 November 2010

Certification of Death (Scotland) Bill: The Committee took evidence on the Bill at Stage 1 from—

Mike Palmer, Deputy Director for Public Health, Frauke Sinclair, Bill Team Leader, Certification of Death (Scotland) Bill, Jacqueline Campbell, Head of Health Protection Team, and Edythe Murie, Scottish Government Legal Directorate, Scottish Government.

35th Meeting, 2010 (Session 3)
Wednesday 12 December 2010

Certification of Death (Scotland) Bill: The Committee took evidence on the Bill at Stage 1 from—

Professor Stewart Fleming, Professor of Cellular and Molecular Pathology, University of Dundee;

Dr Colin Fischbacher, Consultant in Public Health, Information Services Division, NHS National Services Scotland;

Ishbel Gall, Mortuary Manager and Vice-Chair, Association of Anatomical Pathology Technology;

Dr Jeremy Thomas, Consultant Pathologist and Clinical Lead, Scottish Pathology Network;

Jim Nickerson, Chairman of the Scottish Sub Committee, Federation of Burial and Cremation Authorities;

Gerard Boyle, Immediate Past President, National Association of Funeral Directors;

Elizabeth Allan, President of the Association of Registrars of Scotland and Chief Registrar, City of Edinburgh Council.
38th Meeting, 2010 (Session 3)
Wednesday 15 December 2010

Certification of Death (Scotland) Bill: The Committee took evidence on the Bill at Stage 1 from—

Leah Granat, Deputy Director, Scottish Council of Jewish Communities;

Dr Salah Beltagui, Convenor, Muslim Council of Scotland;

Shona Robison MSP, Minister for Public Health and Sport, Mike Palmer, Deputy Director for Public Health, Dr Mini Mishra, Senior Medical Officer, and Frauke Sinclair, Bill Team Leader, Certification of Death (Scotland) Bill, Scottish Government.

1st Meeting, 2011 (Session 3)
Wednesday 19 January 2011

Certification of Death (Scotland) Bill (in private): The Committee considered a draft Stage 1 report. Subject to a number of changes, the report was agreed to.
ANNEXE B: ORAL EVIDENCE AND ASSOCIATED WRITTEN EVIDENCE

34th Meeting 2010 (Session 3), 24 November 2010

Oral Evidence
Scottish Government

Supplementary Written Evidence
Scottish Government

35th Meeting 2010 (Session 3), 1 December 2010

Written Evidence
Prof Stewart Fleming (University of Dundee)
Association of Anatomical Pathology Technology
Scottish Pathology Network
Federation of Burial and Cremation Authorities
National Association of Funeral Directors
Association of Registrars of Scotland
City of Edinburgh Council

Oral Evidence
Prof Stewart Fleming (University of Dundee)
NHS National Services Scotland
Association of Anatomical Pathology Technology
Scottish Pathology Network
Federation of Burial and Cremation Authorities
National Association of Funeral Directors
Association of Registrars of Scotland
City of Edinburgh Council

Supplementary Written Evidence
NHS National Services Scotland

38th Meeting 2010 (Session 3), 15 December 2010

Written Evidence
Scottish Council of Jewish Communities
Muslim Council of Scotland

Oral Evidence
Scottish Council of Jewish Communities
Muslim Council of Scotland
Scottish Government
Supplementary Written Evidence
Scottish Government – 22 December 2010
Scottish Government – 13 January 2011 (Part 1)
Scottish Government – 13 January 2011 (Part 2)
Certification of Death (Scotland) Bill: Stage 1

10:01

The Convener: Item 2 is our first oral evidence-taking session on the Certification of Death (Scotland) Bill. We begin by taking evidence from the Scottish Government bill team. I welcome Mike Palmer, deputy director for public health; Frauke Sinclair, bill team leader; Jacqueline Campbell, head of the health protection team; and Edythe Murie from the Scottish Government legal directorate.

I invite committee members to ask questions.

Helen Eadie (Dunfermline East) (Lab): Good morning. I do not know whether the witnesses have had time to read the British Medical Association Scotland’s submission to the committee, which states:

“We believe the medical reviewer system is less robust and not as comprehensive as the current system or the scheme being introduced in England and Wales. Indeed, there will in fact be a two tier system in the UK, and it is doubtful that this would reassure the Scottish public.”

It also states that it would be better not to “implement inadequate and unsafe changes to save money.”

Would the witnesses like to comment on that accusation?

Mike Palmer (Scottish Government Chief Medical Officer and Public Health Directorate): Certainly. We are proposing to go in a different direction from the proposals in England and Wales. The rationale for our proposals is the implementation of a set of arrangements that we believe are proportionate and provide the necessary level of robustness for the purpose that they are designed to achieve.

We decided to propose the implementation of a set of arrangements for a sample of scrutiny on a random basis. As part of a broader package of measures, we would also implement a system whereby any interested person who was connected to the death would be able to request scrutiny by the team of medical reviewers. We also propose that the medical reviewers would be at liberty to scrutinise up to 100 per cent of cases in any geographical area or any practice where there might be a concern and they believed it was appropriate to go in and implement more intensive scrutiny.

I know that the BMA Scotland has raised concerns that random scrutiny is proposed for only about 500 cases a year, which appears to be significantly lower than the scrutiny in 100 per cent
of cases that is proposed in England and Wales. However, we believe that it is important to look more broadly at the whole package of measures that we are proposing, of which random scrutiny is only one small element.

We have deliberately not fixed the numbers for random scrutiny in the bill. Therefore, we are looking at a system that is potentially flexible and could be adjusted so that if after evaluating the early operation of the system we thought that it would be wise to increase the number of death certificates that are scrutinised, we would be at liberty to do that via secondary legislation. We believe that our proposals have in-built flexibility and responsiveness to changing circumstances, which are desirable.

On the ethos that underpins our proposals, we are seeking to drive up the standard of completion of death certificates at source. In England and Wales, the proposal is to institute a check on every single certifying doctor’s medical certificates. Essentially, the assumption that lies behind that is that it is necessary to check every single doctor’s work, and that that is the only way to institute an effective and robust system around death certification.

We approach the issue from a different perspective. The goal that we are aiming at is to drive up standards at source so that we do not need to worry about having to check every single doctor’s completion of a death certificate. We aim to drive up the attention and priority that are given to that particular function, which we feel is a Cinderella function to an extent in some parts of the national health service. We also aim to drive up the priority and attention that are given to the standards of completion of the certificate, and to change the culture and practice so that certifying doctors complete certificates to a much higher level of accuracy at source. We do not believe that the heavy education and training element in our proposals is as prominent in the English proposals. Almost half of the remit for the medical reviewers will be to do with education and training to drive up standards at source.

**Helen Eadie:** The BMA Scotland also has a concern about the very tight timescales involved. Its submission contains quite an extreme comment. It says:

“If an unrealistic timescale is set, or an emergency arises, or due to pressures from staff absence, a doctor will be required to decide”—

“whether to let patient care suffer or to be imprisoned.”

That is quite a worrying statement, which I would like you to comment on. Obviously, the BMA Scotland feels under pressure with the proposal, and the possibility that it describes is quite worrying.

Will you also comment on the removal of the requirement for two signatures from around 60 per cent of death certificates, where the deceased is to be cremated? That seems to be quite a worrying aspect as well.

**Mike Palmer:** On the first point, I believe that the BMA Scotland was commenting on circumstances in which there might be an epidemic or an emergency, and that it is concerned about the pressures that might arise from staff absences during such times. Our proposals include the suspension of the arrangements in epidemic and emergency situations. I do not know whether Jacqueline Campbell wants to comment on that.

**Jacqueline Campbell (Scottish Government Chief Medical Officer and Public Health Directorate):** Subsection (7) of proposed new section 24A of the Registration of Births, Deaths and Marriages (Scotland) Act 1965, as inserted by section 2 of the bill, sets out that the Scottish ministers may make a statutory instrument to “suspend the referral of certificates ... during an epidemic ... or to prevent the spread of infectious diseases or contamination.”

In the second category, we might be in a situation that is somewhat short of an epidemic but in which, in order to prevent difficulties such as those flagged up by the BMA or delays to funerals, in extreme circumstances we want to suspend the operation of the system.

**The Convener:** There was another part to the question—the removal of the requirement for two signatures.

**Mike Palmer:** We are proposing to abolish what is actually the system of triple signature for cremation, which will affect more than 60 per cent of cases. I go back to my point that the underlying ethos of our arrangements is to drive up standards of completion at source and to ensure that the certifying doctor is achieving the required level of accuracy through education and training and through a change in the overall culture and practice, to the degree that the environment places attention on the process to a much higher level.

We have also observed and had fed back to us from many stakeholders who have looked at the issue, including the independent burial and cremation review group, that the current system of triple signature in cremation cases is not particularly effective in acting as a check or a balance. A number of people have commented on how, in many cases, the signing is done in a relatively perfunctory manner and does not really deliver a robust check. The broad consensus is
therefore that the current system is not really delivering effectively.

**Helen Eadie:** One last question—

**The Convener:** I will let Ian McKee in on that point, and then I will let somebody else in. You have had three good questions, Helen. Perhaps somebody else has a question to ask.

**Helen Eadie:** Okay.

**Ian McKee (Lothians) (SNP):** I am interested in the implication of what you are saying, Mr Palmer. I would be the first to agree that the present method of certifying the death of people whose bodies will be cremated has some defects. However, for the 60 per cent of people who are cremated, the doctor who provides a medical certificate has then to fill in another form with more information than the medical certificate. He or she then has to find a completely independent doctor of more than five years’ standing to look at the first certificate, interview the relatives and inspect the body.

I appreciate that inspecting the body does not do much good in practice, but the process in which an independent doctor interviews the relatives, casts an eye over the certificate and then gives another signature—and finally the medical referee gives a signature—applies to 60 per cent of people who die in this country. You are going to replace it with a system that will allow 98 per cent of people who die to be cremated or buried solely on the certificate of the doctor who has been looking after them. In what way is that a better and more secure system than the one that it replaces?

**Mike Palmer:** The current arrangements do not involve any dedicated team of professionals who oversee the function of death certification, and we are proposing to introduce a dedicated team of medical reviewers.

**Ian McKee:** Sorry, but is the medical referee at the crematorium not a dedicated professional?

10:15

**Mike Palmer:** Yes, indeed, they dedicate part of their time to that function. However, the feedback that we have received from the stakeholders whom we have spoken to has indicated that that system of checks is not working very effectively and is not thorough and robust in cremation cases.

In moving beyond that, we would prefer a system that drove up standards in the education and training of certifying doctors and put in place arrangements to support them. For example, if, in filling in the medical certificate of cause of death, a certifying doctor has a doubt about the cause of death—or, indeed, about any aspect of that certificate—they should be able to contact the medical reviewer for advice. We are looking to certifying doctors to use their professional clinical judgment in ensuring that the new system supports and helps them in completing certificates accurately.

**Jacqueline Campbell:** I should emphasise that although the random sample is 1 per cent—and in interested person cases perhaps another 1 per cent, although we are not yet sure—we have added to the original proposals a very significant power for medical reviewers to carry out additional scrutiny of up to 100 per cent in whatever part of the country they want and for however long they decide. We expect the random sample to form part of a baseline picture of evidence but, as I say, the reviewers can consider other evidence and carry out more targeted work in scrutinising cases in particular areas of the country or particular hospitals where they feel that there are issues to pick up.

One issue that has not yet been mentioned and which is perhaps not such a feature down south is the seriousness with which we in Scotland take links to clinical governance and the national health service’s clinical governance structures. We have made it very clear that there must be very strong links between medical reviewers and medical directors—and possibly directors of public health—at health board level. That would create an avenue for exchanging information and taking forward any emerging issues that I do not think exists in the same way down south.

**Ian McKee:** I will return to those points in my later questions but, as far as this particular supplementary point is concerned, I have to point out that everything in the financial memorandum and statements is based on 98 per cent of people being buried or cremated without any intervention other than that of the doctor who has seen them and who provides a certificate. I fail to see how that system is better than a system in which 60 per cent of deaths are certified by three doctors’ signatures.

**Jacqueline Campbell:** All we can do is reiterate that much of the evidence that we have received from fairly extensive discussions with stakeholders, including people from the medical profession, is that the current system does not work; that getting three doctors to sign a certificate is not a robust procedure; and that many of the checks that are made are perfunctory. There is a fair consensus around the need to change the system in some way and we are presenting a package of measures that we think will take things forward.

**The Convener:** After checking with the clerk, I think that medical professionals will be giving evidence next week, so we can raise those questions then.
If Richard Simpson intends to follow up this issue, I ask him to do so and then move on to his substantial question.

Dr Richard Simpson (Mid Scotland and Fife) (Lab): My substantial question is actually quite a small one, so I am happy to leave it to later.

Following on from the points made by Helen Eadie and Ian McKee, I believe that, initially, the fundamental driver for all this was the Shipman report. Will the proposed Scottish system ensure that any Shipman-type cases are picked up early? If 98 per cent of deaths are going to be certified by a single doctor, I have to wonder, even taking on board your comment that the bill will be able to vary the figure, whether reviewing only 1 per cent of cases will be enough. What statistical advice have you received that has led you to think that this approach would have picked up Shipman in 1980 instead of two thousand and whatever it was?

Mike Palmer: You are right that the Shipman case was the key original driver for examining death certification. However, quite some time ago, we concluded—and our English and Welsh colleagues have reached the same conclusion—that it is not possible to design and construct a death certification system that can guarantee the prevention of another such case. Even if we were to implement comprehensive scrutiny of 100 per cent of cases, it is still unlikely that someone such as Dr Shipman would have been caught.

We have therefore come to the clear view that the arrangements that we are setting out should have, as the key driver, a focus not on preventing another Shipman but on improving the standard of completion in the death certification system and on providing public health information from death data that will drive up clinical standards and make the links with clinical governance.

Within that set of arrangements, we clearly wish to do as much as we can to try to deter the possibility of another Shipman case. We believe that the package of arrangements that we propose provide a deterrent effect, but evidence from stakeholders has indicated to us that it would be folly for us to try to design a system to guarantee the prevention of another Dr Shipman case.

The other point is that we are talking about cases that are not referred to the procurator fiscal, so we are not talking about any cases in which there might be suspicion of malpractice or dubiety about the cause of death. We are talking about cases in which unambiguous and non-suspicious causes of death are being looked at. The clear conclusion that we have come to is that although there was an original driver around Shipman, that is not the key focus of the proposals that we have brought forward.

Dr Simpson: I accept the policy objectives and aims of the bill that are set out in paragraph 16 of the policy memorandum. Nevertheless, as a Parliament and as a committee, we will want to be reassured that any new system will not make it less likely that someone like Shipman will be picked up. The statistical analysis of death certification is obviously important and it might give one some clues. However, it will be possible to cremate 60 per cent of people very rapidly—with, therefore, no recourse, even when one has a suspicion—and the system will do no more than allow the doctor to certify the death. That seems to me substantially to lessen the potential for ascertaining another Shipman.

I accept your basic point that you cannot prevent another Shipman—that can be very difficult because psychopaths are extremely clever. However, we have to have a system that at least reassures the public that it would be more likely, rather than less likely, to pick up such cases.

I have concerns, even given the introduction of the interested person review, which I think is a very important and welcome measure, and the proposal to review 1 per cent of cases. To exercise the additional powers of investigation in a particular geographical area or with regard to specific doctors, you have to be suspicious or to have a reason for doing that. I am not sure that Dr McKee’s point has been fully answered.

Mike Palmer: On your point about whether we are in danger of moving to a system that is less robust than the current one, we have talked a lot about cremation cases, but more than 30 per cent of people are buried. There is no check at all in those cases. That points up the anomalies and weaknesses in the current system.

We are proposing that, for the first time, we will have a standardised, uniform system across both burials and cremations and that there will be checks in cases that go to burial in a way that there have not been before. I think that it should not be lost that that is an important enhancement, if you like, to the current system.

The Convener: Ross Finnie has a supplementary on the same issue.

Ross Finnie (West of Scotland) (LD): I share with all my colleagues a little difficulty in following the two aspects of a system that is perceived to be robust. As I understand it, the current system contains a requirement, in a large number of cases, for more than one signature, and you have found that system to be “perfunctory”, to use your word. Nevertheless, the principles behind it are the general principles of any system that is designed to obviate fraudulent practice through seeking some third-party corroboration of an action that
has taken place. However, I can do nothing other than accept that, having done the work, you have found that perfunctory.

What I find difficult, however, is that, having concluded that the current system involving a second or third check is not working—and notwithstanding all the other systems that seek to insert some check or balance into a procedure that might be open to exploitation or fraud—you have suddenly decided that the answer is not to make that checking system better but to remove it completely. I confess that I find the philosophy behind that extraordinarily difficult.

This might come as a surprise to some members, but a long time ago I operated in the accounting profession, which went to great lengths to make me a better accountant. However, that did not mean that I would not indulge in fraud. The procedures that were placed around me in any operation that I took part in involved a third party scrutinising what I was doing or indicating what I should do. My technical excellence could get better and better—such that I might even fill in a death certificate, if properly trained. However, that system did not itself obviate any exploitation or fraud.

Why, given that generality of dealing with such situations, have you elected almost to eliminate any third-party check?

Frauke Sinclair (Scottish Government Chief Medical Officer and Public Health Directorate): The matter of the second and third signatures was never about fraud. The purpose of the second and third signatures for cremation certificates derives from a historical reason. The main purpose was to catch criminal activity. At the time, the system was set up because death certification was not performed in the consistent way that it is today. Death certification was not done 100 per cent of the time in some cities.

That situation no longer applies today, however. As we accept, the system that we are introducing is not about catching criminals. As you accept, the current system is not working very well. It is indeed perfunctory, and it is not independent. We no longer wish to continue with those arrangements.

Ross Finnie: So we are not looking for fraud or any criminal activity.

Frauke Sinclair: Correct.

Ross Finnie: In fact, we are not looking for any error at all in the system. I am not going to play with words. You can call it fraud, criminality, inadvertence or whatever you like. We can choose any word in the dictionary—we can bring in a thesaurus and choose one. You are telling us that the proposal has absolutely nothing to do with checking anything that might have gone wrong.

Frauke Sinclair: Not quite—

Ross Finnie: That is what you have said. That is exactly what you have just said.

Mike Palmer: We are making a distinction in relation to detecting possible criminal activity in completing the death certificate—for example, knowingly inserting a totally inaccurate cause of death in order to cover something up. That is a criminal activity, and if there was any suspicion or dubiety about the cause of death, or even if it was simply a sudden death, it would go off to the procurator fiscal immediately and it would be dealt with under a different system.

Ross Finnie: Please do not introduce different factors. We understand perfectly that a sudden death will go to the procurator fiscal. The issue is about the completion of a death certificate by a medical practitioner. You seem to be telling us that, if he has made a spelling error or if there is a grammatical infelicity, that is about the extent to which the system is intended to pursue the matter.

10:30

Mike Palmer: No. The system does not seek to detect fraudulent activity in terms of something being knowingly covered up—we would look to the Procurator Fiscal Service to cover that aspect. We are looking to pick up genuine errors that a clinician might have made in an inaccurate recording of the cause of death. Some of those errors might be simply due to a clinical error of judgment, and some of them might be due to less-than-full attention being paid to the filling out of the death certificate—for example, we know of some cases in which “old age” was recorded as the cause of death, which is not a sufficiently accurate cause of death for a death certificate. It is that type of error—as well as more mundane errors, such as those involving illegibility—that we seek to detect.

The Convener: One of the general practitioners on the committee almost choked on his water when you said that “old age” had been put on a death certificate.

Ross Finnie: Does it matter? What is the purpose? Why have an act of Parliament?

Jacqueline Campbell: Some statistics from the General Register Office for Scotland help to give some perspective to the matter. We know that, in 2009, there were nearly 2,500 medical certificate of cause of death forms in which the cause of death could not be identified and the forms had been incorrectly completed. The GROS employs a consultant who looks at the system of coding deaths and writes letters to doctors in such
circumstances. In about 600 cases, those letters were not responded to in any way. We have had discussions with the GROS about that coding system and have also considered how there could be links with the medical reviewers to make that system more robust as well.

**The Convener:** To everyone else on the committee, I say that the two GPs on the committee, who have filled out death certificates, will be given more space to ask questions than those members who have not.

**Dr Simpson:** I welcome the fact that we are modernising our system. However, why are we not moving to an electronic system? That would mean that a death certificate could not be submitted unless it were filled in in a way that was acceptable to the GROS, and it would also remove from the process the need for repeated data entry, which is another source of possible error. It would, for example, stop someone writing “old age” on a death certificate—although, on that point, Ian McKee and I would both agree that, in a case in which, for example, someone was 103 years old and there was no other diagnosis of death, it would be acceptable to say that they had died of old age. Using an electronic system would establish a chain of evidence and would do a lot to clarify matters. It would also introduce some of the other issues that I will raise later.

**Mike Palmer:** We have not included a proposal for electronic underpinning of death certification.

**Dr Simpson:** Why not? I do not think that simple training will solve the problem that results in 2,500 death certificates being incorrectly submitted.

**Jacqueline Campbell:** Obviously, we can see the advantages of doing it electronically, but I do not think that we have a system at the moment that would allow that.

**Dr Simpson:** It would also allow there to be immediate, almost real-time, analysis. A medical reviewer could use that to pick up very quickly whether something was going wrong. Software packages could be used to analyse series of two or three deaths, which could be statistical blips, so we would not have to wait for the GROS to deal with the matter, which, as you know, it will not do until six months to a year afterwards.

**Jacqueline Campbell:** As an integral part of the system, we will employ a national statistician, with an assistant, who will produce national and local statistics that we would expect the medical reviewers to be able to use. That might, in part, be the answer.

**Dr Simpson:** They will have to enter all the data manually or wait for the information from the GROS.

**Jacqueline Campbell:** Unfortunately, I do not think that we can get around that. Registrars do a brief check on the death certificates that they receive, and they will also be able to refer certificates to medical reviewers.

**Dr Simpson:** I just think that we are missing a chance. If we are going to modernise the system, we should modernise it. We should be moving to the 20th century before we leave the 21st.

**The Convener:** I did not understand that.

**Helen Eadie:** He is talking about e-health.

**Dr Simpson:** Computers came in in 1990, in primary care at least. It is perfectly feasible to have an electronic system for this, but we are not even proposing it in the 21st century, which is a shocking omission.

**The Convener:** I follow you. I was just working out which century I was in. It has been a long week so far.

**Rhoda Grant:** has been very patient.

**Rhoda Grant (Highlands and Islands) (Lab):** I want to talk about some of the concerns of island authorities, and the concerns of ethnic groups—for example the Jewish community—about delays in burial. In its submission, Orkney Islands Council talked about the custom and practice of keeping a body at home until burial. Any delay will cause additional distress and could have health implications.

**Frauke Sinclair:** We expect that, on average, the scrutiny that we are proposing will take up to half a day of the medical reviewer’s time, stretched over one to two days on average, so we do not anticipate that it will usually have any effect on funerals. We appreciate that in circumstances like the ones that you mentioned, there will be an effect on communities in remote and rural areas as well as faith groups. That is why we have proposed in the bill a section on a so-called expedited procedure for which anyone who is chosen for random scrutiny can apply. That will mean that scrutiny will take place in parallel with registration, and when registration is complete the disposal/funeral can take place. That is how we answer the concerns that faith groups have raised. They would certainly be eligible to apply for the expedited procedure. With regard to remote and rural communities, we want to test in the pilots before implementation how long it will take to access medical notes et cetera.

**Rhoda Grant:** Can I take it that you expect to have a network of medical reviewers throughout the country so that, for example, somebody will be based in Orkney and will be able to carry out the review very quickly? You are nodding, so I assume that that is the case.
Frauke Sinclair: In the financial memorandum we propose having six medical reviewers and the same number of medical assistants. The medical reviewers may be part-time, so there may be up to 12 reviewers. We have not decided exactly where they will be based, but we expect them to be based in different locations around the country and that they will be mobile.

On accessing documents, we expect that some of them will be electronic. You will know that hospital documents are available electronically. As I said, in the test sites, we will pilot accessing and transferring documents as quickly as possible. We will also make use of other means of quick communication. For example, if there is a comprehensive review, health personnel will need to be interviewed, which will be done by telephone to ensure that it is done as quickly as possible so as not to inconvenience anyone.

Rhoda Grant: That sounds great, but the problem is that in remote and rural areas broadband might not be available and it can be difficult to transfer information electronically. I cover the Highlands and Islands, and I have been stranded on islands due to bad weather, which can happen in summer, winter or whenever. There can be fog in Orkney and storms, which can stop people moving about, so the physical transfer of people and information can be difficult, and the wherewithal to transfer information electronically might not be available either.

Is there a way of taking into account those issues when a random review is done? In the middle of winter, if people do not have access to electronic equipment, or if bodies cannot be transferred, could people appeal to have the review suspended because of the distress and delay that it would cause?

Frauke Sinclair: When cases are chosen for random review, people will be able to apply for an expedited procedure. People might well be able to do that in the circumstances that you describe, and we will consult on that in due course. As I said, the test sites will look into that.

As we explain in our policy memorandum, the random review’s purpose is not to deal with specific concerns, so the only reason for a hold-up would be the need to access the body, which would be rare. I am confident that we will be able to meet the needs that you mentioned.

Rhoda Grant: So a funeral could proceed without the need to wait for the review to be completed.

Frauke Sinclair: The expedited review would achieve that purpose.

The Convener: Is the expedited procedure to which you refer in section 6?

Frauke Sinclair: Yes.

Rhoda Grant: The Jewish community has pointed out that it would like burials to take place before sundown on the day of death or—at the latest—on the day after death. Given your earlier answer, could people from that community apply for a burial to take place while a review was ongoing?

Frauke Sinclair: The circumstances are the same—the expedited procedure could apply.

Rhoda Grant: How long do you estimate that it would take to apply for clearance to use the expedited procedure?

Frauke Sinclair: We would expect that to be done over the phone within an hour or so.

The Convener: I thank Rhoda Grant for that interesting line of questioning.

Mary Scanlon (Highlands and Islands) (Con): I apologise for being late—

The Convener: It was a delight—everybody else got to ask questions first.

Mary Scanlon: I came down on the train from Inverness just this morning, which gave me an opportunity to read the submissions.

Ian McKee: Unlike the rest of us.

The Convener: Stop digging—just ask your questions.

Mary Scanlon: If my question has been asked—

The Convener: I will stop you.

Mary Scanlon: In that case, I will read the Official Report.

The 36 submissions do not seem to show anything like unanimous or even majority support for the bill. I was surprised that many say that the bill is “a retrograde step”, that 32,000 bodies will be cremated with no scrutiny and that the system will be “less robust” than what is in place and considerably “less robust than the system in England & Wales”.

The Convener: We have covered that.

Mary Scanlon: I appreciate that. We have talked about Shipman. Many respondents have said that GPs will be checked every eight to 10 years.

If that has all been covered, I will move on. Concern has been expressed about a conflict of interest or loyalties, because medical reviewers will not be independent—they will be NHS employees. How can someone whom the NHS employs be an independent person? That is my
question, as the rest of my questions have been covered.

**Mike Palmer:** Medical reviewers will be employed by healthcare improvement Scotland—

**Mary Scanlon:** Which is in the NHS.

**Mike Palmer:** Yes—it is part of the NHS. However, healthcare improvement Scotland is not a territorial NHS board that delivers services with patient contact, so medical reviewers will not be employed by the same territorial NHS boards as employ doctors.

**Mary Scanlon:** The respondents know that. I did not say that medical reviewers would be employed by territorial boards. I have the submission from the Royal College of Pathologists, for example, which knows about the arrangement and is concerned that medical reviewers will be employed under the NHS’s umbrella and will not be impartial.

**Mike Palmer:** The fact that they are employed by a totally different organisation—albeit within the NHS—from the employing organisation of the doctors that they are reviewing gives them sufficient impartiality. There is sufficient separation and independence. We do not believe that there will be a conflict of interest, because they will not be employed by the same employer.

10:45

**Jacqueline Campbell:** HIS, which is the body that we are talking about, will replace the existing NHS Quality Improvement Scotland. One of the reasons why we think that it is worth while locating the medical reviewers there is that they already perform a range of similar functions for the NHS. There is a similar model for the healthcare environment inspectorate, which will be part of the same body, and performs a similar function in a different field. We have discussed with HIS the importance of the independence of the medical reviewers. They will be able to work independently within that framework while having accountability to the board of HIS.

**Mary Scanlon:** I still have significant concerns, but I will move on to my second question.

The Convention of Scottish Local Authorities and others refer to what they call the £30 death tax. Local authorities do not want that statutory requirement to be imposed on people who are registering a death. People who come straight from the hospital might not have the money with them. It is not clear who will collect the fee, or death tax. Are you assuming that it will be the registrar?

**Mike Palmer:** Our preference is for the registrar to collect the fee. The fee will be significantly lower than the fee that bereaved families currently pay to doctors to countersign cremation certificates. More than 60 per cent choose cremation as their method of funeral, so there will be a significant lessening of the financial burden on the majority of families.

We are still discussing the collection of the fee with the registrars. The other candidate for collecting the fee is the funeral director. The registrars, as a body, and the funeral directors have raised concerns about collecting the fee, therefore we have not yet resolved the matter with them.

**Mary Scanlon:** To be fair, I did not ask about cremation or disposal of the body; I asked about the registration of the death. Would I be right in saying that, at present, if you register a death at the registrar’s, you pay no fee, but if you wish an additional copy of the certificate, you pay £9?

**Mike Palmer:** Yes. If you register a death, you pay no fee to get a summary of the extract from the death register. If you want the full extract, you pay a fee. It is our understanding that almost 100 per cent of people who register a death pay for the full extract.

**Mary Scanlon:** But am I right in saying that if the bill is passed, everyone who registers a death will have to pay the £30 death tax? It is nothing to do with whether the body is buried or cremated; I am talking about when they register the death.

**Mike Palmer:** Yes, that is correct. Under our proposals, when they register the death, they will be liable to pay the fee.

**Mary Scanlon:** Councils see that as a death tax.

**The Convener:** To clarify the money business, while there is a lot that one might not like about the bill, I take it that the £147 that is currently paid for cremation disappears.

**Mike Palmer:** Yes.

**Frauke Sinclair:** In addition, there is a fee to be paid for the services of the medical referee, which can be up to £70.

**The Convener:** That is under the current arrangements.

**Frauke Sinclair:** Yes.

**The Convener:** What effect will the bill have on the fee to the medical referee?

**Frauke Sinclair:** It will be abolished.

**The Convener:** That disappears as well. I wanted to clarify how the money would work out for people in hard times and difficult circumstances.
Mary Scanlon: My concern is the registration of the death.

The Convener: In fairness to the bill team, people who do not have a lot of money will not pay an additional amount; they will, in fact, be better off.

Ian McKee: Not if they are being buried.

Mike Palmer: They will in cremation cases.

The Convener: What is the difference in terms of money?

Mike Palmer: There is no fee at present in burial cases, so it will be an additional charge for those who are buried.

The Convener: So there is an additional charge for burial, but for cremation will pay considerably less. I just wanted to clarify the money issue.

Mary Scanlon: My final question—which you may have been asked by our doctors already—concerns the death certificate itself, and relates to contributory, underlying or risk factors. For example, someone may have died from cardiovascular disease, but the main underlying risk for many years could have been diabetes. Another issue that has been raised with me as an MSP concerns cases in which hospital infections have been a contributory, underlying or risk factor—whichever term you want to use. How much more accurate will death certificates be with regard to such factors? Will more of them be mentioned? Will the information be more extensive? Will families and the health service have a better understanding of the main risk of death than they do at present?

Jacqueline Campbell: A couple of issues are relevant to that. The bill provides for a system in which families as interested parties can take a case to the medical reviewer, for example where there has been a hospital-related infection and the family are not content with what is stated on the death certificate. Under the bill, they will be able to bring forward an interested person review.

We examined those issues in considering the importance of training and education, and the culture change aspects of the bill. We know that training and education for doctors in death certification could be far better, and we would like the medical reviewers to tackle that issue. We expect to see an improvement in the recording of cause of death over time.

Mary Scanlon: So no change is planned; a review would take place only if a family appealed. One or two examples have been given in which dementia was not the main cause of death; it was due to other factors. You are saying that no changes are proposed, and we will not have any more extensive and thorough information. We will get that only if a family member is unhappy and appeals.

Jacqueline Campbell: No. I have mentioned the two areas that are most pertinent to your question. It comes back to the robustness of the whole process, which we discussed earlier. We do not feel that the current system, in which the checks are performed by three doctors for cremation only, is sufficient; the evidence that we have received is that it does not work. We suggest that we should implement a system with several different layers. The issue is the whole system and its robustness. Interested person reviews are an important part of that, where a family has concerns about what was recorded as the cause of death, but such issues will also be picked up through the random sampling, and in particular through the additional—up to 100 per cent—sampling that the bill will put in place.

Mary Scanlon: I am not clear about what you are proposing. If a GP is to be randomly sampled once every 10 years, he is hardly likely to put more information on a death certificate.

Putting aside the appeals to the medical reviewer, you say that there will be more training and education. If the bill is passed, what can people in Scotland expect in terms of additional information—where it is appropriate—on death certificates that they do not have now? Without appeals or anything else, will they be able to register underlying, contributory and risk factors as well as the main cause of death?

Jacqueline Campbell: One of our aims in putting the system in place is to improve the quality of information on death certificates, so the answer is yes. Over time, that information will improve, so the family will have access to better information on the death certificate.

Mary Scanlon: So that is an aim over a period of time, but it has nothing to do with the bill. There is nothing in the bill that will make this clearer.

Jacqueline Campbell: I am not entirely following you, but I think that the point that I have made—

Mary Scanlon: You said it is an aim over a period of time. One thing that I did not have on the train was the bill itself. I am not sure what is going to happen over a period of time.

Jacqueline Campbell: The intention is that the national statistician will be put in place before the legislation comes into force, so part of the new process will come in then. When the legislation takes full effect, all the scrutiny will be in place, which will improve the quality of the current system, plus medical reviewers will be conducting scrutiny and taking a lead in the culture change, training and education aspects.
Mary Scanlon: Is there anything in the policy memorandum, explanatory notes or the bill that will reassure me that people in Scotland will have the appropriate causes and information on the death certificate? Where can I get that reassurance?

Mike Palmer: I do not think that we have written specifically on that point about contributory causes, because the policy memorandum is at a higher level than that level of detail. We could write to you on that specific point if you wish, but the key point is that we definitely expect the accuracy and quality of the information on the cause of death on the medical certificate to be significantly improved under the arrangements, because the dedicated team of medical reviewers will be in place and they will be doing education and training. An annual report will be produced and put in the public domain, and that will make the team of medical reviewers accountable to the Government, the Parliament and the public. There will be an opportunity to direct the work of the medical reviewers into areas where it is felt that there is a need to direct that work.

The arrangements will absolutely create a platform for improving the accuracy and quality of the information on the certificate, including on the cause of death.

The Convener: Forgive me—I am treading dangerously in telling the bill team where something is—but is it not in section 19(2)(b)? It states that the medical reviewer is to

"provide training, guidance and support to persons who are required to complete medical certificates of cause of death".

Is that not what Mary Scanlon is trying to get at, so that we have the information—

Dr Simpson: No, it is in section 25(2). That is what she is getting at.

The Convener: I understand that bit. I am saying that there is a duty to improve the people who fill in the forms. If they do not comply with section 25(2), part of the medical reviewer’s job is to do what is described in section 19(2)(b). I think that I understand this. We are trying to get at what is going wrong with health in Scotland. As Mary Scanlon says, it may be that the underlying cause of a death was diabetes, but we have something else on the death certificate, so we perhaps do not have the right information for health prevention. Is that correct? Is section 19(2)(b) the relevant bit?

Mike Palmer: Yes. The bill contains a duty on health boards and the clinical governance arrangements within them to collaborate and cooperate with medical reviewers in improving the quality of death certificates.

The Convener: So there is stuff in the bill—to use a technical word. There is a duty to improve so that we have more conformity and more relevant information.

Mike Palmer: Absolutely.

The Convener: Okay.

Dr Simpson: My main question is now a supplementary to Mary Scanlon’s point. Your second and third policy objectives are

“To improve the quality and accuracy of the medical certificate of cause of death form”

and

“To provide improved public health information and strengthened clinical governance”.

However, the only section that looks at giving augmented information, which is what my colleague Mary Scanlon has been going on about, is section 25(2). We have no clarity from the explanatory notes as to whether, for example, health care acquired infection will be included, or ethnicity. There is a growing concern as to whether there are higher death rates or lower death rates in certain black and minority ethnic communities, and we need to know about that from the public health point of view, but there is no indication that that will be included.

We have been debating the Palliative Care (Scotland) Bill and collecting information on whether palliative care assessment has been carried out, which is not indicated. I understand that all of that can be included in “such other medical information as may be prescribed”, but once again we are faced with a bill that does not modernise the system. As Ross Finnie said, the bill simply changes the review system to a less restrictive approach; it does not do what it says on the tin. Unless we get a much clearer explanation during the bill process of what additional information you will seek, what evidence you have taken and what consultation you have undertaken, so that we end up with a modern system, the bill will have difficulties.

11:00

Mary Scanlon: I agree.

Jacqueline Campbell: The bill establishes a framework and does not go into detail. We need to consult on what additional medical information should be provided. We are happy to take your views on that, because it sounds like you have concerns about one or two issues. We have already had a couple of discussions with medical directors. They have not yet come back to us, but we have asked them to inform us of the kind of additional information that they would find helpful.
through the clinical governance process. Things are not yet set in stone, which we hope will be an advantage in some ways, because we are happy to take your advice on the matter.

The Convener: I will take a question from Ian McKee.

Helen Eadie: You cut me off earlier.

The Convener: I did, but I was hoping that the question that is burning inside you had been answered.

Helen Eadie: I have more than one.

The Convener: I am looking at the clock.

Ian McKee: I will ask about two issues. First, how many doctors in Scotland do you estimate are eligible to sign death certificates?

Jacqueline Campbell: I doubt that we have the figure with us, but I am sure that we can find out what it is. A doctor can sign death certificates once they have been certified. Under the Scottish Government’s new proposals on revalidation, doctors who have gone through the revalidation scheme will be able, as part of their functions, to sign death certificates.

Ian McKee: We know that there are 5,000 GPs, but there are also many hospital doctors. You do not know the figure. You say that medical reviewers will have an important training function—that they will drive up standards of service and place a heavy emphasis on training doctors. According to the bill, there will be about six medical reviewers. If we take into account holidays, continuing professional development days and sickness absences, we will probably be left with five. The medical reviewers will both carry out investigations into random and reported causes of death and be responsible for the heavy emphasis on training a number of people. You do not seem to know what that number is, but it will be in the thousands.

Jacqueline Campbell: It will, because it will cover most doctors. As you know, there are procedures in place in Scotland for the training of doctors. We have already had discussions with the royal colleges and postgraduate deans about how the system will link into the existing system of training for medical professionals in Scotland. We need to do more work on that. Clearly, medical reviewers will not be in a position to undertake all the training themselves, but they will not need to do that, as we already have a system that will allow the training to be rolled out. However, they will have a role to play in directing that.

Ian McKee: What will that role be?

Jacqueline Campbell: We have just started to discuss the detail of that with the royal colleges. We are happy to keep you posted about it.

Ian McKee: So you do not know at the moment.

At present, the charge for a cremation certificate is quite high because the body is burned, which means that less evidence is left. The principle is that if someone wants a cremation, you need to make a bit more certain that there is nothing that will need to be investigated later, whereas if someone is buried, the body can be exhumed and investigated. I am concerned about what will happen if that distinction is not made and the cost is spread over everyone in the system. I suspect that looking into individual certificates and getting notes together will be much more time consuming than you think, especially given geographical issues. I have a feeling that costs will rise rapidly, given the large number of people who need training, and that, in effect, the measure will be a cost on registration of death that everyone will have to bear. I understand that you cannot answer my question, but I want to put my concern on the record.

Jacqueline Campbell: I understand.

People have quite a wide range of views on the timings that we have proposed for the medical reviewer to conduct a review. We have allowed half a day, which we think is fairly generous. Some people agree with that, but others think that it is far too long a period and that a review could be conducted far more quickly. We will have to test that. Our view is that there is some built-in flexibility, because we wanted to allow for the additional training role and the additional 100 per cent scrutiny that we have discussed.

Ian McKee: Yes.

My other question is about Mr Palmer’s statement that most causes of death are unambiguous and the desire for death certificates to be accurate. I am not 100 per cent certain that most causes of death are unambiguous; it is certainly true that many are not.

I will give an example. Let us suppose that an elderly person who has been active injures their foot in a fall and goes into hospital. They have been treated for high blood pressure and have had a few other problems. Three weeks after being in hospital, they are found dead. They were in their 90s—people die in their 90s. It is not possible to know whether it was a heart attack or a stroke, or whether they had a pulmonary embolism as a result of their visit to hospital. There is only one way of being unambiguous, which is to conduct a post mortem. If I were a GP who was a certifier of death and you were to say to me, “You must be accurate on the cause of death,” I would insist on a post mortem for just about every death certificate that I issued.

We have been told that in Dundee post mortems cost £500 each. I doubt that we have enough
pathologists to do the large number of post mortems that would be required to give an unambiguous cause of death in every case. I suspect that we get a lot of doubtful certificates not because of poor training but as a result of clinicians making practical judgments with a view to speeding up and easing the practicalities of the funeral process and putting a cause of death on the certificate that allows the funeral to take place and which no one has any doubt about, even if they do not know exactly what the cause of death was. That is my problem with the idea that somehow training will sort everything out. If you want to have a high level of accuracy on cause of death, a great deal of money will have to be spent and a lot more pathologists will have to be provided.

Frauke Sinclair: The chief medical officer has issued guidelines on how to complete medical certificates of cause of death. The aim of the new system is to achieve consistency in the filling in of certificates. That is what we mean when we talk about improving the quality of the certificates that are issued.

I agree that some people think that a post mortem is one way of achieving greater accuracy, but other people have said that even a post mortem does not necessarily provide an accurate cause of death. That is not how we would define quality. It is about implementing guidelines consistently. With six medical reviewers—or perhaps 12 part-time reviewers—who will be managed by a senior medical reviewer, we expect to achieve consistency in the certification of death.

Ian McKee: What do you mean by consistency? It is possible to be consistently wrong. In the example that I gave, if you were the doctor, which cause of death would you choose? Would it be right? If you put “pulmonary embolism”, that would have implications for how elderly people are looked after in hospital; maybe it should. If you put “heart attack”, you would add one more to Britain’s heart attack statistics, which could lead to a change in policy on managing cardiovascular disease. If you put “stroke”, the incidence of strokes would increase, which could mean altering all the public policies on strokes. If you always put “stroke”, “heart attack” or “pulmonary embolism”, that would provide the desired consistency, but it would result in huge alterations in public policy based on lack of knowledge.

Mike Palmer: I think that we are talking about consistency within certain standards. We are simply acting on the evidence that we have been given by stakeholders—that there is considerable scope for improving the accuracy of MCCDs. Clearly, Dr McKee is speaking on the basis of his professional experience of providing such certificates himself. Professionals and clinicians have told us that there is quite some scope for improving the accuracy, although there will be a number of cases in which it is genuinely difficult to do so.

Ian McKee: A procurator fiscal has told me that he felt that “old age” was an acceptable diagnosis in the circumstances that I presented to him.

The Convener: You rest your case—thank you. We can put many of these points to the stakeholders when they come before the committee.

Helen, your time has come.

Helen Eadie: My question is in three parts, as your friend Alex Neil would say, convener. If you would like to take a note of them as I run through them, we will all know exactly what they are.

My first question is on equal opportunities impact assessments. How did you approach that issue, and what stakeholders were involved? I ask that question in light of the point that my colleague Rhoda Grant raised in relation to the Jewish community, from whom we have received quite a powerful submission.

My second question relates to your engagement with local authorities and COSLA, and in particular to your engagement with the City of Edinburgh Council. The submissions from the council and COSLA repeatedly refer to this proposal as a “death tax”. The council is unambiguous in its comment that the proposal will simply require the general public to pay up front, and that the proposal will vastly increase the cost. The cost would not be just £9; there would be a big increase to £30 for the certification fee for an extract. The council says that it would be obligatory—and not only for an extract—for every member of the public to pay that £30. That is causing concern.

The council is worried about the moving of responsibility from local health boards to local authorities. At a time of huge economic cuts across the public sector, the council fears that it will be required to find additional capacity in order to take on additional work. COSLA wonders, clearly and unambiguously, why the public should be required to pay for a scrutiny system, for which the misleading name “certification system” will be used. What you will be putting in place is a scrutiny system; you are not really changing the certification. Certification is provided to everyone.

The Convener: Let me just say that there were questions on equal opportunities impact assessments, engagement with COSLA, and—

Helen Eadie: My third question got a bit lost in transit. The BMA—
The Convener: I have written down three questions. Is this number 4, or is it part B of number 3?

Helen Eadie: It is a very quick question, about the BMA’s concerns over confidentiality. The BMA wants guarantees that, when documents are in transit, patient confidentiality will be taken very seriously.

The Convener: To some extent, the points about costs and charges were dealt with in the answers given to Mary Scanlon. The witnesses may therefore be brief if dealing with those points again.

Another question was on the transfer of responsibility from health boards to local authorities and on financial constraints. The question relating to the BMA and confidentiality has not been asked before.

The witnesses should feel free to address those questions as a group or individually. I leave the choice to you. It is very exciting.

11:15

Frauke Sinclair: I can answer the first question, on equal opportunities impact assessments. As our statement says, our main focus has been on dealing with religious and faith groups, and we have used various forms of stakeholder engagement, including public consultation and subsequent meetings. We held face-to-face meetings with the Muslim Council of Scotland, the Scottish Council of Jewish Communities, and representatives of other groups. We have received submissions from them, and they have been very supportive of the general principles of our model. They have raised concerns with regard to delays, which I addressed in my reply to the question on the expedited procedure.

The Scottish Council of Jewish Communities was not sure whether the expedited procedure applied to registration as well as disposal—that is, a funeral. I should just confirm that it applies to both those circumstances. When registration is complete, disposal—the funeral—can take place. They are, actually, the same thing. The council also raised concerns about medical reviewers exercising discretion in the implementation of the expedited procedure. We feel that, because there are only a few medical reviewers, and there are guidelines on which stakeholders will be consulted, discretion will not be a concern in the application of the procedures. We can reassure the council on that point.

Helen Eadie: Concerns were also expressed about out-of-hours services, in relation to the fact that there are no contact details.

Frauke Sinclair: That related to something that was outwith the scope of the bill. It involves registration services that are run by local authorities, which the bill does not cover. The bill does not say anything about the availability of registrars, who are provided by local authorities, so I cannot comment on that.

Mike Palmer: On the question of the fee—

Helen Eadie: Is that the death tax question?

Mike Palmer: Indeed.

Helen Eadie: Those are not my words; they are the words of COSLA and the City of Edinburgh Council.

Mike Palmer: That is fine.

The Convener: You should never accept a phrase like that so willingly. You must learn to spin.

Mike Palmer: I note it, no more.

Helen Eadie: They are not my words.

The Convener: I am not saying that they are your words, Helen; I am saying that Mr Palmer need not accept them and could call it something else—a fee, perhaps.

Mike Palmer: We are not calling it a death tax. The fee that would be charged would not be a fee for receiving the extract of the death register. That fee of £9 will remain.

Helen Eadie: According to the City of Edinburgh Council, it will increase from £9 to £30.

Mike Palmer: No, that is a confusion. The fee that we are proposing to charge for the scrutiny process would be around £30. That would be for the scrutiny process, which is a totally separate function from issuing the full extract of the death register, which will remain, and will continue to cost £9. There will be two separate fees: one of £9; and one of £30.

Helen Eadie: But the City of Edinburgh Council presents it differently. It says that £11 will go to the local authority and £9 will go to the certification fee. I do not know where the rest of the money goes, because nobody says. The reality, according to the council, is that the fee will be mandatory and that everyone will be required to pay £30 as a certification fee. The point is that this is not a process fee; it is a scrutiny fee. COSLA argues that scrutiny should be paid for by central Government, not the general public, particularly at a time when we are reducing wages and bonuses and society has big problems.

Mike Palmer: Ministers have decided that the process should be self-funded through a public fee. You might wish to ask the minister about that policy position.
I can absolutely confirm that the scrutiny fee, which we estimate will be about £30, is separate from the registration fee that is paid for the full extract from the death register. Part of that £30 scrutiny fee will be a charge that the local authority will make for the cost of collecting the fee. The City of Edinburgh Council might be breaking down the constituent parts of that fee.

Helen Eadie: Paragraph 14 of COSLA’s submission talks about it as well.

The Convener: I want to move on to deal with the BMA and confidentiality, which has not been raised at all.

Mike Palmer: Clearly, we will have to have arrangements that will protect the confidentiality of documentation in transit and throughout the process. As we draw up detailed plans for the operation of the arrangements, we will need to agree with clinicians and the BMA what arrangements will need to be put in place to ensure that that protection is there. We are going to be running test sites to test the administrative processes around the new arrangements, including the transportation of documents.

The Convener: I thank our witnesses for their evidence. We will now move into private session.

11:21
Meeting continued in private until 12:01.
Our ref: F3453590

9 December 2010

Dear Convener

HEALTH & SPORT COMMITTEE – OFFICIALS’ EVIDENCE SESSION
CERTIFICATION OF DEATH (SCOTLAND) BILL

I am writing to the Committee to provide the further information that the Bill Team agreed to supply during the evidence session held on 24 November 2010 as part of the Stage 1 deliberations of the above Bill.

Firstly, you asked whether contributory factors relating to the death of a person would appear on the medical certificate of the cause of death:

The MCCD has two parts. Part 1 starts with the immediate and direct cause of death, followed by the sequence of events or conditions that led to the death, including the condition that started the fatal sequence and the additional conditions arising as a result of this underlying condition.

The initiating condition is the underlying cause of death as defined by the WHO as follows:

- the disease or injury which initiated the train of morbid events leading directly to death;
- or
- the circumstances of the accident or violence which produced the fatal injury.

From a public health perspective, the greatest health gain can be achieved from preventing this initial disease or injury, which may be a long term condition, and routine mortality statistics usually use the ‘underlying cause of death’.

Part 2 of the MCCD requires the entry of any other diseases, injuries, conditions or events that contributed to the death but were not part of the direct sequence leading to death.
I have included a link below to the Chief Medical Officer's letter to Health Boards and all registered (and licensed to practise) medical practitioners. This letter asks them to take the necessary steps to implement the Guidance For Medical Staff Completing Medical Certificates of the Cause of Death. This advice was published in September 2009: [www.sehd.scot.nhs.uk/cmo/CMO(2009)10.pdf](http://www.sehd.scot.nhs.uk/cmo/CMO(2009)10.pdf).

Secondly, you asked us to confirm the number of doctors in Scotland currently eligible to sign a death certificate and I can now update the Committee on this issue. The General Medical Council (GMC) advise there are some 19,224 licensed doctors with a registered address in Scotland. Any one of these practitioners would be eligible to sign a death certificate.

Thirdly, you asked for information on how medical reviewers would oversee/undertake the revalidation and training process for doctors and I have discussed the issue further with workforce planning colleagues. There is no direct link between the proposed role of the medical reviewer and that of the Responsible Officer (RO) under medical revalidation (see following paragraph for an explanation of the RO's role). They are distinctly separate roles with different duties and responsibilities. RO regulations are reserved and have recently been approved by the UK Parliament. Under the proposed new system, medical reviewers would have no direct role in the revalidation process. However, medical reviewers, particularly the senior medical reviewer, would have a key role in promoting education and training on death certification.

Recommendations on a doctor's fitness to practice will be made by an RO in each health board; this is a new statutory role and he/she will primarily base their recommendation on information gathered through the annual appraisal process, as augmented by clinical governance arrangements. Upon commencement of medical revalidation, scheduled for late 2012, each doctor's Licence to Practice will be renewed every five years through the revalidation process, which is based predominantly upon five successful annual appraisals. In practice, the RO will rely on effective local appraisal and clinical governance systems providing sufficient information for him/her to make a recommendation to the GMC. It is through effective information exchange at local level that we expect a medical reviewer would highlight to an RO any concerns that may lead to considerations of individual doctor's fitness to practice. However, only the GMC (as regulator of the profession) can suspend or withdraw a doctor's licence.

Finally, we offered to update the Committee on discussions that have taken place with the Royal Colleges on the training programme for doctors. Undergraduate education and training is undertaken by Medical Schools to deliver the standards set by the GMC. The GMC is also responsible for the standards of postgraduate and speciality education and training of doctors. This is undertaken by NHS Education for Scotland (NES) through the Scottish Postgraduate Deans. Postgraduate Deans link with the Royal Colleges and the Academy of Royal Colleges and Faculties in Scotland to deliver appropriate training. The Deans have indicated that they are keen to emphasise the responsibilities of the educational supervisors and trainers of doctors in the area of death certification. One of the roles of the medical reviewers in Scotland would be to work with the Postgraduate Deans and educational supervisors and trainers to better embed death certification in the training and ongoing continuing professional development of doctors.

I also want to take the opportunity to address another issue raised by the Committee, concerning organ and tissue donors. We have had early discussions with relevant stakeholders to ensure that the new system will not adversely impact on organ and tissue
donation. Specifically, we have spoken to the Tissue and Cells Medical Director at the Scottish National Blood Transfusion Service and concluded scrutiny would not affect organ and tissue donation because by the point at which scrutiny is flagged up (when the MCCD is presented to the registrar) tissues or organs would already have been removed. Equally, it would be of no concern for the purposes of scrutiny that some parts of the body had been removed.

Incidentally, we have also considered the issue of bodies donated for medical research to gauge whether scrutiny would cause a delay which would impact on whether or not a bequest could be accepted. We have had early discussions with university anatomy departments and will be continuing these to consider the need to develop guidance. In the meantime, we have noted that these cases would be justifiable reasons for the expedited procedure (section 6 of the Bill) to prevent any delay and deterioration of the body.

Response to Written evidence to Finance Committee

We also want to respond to a couple of points to the BMA’s written evidence to the Finance Committee. Firstly, we note the BMA’s concerns about the cost estimates but believe that our estimates are robust.

Secondly, in relation to the BMA’s concern about medical reviewers’ powers to require the provision of documents, we believe it is necessary to have an offence provision in place because without access to the relevant documents, the review system could not operate, or it might operate at a far, far slower rate than anticipated which would lead to lengthy delays for families. There is therefore a need for a power to require documents which carries the threat of imprisonment in order to compel persons to comply with a request by the medical reviewer. The offence provision also deals with the situation where a person deliberately alters or destroys documents.

It is a defence to a charge of refusing or failing to produce a document following a request under section 14 to prove that there was a reasonable excuse for the refusal or failure. So if there was some form of emergency in a hospital context, for example, and documents could not be produced within the deadline set by the medical reviewer, it would be possible to avoid prosecution if the doctor could persuade the court that the circumstances justified the failure to produce the documents within the timescale. Saying that, the notes requested by the medical reviewer are likely to be handled by administrative staff at the practice and the medical records department or ward/department administrative staff in a hospital setting.

We note the BMA’s concerns and are of course happy to work with them to ensure implementation is proportionate.

Lastly, we would like to take the opportunity to explain our intelligence-led quality approach to scrutiny tied to quality improvement and clinical governance. This proportionate approach which delivers value for money comprises:

- a random sample of real-time reviews (annual audit cycle) to provide Scotland level data of the proportion of inaccurate MCCDs - this will give a benchmark against which to measure changes against, as well as of course providing outcomes from the actual reviews, which would be followed up where necessary
- interested person reviews - which will for the first time empower individuals to request reviews where they have concerns e.g. to raise the issue of health related problems or contributory factors that have not been included in the MCCD forms, with the outcomes again being followed up where necessary
targeted (retrospective/prospective) reviews - carried out on basis of intelligence gathered from a number of ISD / GROS data sources, with the work by the national statistician crucial.

The scrutiny outcomes will be linked to the education and training activities. The senior medical reviewer will have a key role in taking a leadership role for these. Medical reviewers will also directly support, through being available by phone, certifying doctors in filling out MCCD forms. Together, the elements of scrutiny are primarily aimed at improving the quality of death certification while also providing a level of deterrence, both from the scrutiny and legislative requirements. Other key benefits of the proposals include a uniform death certification system and better public health data.

I hope that this information is helpful and clarifies matters. If the Committee requires further information on any aspects, we would be happy to provide this to you.

FRAUKE SINCLAIR
Bill Team Leader
Thank you for the opportunity to comment on the proposals contained in the Death Certification Bill and the accompanying papers. I have been involved in the progress of this legislation for several years having represented the Royal College of Pathologists on the Burial and Cremation Review Group set up under the previous administration and chaired by Robert Brodie and as Chairman of the Scottish Council of the Royal College of Pathologists for the past three years I have participated in a number of meetings and consultations with the Health Department staff working on the Bill and accompanying papers.

1. Do you agree with the general principles of the Bill?

1.1 As I understand it, the proposals are the establishment of and granting of powers to Medical Reviewers, abolishing the separate cremation certificate, introducing a new single signature certificate of the medical cause of death and review or audit procedures to seek to improve the bureaucratic and medical accuracy of death certification. There will be three parts to the review process namely, interested party request of review, central statistical review and audit of 500 certificates per annum. While I agree with the aims and indeed with many of the measures proposed there are important details in the proposals with which I disagree. I strongly support the powers given to Medical Reviewers, the interested party review, the statistical review and the principle of the audit proposal although I have concerns around the scale of this latter proposal (see below). In the discussion below I have inevitably devoted more space to the issues with which I disagree, however, it is important for the Committee to give weight to my areas of agreement even if these are presented only as a single sentence of support.

1.2 The Brodie Review Group and report examined two options the Medical Investigator (now Medical Reviewer) and a Medical Examiner model. Briefly the Medical Reviewer will have powers to conduct a post hoc review of certification of the medical cause of death, whereas a Medical Examiner would, as part of the issuing of the certificate, enquire into the circumstances and mode of each individual death to confirm the medical cause of death declared by the first doctor. Throughout the working of the Brodie group and during the consultation on the Bill proposals I have expressed the view, supported by evidence from other countries and from our current practice, that for the accuracy of certification of the medical cause of death the Medical Examiner model is superior to the Medical Reviewer model. I accept that the former may be significantly more expensive but I see my role as providing an academic and professional judgement against which cost evaluations should be made and in that respect the Medical Examiner model is more robust and more likely to deliver the aims than the medical Investigator (now Medical Reviewer) approach..
1.3 The doctors groups on Brodie, including my own Royal College, BMA, Forensic Physicians, Crematorium referees, Royal College of General Practitioners, with experience and expertise in the area of Death Certification, opposed the introduction of the Medical Investigator (Reviewer) model. We believed, and continue to believe, that the proposals within the Medical Investigator model could not re-assure the public and that we could not support the introduction of such a model. We strongly favoured a Medical Examiner system to confirm the medical cause of death as accurately as possible. This is similar in principle to the current cremation confirmatory certificate. These concerns were published as a separate paper amongst the Burial and Cremation Review Group documents (5th December 2005., paper 2 paras 31-42) and it remains available for consultation.

2. Do you agree with the proposed changes to the system of death certification in Scotland?

2.1 I do support abolishing the current dual certification of Medical Cause of Death and separate Cremation certificate and moving to a single certificate of the medical cause of death. I do have major concerns that the proposal for a single certifying doctor will meet neither the stated desire for improved accuracy nor provide a safeguard to the public.

2.2 One of the principles enshrined in the Human Tissue Act (Scotland) 2006 is that our duty of care to our patients extends through their illness to their death. It therefore behoves us to put in place a system to ensure accuracy in the diagnosis of the patient’s death as much as the diagnosis of their illness during life. For the investigation and diagnosis of serious disease in life it is rare nowadays for this to rely on the clinical acumen of a single doctor. Rather multiple practitioners are involved often through multidisciplinary team meetings or consultations. I believe the same quality of care should be extended to assigning a medical cause of death through introduction of a second doctor’s review of each death.

2.3 Although it is not stated as an aim of the proposals it remains important that a death certification procedure identifies and leads to the investigation of unnatural death. The proposals for a single certifying doctor do not provide such protection. The current system of cremation certification, which covers approximately half of all deaths, involves a second confirmatory medical signatory and tertiary review by a crematorium referee. These procedures will disappear under the current proposals. A brief review of the Tayside and Fife experience expanded for Scotland as a whole has shown that for about 100 cases per year the second signatory on cremation certificate upon enquiry of the primary signatory and other clinical care staff, as required by law, of the circumstances and mode of the death is sufficiently concerned to have the case notified to the Procurator Fiscal. Twenty to thirty of these cases per annum progress to a full enquiry by the Procurator Fiscal including post mortem examination and are eventually assigned as an unnatural death. These include cases of suicide, accidents, death due to a designated industrial disease and medical mishap. These cases have only been detected through the detailed scrutiny by second doctor. Twenty five cases per year is
a relatively small number but the findings have major implications for twenty five families. These represent only 1/2400 of the deaths in Scotland. These are not mistakenly certified deliberately or with any malicious intent merely by error or inexperience on the part of the primary signatory. This is a relatively good performance by the standards of any activity involving people, namely 99.94% safe, however, the system we have at the moment detects this small number of errors raising further the safety level. Would the new proposals improve safety? Some, but not all, of these cases may be detected by interested party review. The cause of death is varied, as is the geography, so statistical review will not identify these cases. By random sampling of <1% of deaths it would take on average 24 years to detect one of these by which time 600 such unnatural deaths would have passed undetected. The deaths show no fixed pattern of cause nor locality, so population based analyses by certification patterns would not detect these cases. The cause of death as certified would not raise suspicion. Patients die of liver failure in a hepatology unit, they die of malignancy in an Oncology unit and of cardiac tamponade in a Cardiology unit. Only by enquiry of the circumstance did it become evident that these were cases of suicidal paracetomol poisoning, mesothelioma related to industrial exposure to asbestos and perforation of ventricular wall during cardiac pacing. These were not deliberate false certification merely human error in completing the certificate, but they would not be detected by the systems proposed. Would the public be reassured by a process which allows hundreds of unnatural deaths to pass undetected?

2.4 Previous studies have shown that single medical practitioner certification of death had a 15-30% error rate when reviewed by enquiry of the circumstances and mode of death by a second doctor and a 25-30% error rate when a subsequent post mortem has been performed. In analysis of these studies it is evident that less common conditions are frequently missed, consequently these disorders are underrepresented in statistical analysis of causes of death. Such frequently underdiagnosed conditions including aortic dissection often certified as coronary thrombosis or myocardial infarction, acute pancreatitis often misdiagnosed as peritonitis and subarachnoid haemorrhage misdiagnosed as intracerebral haemorrhage. These misdiagnoses are crucial for many aspects of health care planning and for health education. While I am not advocating a return to the high post mortem rates of the 1970’s and 1980’s the introduction of a confirmatory certificate issued following independent enquiry by a second doctor would improve death certificate accuracy.

2.5 Based on this experience and the principles of patient care extending to the deceased I strongly urge the introduction of a second confirmatory medical signatory on all death certificates.

3 Do you agree with the proposals of a system of Medical reviewers?

3.1 I have discussed in para 1.2 my preference for a Medical Examiner system. However, if a Medical Reviewer system were to be introduced I would strongly support the powers granted to the Medical Reviewer, powers which I would consider essential for him/her to carry out his/her duties.
3.2 I strongly support central statistical review of death certificates as a tool for improving accuracy, analysing trends and identifying concerns.

3.3 I strongly support the interested party review as a mechanism for the reassurance of bereaved families and for the safety of the public.

3.4 I strongly support the principle of audit of death certificates but consider the proposed sample to be insufficiently sensitive as a tool to detect poor practice.

3.5 The details of statistical advice given to the Health Department is not available but differs markedly from the advice from the Royal College of Pathologists and from the University of Dundee during the several stages of the progression of the proposals. This is essentially an audit of diagnostic accuracy in certification but the proposed sample size is less than 1%. The Royal College of Pathologists has considerable experience in this field through audit of very large population based screening programmes for cervical cancer, breast cancer and bowel cancer. Each hospital laboratory also conducts similar audit of laboratory testing of many different types involving 50,000-500,000 tests per annum. My academic and clinical experience and information gained from analysis of screening programmes lead me to conclude that a much larger sample would be required for meaningful audit.

3.6 A very small sample size of the type proposed only has the power to detect common errors of a single type. In death certification there are many causes of death which can be entered correctly for the certifying doctor, equally there are many inaccurate causes of death, so we would not be dealing with a fixed pattern of error but many different errors. Each separate incorrect diagnosis is therefore relatively uncommon. When each error is uncommon a large sample size is needed to identify these by audit. Our analysis suggested that 10-20% at least would be required for an audit of any significant power to detect errors or patterns of error.

3.7 Each doctor in Scotland would only have on average one certificate reviewed every 5-10 years. If an inconsistency is detected do we wait another 10 years before a second certificate from that doctor is reviewed or do we institute an investigation every time an error is detected? If the former then a long time and many incorrect certificates would pass before action is taken. If the latter then it has been estimated that in primary care 15-25% of GPs would be investigated for ‘false alarms’ for each genuine problem practitioner to be detected.

3.8 There is an important education and training component to the recruitment of Medical Reviewers and there is a need for the involvement of parties with expertise and interest in the medical cause of death. These parties would include the Crown Office Procurator Fiscal Service, Forensic Physicians, Royal Colleges of Pathologists and General Practitioners, crematorium referees and NHS Education Scotland.
4. Do you have any comments on the costs identified in the Financial Memorandum?

4.1 The costs identified are based on the proposals as presented but as I have argued I believe the proposals to be unsatisfactory. Adequate audit, confirmatory certification and full costs of in depth systematic review when needed are not included. Costs to Health Boards for medical and administrative time in co-operating with the investigative activity of Medical Reviewers have not been included. I therefore believe the costs identified in the Financial Memorandum to significantly under-estimate the true costs of Death Certification as proposed.

5. Are there other comments you wish to make on the Bill?

5.1 The provision to allow a fast track process to accommodate the beliefs and practice of different faith groups is important in a multicultural society and should be supported.

5.2 The views expressed above are personal and are based on my academic and professional judgement. I have also contributed in part to a response to be submitted by the Scottish Council of the Royal College of Pathologists.

Professor Stewart Fleming
Professor of Cellular and Molecular Pathology
University of Dundee
15 November 2010
Certification of Death (Scotland) Bill

Association of Anatomical Pathology Technology (AAPT)

Any changes to the Certification of Death will impact on both NHS and Local Authority mortuaries across Scotland especially on the amount of time deceased may spend in their care.

Do you agree or disagree with the general principles of the Bill?

In principal improving the quality of what is written on a Medical Certificate of Cause of Death (MCCD) and being able to identify the registered medical practitioner who has written it is a good idea. Training and education in the completion of MCCDs must be improved for any statistical analysis to produce any meaningful data which may be used for disease prevention, treatment and workforce planning. The number of MCCDs which are being suggested for review (1-2%) will not provide enough information or impact on the practice of many medical practitioners and should not be advocated as a method of preventing another “Shipman”.

In reality most impact will be on medical practitioners in the hospital setting rather than those working in General Practice. In practice the bill will do nothing to improve the accuracy of death certification and may lead to many cremations taking place which might otherwise have been delayed under current legislation. The impact on the bereaved as funerals are delayed is not offset by a much improved quality of death certification.

Do you agree with the proposed changes to the system of death certification in Scotland?

The Bill gives little information on the on just how the quality or checking of MCCDs will improve. Random audit of such low numbers will inconvenience many bereaved and slow down the funeral arrangements for many. Many funeral directors have little or no refrigerated storage capacity so it is unclear where those dying in the community will be taken until a MCCD has been successfully registered. Similarly in the hospital setting it is common practice for a deceased to be released to the funeral director along with the MCCD especially in rural areas where travel may be difficult or prohibitively expensive.

The logistics for movement of the deceased, medical records and body storage have not been outlined and this is a concern.

It is assumed that the Medical Reviewer would not be available 24 hours a day; 7 days a week and so at traditionally busy times with public holidays there will be a severe shortage of refrigerated storage due to inevitable delays in registering deaths. The system will cause delays to all funeral arrangements, even those where the death is expected as the random review
process will potentially apply to all MCCDs except those sanctioned by the Procurator Fiscal.

It is not made clear in the Bill if MCCDs issued after an authorised, or hospital, post mortem examination will be accepted without review or they too will be subject to random scrutiny.

Under current legislation a family member, other interested party or the registrar can query the cause of death and refer the death to the Procurator Fiscal so there would appear to be some duplication or overlap in the Bill.

It is not made clear that the Registered Medical Practitioner would have to make a thorough examination of the deceased prior to issuing the MCCD which they do not have to under current legislation, currently only cremation certificates require the body to be examined after death. If this is not the case then it would be possible for a deceased to be cremated without any examination whatsoever by a Registered Medical Practitioner which will provide a system much less robust than is in place now. Certain Healthcare Professionals can PLE currently, although only a Registered medical Practitioner can issue the MCCD.

It is unclear what provision as been made for tissue or organ donation which has in the main to be carried out within a restricted timescale. Currently the Procurator Fiscal will sanction these outwith normal hours for reportable cases but would permission need to be sought from the Medical Reviewer for all other deaths? Viewings also need permission if the death has been reported to the Procurator fiscal, would the Medical Reviewer have any say in whether a viewing could take place? Ultimately if the Medical Reviewer is not happy the death could end up being reported to the Procurator fiscal after review of the MCCD.

The numbers and locations of the reviewers as well as their complete independence from all Health Boards needs clarification. The role as outlined would not be independent of the NHS in Scotland as it is proposed the Medical Reviewers be employed by Health Improvement Scotland.

Do you agree with the proposed creation of a system of Medical Reviewers?

In the proposed Bill it is unclear how effective a Medical Reviewer will be, what powers they will have and the exact scope of their remit. There appears to be little overlap with the work of the Procurators fiscal who has the power to instruct a post mortem examination which the Medical Reviewer apparently does not. It would seem that the reviewer would have to report a death to the Procurators fiscal in the same way as anyone else currently can but, with the extra delay of going through a second more senior reviewer. The effect may be that more deaths are reported to the Procurators fiscal service in order to expedite funeral arrangements.
As a death can be registered anywhere in Scotland there is potential for a death to be randomly reviewed in a completely different area from where the death occurred. Logistically discussing individual cases with hospital staff or relatives may prove difficult especially when medical and nursing staff are frequently working shift patterns which will not coincide with the working hours of the reviewer. In rural areas the arrangements for meeting with relatives and/or viewing the deceased may involve lengthy travel taking up much of the day which will also have a cost implication which will often exceed that which has been budgeted for.

The fact that cremation will be able to take place without a registered medical practitioner examining the deceased seems to be a retrograde step and decreases confidence in the system rather than making it more robust. Elderly people with longstanding illnesses where their death might not be unexpected could be especially let down by the proposed changes.

In the case of deaths outwith Scotland it would certainly be more appropriate for a mandatory thorough examination of the deceased as well as any available medical notes in order to exclude any reason for the cremation not being able to take place.

**Do you have any comments on the costs identified in the Financial Memorandum?**

The costs outlined in the financial memorandum show that the finance available for introducing any change to Death Certification is very small. The budget available for a system of six reviewers does not seem to take into account the large distances which they or the deceased may have to travel or other associated costs which will be inevitable.

The costs to NHS Boards and Local Authorities regarding body storage have not been appreciated; neither has the monetary and emotional costs to the bereaved who may have travel long distances to collect MCCDs and visit registrars on more than one occasion.

**Are there any other comments you wish to make on the Bill?**

The medical reviewer role as currently proposed will do little to change current practice or the accuracy of the MCCD. The numbers of cases proposed for review are not sufficient to provide a robust system of regulation and any retrospective review based on statistical analysis would not bolster the public confidence in the system. A budget for training and education as well as encouraging an increase in hospital post mortem rates would give a more accurate picture of causes of death than the proposed changes.

Bereaved wishing quick burials for religious or cultural reasons will not be able to do this, neither will they be able to remove deceased home immediately as is often the case with children where death is expected. If there are some proposed method of fast-tracking these deaths then this would be seen as being a service which should be available to all.
AAPT do not think that the proposed changes to Death Certification proposed in the Bills current form will work in practice and that there will be no improvement to the quality of MCCD.

All funerals will be somewhat delayed, especially burials and mortuaries will have storage issues as will Funeral Directors. Burials which on average take place within 3-4 days and cremations which are usually carried out within a week, except over periods such as Christmas & New Year, will all be delayed considerably. Average length of time for funerals to take place which the Government has used as a guideline include those cases where the death has come under the auspices of the Procurator fiscal and considerable delays are frequent due to police investigations, toxicology and other factors.

Have the Registrars in Scotland agreed to be responsible for informing the bereaved that they MCCD they are presenting has been selected for review and there will be a delay before registration?

Ms Ishbel Gall
Vice-Chair
Association of Anatomical Pathology Technology (AAPT)
18 November 2010
Certification of Death (Scotland) Bill

Scottish Pathology Network

The Scottish Pathology Network (SPAN) is supportive of the general need to modernize the whole area of death certification and cremation/burial and welcomes the general thrust of this initiative. SPAN has already submitted a response at the consultation phase of this process and now welcomes the opportunities to respond to the draft Bill and accompanying documentation. It should be noted that the main motivation behind these changes should be to drive up quality standards. It is also accepted widely that it would be practically impossible to devise a system to prevent another Harold Shipman type tragedy and such references are not helpful in any preamble to the justification for making change in this area. SPAN’s response to the specific questions asked in this consultation are as follows:

Do you agree or disagree with the general principles of the Bill?

Agree.

Do you agree with the proposed changes to the system of death certification in Scotland?

Representatives of SPAN have met with colleagues from SGHD and notes of our detailed comments are given below.

Do you agree with the proposed creation of a system of Medical Reviewers?

Yes.

Do you have any comments on the costs identified in the Financial Memorandum?

No.

Are there any other comments you wish to make on the Bill?

Please see below

Representatives of SPAN met on November 4th 2010 with the Deputy CMO, Dr Aileen Keel and colleagues from SGHD to comment on various points raised. The three principal areas of discussion were as follows:

1. The proposed system of review particularly the size of sample of Death Certificates to be scrutinized by the Medical Reviewer

Representatives of SPAN were concerned that a sample of approximately 1% of all Death certificates (excluding cases referred to the Procurator Fiscal)
would be insufficient to detect significant errors in the certification process, particularly if the error rate was relatively low. From the point of view of detecting suspicious deaths it was not fit for purpose. SPAN drew on experience of methodology used to detect errors in reporting biopsies by diagnostic histopathologists where it was agreed that a sample of 10% or greater was more realistic.

Colleagues from SGHD explained that the proposed system and sample size was not designed to detect errors in a substantial way but was to act as a deterrent against bad practice. It was explained that the Medical Reviewer and his/her team would have a wider remit than simply reviewing a small sample of deaths but would have a central role in putting in place focused audits locally, educating doctors in their area and encouraging the raising of standards generally. Representatives of SPAN were reassured by this explanation.

There was further discussion about the additional safeguards of ongoing statistical review by National Services and review on request by an interested party which was further welcomed.

Following the meeting there was informal discussion about the importance of effective performance management of Medical Reviewers to achieve these goals.

At a meeting of the SPAN Steering Group on November 11th this was discussed further and the Group remained unconvinced about the effectiveness of the sample as proposed and associated measures as effective means of raising standards.

2. The proposed system of Death Certification

Representatives of SPAN were concerned that that a single signatory on a Death Certificate was a substantial step backwards from the current system where, in cases of cremation, at least three signatories are required two of whom are at a senior level in the profession. Evidence was presented from a study in Fife and Tayside where a number of instances of detection of serious irregularities had been detected by the Form C (senior) signatory which if extrapolated across Scotland would amount to 25 cases per annum.

Colleagues from SGHD argued that multiple signatories \textit{per se} would not ensure the quality of death certification and that the systems introduced by the Medical Reviewer would be much more effective.

Representatives of SPAN remained concerned about this particularly in relation to the relatively unmanaged primary care sector. Colleagues from SGHD agreed that this was a concern and that systems would have to put in place in relation to sound clinical governance and appraisal to reinforce this area.
At a meeting of the SPAN Steering Group on November 11th this was discussed further and the Group voiced further concerns about changing the unified form to having a single signatory only.

3. Potential delays introduced by case reviews by the medical Reviewer

Representatives of SPAN were reassured that although there would be delays in death registration occasioned by the new system there should be no appreciable delays to funeral arrangements. Representatives of SPAN were also reassured by proposals for a “fast track” system of medical review for special circumstances.

4. Other matters

Representatives of SPAN welcomed the replacement of cremation fees with a uniform death certification fee levied simply to cover the costs of the new system. It was anticipated that the cost of the Certificate would be around £22 plus an administration fee.

Representatives of SPAN welcomed the clarification of procedures relating to deaths abroad.

Representatives of SPAN were reassured that governance arrangements would be tightened in relation to the responsibilities of Health Boards/Medical Directors to ensure that good practice was observed by their staff in the performance of death certification.

Representatives of SPAN welcomed the proposal to introduce a robust mechanism of comparison of quality indicators of the new and old systems during the pilot phase. It was suggested either a comparison with the same Board Area pre pilot or similar Health Board Area. It was suggested that the review should encompass not only the generality of how the system works but also the specifics of delays for families, numbers of illegible forms and numbers of cases referred to the Procurator Fiscal, numbers of phone calls to doctor who signed the forms. Quality indicators might include: Legibility; completeness of data items; quality of medical cause of death when examining the details of the medical records and the accompanying Death Certificate.

Dr Jeremy Thomas
Clinical Lead
Scottish Pathology Network
16 November 2010
Certification of Death (Scotland) Bill

Federation of Burial and Cremation Authorities

1. The Federation of Burial and Cremation Authorities agrees that there is a need to change the current arrangements in place in Scotland to deal with Death Certification, however the Federation is not in agreement with some of the principles applied within the proposed legislation.

2. The Federation agrees that changes are necessary however it is concerned that the level of scrutiny suggested within the proposals is inadequate to put in place the safeguards to ensure a significant improvement within the process. We are aware of the proposals that suggest that approximately 500, or 1% of deaths will be referred to the Medical Reviewers each year by a random choice selection process applied at the point of registration. If we take the example of the current system where approximately 60% (32,500 in 2009) of deaths result in cremation, all of these deaths currently receive some level of scrutiny with the Procurator Fiscal, Second Doctor and Medical Referee procedures in place. In future there will be at least 32,000 bodies going for cremation without any form of scrutiny at all, which would seem a significant retrograde step. One of the stated aims of the proposed method of Death Certification is to "deter criminal activity/malpractice (indirectly)". It does not seem credible that the proposed system can act as a deterrent to malpractice of this type when the planned level of scrutiny is approximately 1%.

3. The Federation is aware that under the current system, when a person dies abroad and the body is to be cremated, any documents regarding the death are sent to the Scottish Government who then scrutinise the submission and ultimately give written authority to the Medical Referee at the relevant crematorium to authorise the cremation. This written authority is accompanied by a copy of the documents that the Scottish Government have received. The primary document that accompanies the deceased is the local version of the death certificate (or a translated copy of it) plus on some occasions, proof of the registration of death. The content of the death certificate varies from country to country, but does not normally contain any information regarding pacemakers or other implants that can be hazardous when subjected to severe heat during the cremation process. The Medical Referee then reviews this paperwork plus Form A, the Application for Cremation in order to determine whether he will finally authorise the cremation. Information regarding implants is obtained from information supplied which is completed by relatives of the deceased. A weakness of the current system is that there is no requirement for any documents to be provided in the case of burial.

4. Under the proposed scheme, when cremation is required, the Medical Reviewers will determine whether it is safe to cremate the body,
presumably by referring to the deceased’s medical history. Determining the validity of the paperwork accompanying the deceased for both burial and cremation however is to be the responsibility of those in charge of the place of burial or cremation to authorise final disposal. If so this is so, it would appear to the Federation to be most inappropriate. While there are only 26 crematoria in Scotland there are innumerable burial grounds, some of which are rarely used. Home burials are also a legal possibility in Scotland. The policy memorandum that relates to the Certification of Death (Scotland) Bill states that “the disposal is authorised by the correct certification (which for deaths outside Scotland is likely to be certification equivalent to the MCCD and the certificate of registration of Death).” As reported above a certificate of registration is not always provided and the death certificate (MCCD) varies from country to country. A stated aim of the proposed method is for a "single system of independent, effective scrutiny of deaths that do not require PF investigation". To delegate decision making to an inestimable number of people, when the documents they have to verify are subject to wide variation, cannot be called a “single system of independent, effective scrutiny”. The proposed method is likely to cause uncertainty and confusion amongst cemetery and crematorium staff, and will be extremely difficult to audit. To be effective the decision making must remain central and logically be given to the Medical Reviewers. Unlike an average cemetery or crematorium staff member, a Medical Reviewer will have been medically trained and will be familiar with MCCDs. The Medical Reviewer also has ready access to the Senior Medical Reviewer, to discuss and decide on a consistent course of action, for those occasions when the documents do not seem to fully comply with the requirements.

5. The Federation is not opposed to the creation of a system of Medical Reviewers; however it is opposed to the resulting level of involvement and scrutiny that has been indicated. The Federation is very much more comfortable with the level of scrutiny that is being applied within the new proposals for England and Wales, where all deaths will be scrutinised. In addition the new system in England and Wales will continue to require the Coroner to authorise the disposal of a body brought in from overseas. The Federation feels that as the Scottish Government currently scrutinises documents accompanying bodies brought into Scotland from abroad for disposal, this responsibility should also be passed to the Medical Reviewer for authorisation in all cases regardless of the preferred method of disposal.

6. The Federation recognises that the proposed costs identified within the Financial Memorandum are significantly lower than those proposed south of the border for the Medical Examiner model that is to be introduced there. However it is apparent that this is as a result of the much lower rate of inspection and scrutiny that is to be applied in Scotland by the Medical Reviewers, which is clearly resulting in a lower cost system, which in turn may result in a system that is unable to perform to the satisfaction of all concerned. The Federation also feels
very strongly that any fees chargeable to the bereaved families that result from the introduction of the Medical Reviewers system should be recovered at the point of Registration of the death. It will not be practical to implement and audit a system where fees are either collected by Funeral Directors or Burial or Cremation Authorities scattered across Scotland.

7. The Federation is most concerned about the significant differences that appear to exist between the proposed Death Certification system for Scotland and the progressing plans that have been supported by several pilot schemes that are being trialled in England and Wales. We were hopeful that as the two projects are running on very similar timescales, that there would have been more parity between the proposals to ensure the minimum of inconvenience for families, Burial and Cremation Authorities and Funeral Directors when dealing with the transfer of remains to and from Scotland.

Mr Richard Powell
Secretary
For and on Behalf of the Scottish Sub-Committee
Federation of Burial and Cremation Authorities
12 November 2010
With reference to your call for written evidence, we would respond seriatim as follows:-

Do you agree or disagree with the general principles of the bill?

The Association accepts the general principles of the Bill, with its reservations being as previously submitted during the consultation process.

Do you agree with the proposed changes to the system of death certification in Scotland?

As an Association, we feel any improvement in the death certification procedure is welcome to provide better statistical analysis and information to the families and those handling the deceased. However, as previously submitted, we do have concerns about the robustness of the proposed system in terms of proper scrutiny of the disposal certification.

Do you agree with the proposed creation of a system on Medical Reviewers?

The Association has deep reservations that the system is less robust than the existing three Doctor system, and we struggle to see how six Medical Reviewers will be able to cover the geographical area whilst trying to maintain present timescales.

Do you have any comments on the costs identified in the Financial Memorandum?

Having previously mentioned our concerns at the number of Medical Reviewers, we would fear an escalation in costs if the number of Reviewers had to be increased and this would have a corresponding effect on any financial model previously proposed.

Are there any other comments you wish to make on the Bill?

We are disappointed that this Bill only relates to the certification aspect. The original review group also discussed burial revision. We are especially disappointed that there is no mention of the recommendations made by the Scottish Cross Party Parliamentary Group for the Funeral and Bereavement Service on the issue of retention and disposal of ashes.

The collection of the proposed statutory fee by the Registrar seems the most appropriate as the Registrar of deaths is the only constant in the whole process. Administratively, it would seem to be preferable as there are fewer
Registrars than funeral directors and accountability would also be improved through this method.

We are disappointed that the opportunity has been missed to adopt one system for Scotland and England and Wales which would have avoided the cross-border issues.

Again, we wish to emphasise our stance as has been laid out in our previous submissions throughout the consultation process. The National Association of Funeral Directors values the opportunity to work with the Scottish Government and it is our hope that the bereaved will continue to receive a prompt, seamless and efficient service whatever the outcome of the Death Certification Bill.

Alan Slater
Chief Executive Officer
National Association of Funeral Directors
17 November 2010
Certification of Death (Scotland) Bill

Association of Registrars of Scotland

The Association of Registrars of Scotland (ARoS) understands the objectives of this Bill and fully agrees with the need for medical review to ensure accuracy on medical certificates of cause of death (MCCD). ARoS also recognises the need to amend the current MCCD to show additional information on the form. However, the collection of a fee to pay for this additional service should not rest with the Registrar.

Background

At the moment a death is registered by a relative of the deceased or, if there is no family, a friend or the Executor can act as informant, providing they have adequate information. In some cases the person responsible for the nursing home in which the person resided may register the death and, in exceptional circumstances, it may fall to the undertaker or the Police.

There is no charge for registering a death. The informant of a death will receive an abbreviated certificate of death, showing the name, age, date of death and place of death. The Registrar will also provide a form 14 for the undertaker to allow the funeral to proceed and form 334 S1 for the DWP for state benefit purposes. The Registrar will also inform the Council Tax office where the deceased resided along with the office responsible for the Electoral Roll.

If the informant requires advising a bank, solicitor, insurance company or any other such organisation, then they need to purchase an extract of the death entry, which costs £9.

Collection of Fees

ARoS is concerned that Registrars may be called upon to collect the scrutiny fee in respect of the medical reviewer functions at the time of registration. The collection of a fee is detrimental to the statutory registration process, which leads to the question of the registration being allowed to proceed if the informant is unable to pay the fee. Whatever name this fee has, it will be considered as a fee to register a death.

To collect the fee at the time of registration may deter the informant, particularly if they are a friend or a neighbour. The friend or neighbour may be the closest person and have most knowledge of the deceased but would not have any interest in the estate or any benefit from it. They may not be in a position to pay the proposed fee as they may wonder how they will be reimbursed or they may not have any money to spare for such a charge.

If the informant of the death registration is a Police officer or the person in charge of the nursing home in which the deceased resided, that person has
no connection with the deceased and is registering the death as a duty of their profession. They are part of a group of people who may be able to assist in the registration of a death but have no access to or interest in the estate.

ARoS is also concerned about the proposal that the local authority add an additional administration charge to cover the cost of collecting the fee. This may vary between Councils and, therefore, may attract or deter those needing to use the Registration service.

It has been advised that if Registrars are the preferred option for the collection of the fee, the Health Boards will work closely with the Registrars to make sure the public are properly informed about the fee and its purpose but the concerns are that the recently bereaved families are not always able to take on board the information given to them at the time of the death of a loved one. Paying the fee to the Registrar for one aspect of the NHS service and then to the Funeral Director for other aspects may cause confusion.

It is suggested by ARoS, therefore, that the Funeral Director collects the scrutiny fee as they have experience in collecting fees on behalf of the NHS for other services surrounding a death.

Exemptions

It is noted that it is expected that still births will be exempt from scrutiny and, therefore, exempt from paying the fee and it is suggested that deaths of children will also be exempt.

Training

The Bill explains the need for training for Registrars to deal with the new MCCD and questions from the recently bereaved about the scrutiny fee, and ARoS is pleased that consideration for training and development for Registrars have been recognised as a cost on local authorities and that the Scottish Government will meet these costs.

Mrs Alison Quigley
Honorary Secretary
Association of Registrars of Scotland
17 November 2010
Certification of Death (Scotland) Bill

City of Edinburgh Council

The City of Edinburgh Council welcomes the opportunity to submit written evidence in connection with the above bill.

The City of Edinburgh councils accepts the objectives of the bills and agrees with the introduction of medical reviewers to improve the accuracy on the Medical Certificate Cause of Death and the proposed changes to the MCCD.

However the proposal that the scrutiny fee be collected by Local Authority registrars is fraught with potential difficulties and as Chief Registrar for this Council I have grave reservations regarding how this will be achieved in a way that will not be detrimental to the work of the registration service or the good reputation of the registration staff.

Proposed collection of fees by Registrars on behalf of the Scottish Government

Registration of a birth or death is a statutory requirement and therefore there is no charge for these services. This is a necessity to ensure all births and deaths are registered, regardless of an informant’s financial position. At present it is possible for an informant to call into the Registrar’s office and register a death, receive the necessary form to allow the funeral to take place, another form to notify DWP and be issued with an abbreviated copy of the death certificate without spending any money. This is necessary as many people attend the registrar’s office straight from the hospital and may not have any means of payment with them. A statutory fee is only charged should the informant want further copies of the death certificate. These can be purchased at any time after the death has been registered.

Relatives who come into register the death of a loved one are often upset and do not always understand fully what is being explained to them. If registrars are required to collect the fee in respect of the new procedures set out in this bill, within a very short period of time and regardless of any publicity or information given, the perception will be that this fee is for registering a death or a death tax. It seems unfair that this fee will be taken at a time when people are at their most vulnerable and not in the right frame of mind to question the payment. At present the fee for a second doctor’s signature required for cremation purposes is collected by the funeral directors and is presented as part of the total bill after the funeral has taken place. This seems a far more considerate and sympathetic system of collection of the fee and may result in less un-collected fees.

Although it is statutory requirement that falls on certain people to register a death it may be that in the cases where there are no relatives available this fee may deter friends, neighbours or those on limited funds from carrying out this important task. Many deaths are also registered by professional bodies
such as police officers, Local Authority care home managers and social workers. Although these people are classed as secondary informants to register the death, they will have no interest in the deceased’s estate, if indeed an estate is available and therefore no way of being reimbursed.

The bill does suggest exemptions to payment of the fee. Although this is appreciated in the case of still-births and deaths of children, it will be difficult to determine what other categories should be identified as being exempt from payment. It will also be difficult for registrars to manage a payment system as some informants may be liable to pay but do not have the payment with them and say they will come back in then do not do so, or people paying with credit/debit cards where the payment is subsequently stopped. It may also result in two deaths being registered at the same time where one person has to pay the fee and one is exempt. As this fee has nothing to do with the registration of a death it should not be part of the registrar’s duties to explain the fee and the reasons for the exemption it should also not be the Local authorities duties to follow up non-payments.

It is imperative that the payment of the scrutiny fee should never stop or even delay the registration of a death.

It would seem to make more sense to leave the collection of fees with the Funeral Directors as part of the funeral bill as this is an established process and cannot be deemed to be offensive or insensitive to the recently bereaved.

Mrs Elizabeth Allan MBE
Chief Registrar
City of Edinburgh Council
17 November 2010
Certification of Death (Scotland)
Bill: Stage 1

10:34

The Convener: Item 2 is an evidence-taking session on the Certification of Death (Scotland) Bill with two panels of witnesses representing medical and legal groups as well as professional organisations. Our first panel comprises Professor Stewart Fleming, professor of cellular and molecular pathology at the University of Dundee; Dr Colin Fischbacher, consultant in public health at the Information Services Division of NHS National Services Scotland; and Dr Jeremy Thomas, consultant pathologist and clinical lead with the Scottish Pathology Network. I am advised that Dr George Fernie, registrar at the Faculty of Forensic and Legal Medicine, cannot make it because of the weather conditions and Ishbel Gall, mortuary manager and vice-chair of the Association of Anatomical Pathology Technology will be joining us very shortly.

I move to members’ questions.

Dr Richard Simpson (Mid Scotland and Fife) (Lab): Last week, I asked the bill team whether the proposed new system would prevent another Shipman. That might have been a little strong, given the unusual nature of that case but, nevertheless, can we be sure that the new system will have the public’s confidence?

Dr Colin Fischbacher (NHS National Services Scotland): No. Allowing interested parties to raise concerns about a death, sampling or the collection of other information might have a small deterrent effect, but no absolute assurance can be given that someone like Shipman would be detected. Indeed, as research carried out by Bruce Guthrie and colleagues in my organisation indicates, it is not feasible simply to rely on statistical methods to detect criminal activity and the response to the Shipman case depends not only on changes in death certification but a range of actions including better clinical governance, the revalidation of doctors and the reform of opiate prescribing. The short answer, therefore, is no.

Professor Stewart Fleming (University of Dundee): Although the whole process was kicked off as a response to Shipman, we need to examine the principles of the death certification process. As I see it, there are three aims above all else: first, to confirm the fact of death; secondly, to confirm as accurately as possible the cause of death for input into health care planning; and thirdly, to allow the detection and investigation of unnatural death. However, even within the third group, deaths that come about as a result of a Shipman are so rare compared with other
unnatural deaths such as industrial disease, suicide, road traffic accidents and so on that they cannot be detected by statistical or other methods.

**Dr Jeremy Thomas (Scottish Pathology Network):** I concur with my colleagues.

**Dr Simpson:** I am interested in Dr Fischbacher’s comment that a statistical approach will not be helpful. Surely the fact that under the proposed surveillance system a doctor’s certificate is likely to be examined in detail only once every 10 years will neither give the public confidence nor allow something to be ruled out. I accept the tenet behind your comments, but I have to say that I am surprised that you feel that statistical analysis will not help. If that is the case, and given that eliminating the need for two other doctors’ signatures in respect of cremations means that surveillance will be reduced, we will not be strengthening the system, but weakening it to a degree that might jeopardise public confidence.

**Dr Fischbacher:** It would not be wise to claim for the existing system or any new one something that cannot be supported. That would be misleading the public. It is quite wrong to suggest that at the moment we have a feasible way of detecting murderers. Professor Guthrie’s and other research has concluded that, if a statistical approach were to be employed in such matters, the number of false alarms would far exceed the number of true signals. This approach cannot feasibly be taken and we should not pretend that it can be. Other approaches are more appropriate for detecting murderers.

Moreover, because of the way in which patients in Scotland are registered, we can monitor mortality in general practice only at practice level, not at individual doctor level. Murderers are clever. Dr Shipman moved practice during his career, perhaps deliberately to avoid detection, and we cannot be sure that that will not happen again. This is just a distraction from the real purposes of statistical monitoring.

**Dr Simpson:** Last week, I raised the issue of an electronic death certificate system—

**The Convener:** Before we move on to that, Ross Finnie wanted to come in on the Shipman point.

**Ross Finnie (West of Scotland) (LD):** We are seeking clarity, and you have answered with clarity, particularly in relation to the fact that you cannot give guarantees, which is accepted. That is true, however, of every walk of life; it is not unique, and you did not say so. I am not saying anything that you have not said. Whether someone is in the financial or any other sector, to give guarantees that every fraud will be found out is palpable nonsense.

I do not want to overstate this, but the committee has found the way in which the Government has presented the bill to be a little bit difficult. Last week, there was an indication that the key driver is not about Shipman, and the bill team leader went on to say that that is because we simply cannot deter everyone. The fact that we cannot deter everyone has not stopped other walks of life putting in place measures that try to make it more difficult for people to obviate or circumvent the system.

The Government put it to us as an absolute last week that, as we cannot deter everyone, we should forget about that—the Shipman case has nothing to say to us and is not part of what we are talking about. The Government keeps mentioning the case, however. As you well know, the burial and cremation review group that reported in 2007 made it clear that it does not attempt to claim that we can legislate to eradicate a Shipman, but it did say that “change was indicated to the current death certification process in Scotland, not only as an outcome of the Shipman Inquiry.”

but to reflect the real need to modernise the system. Is there a balance or should the committee simply proceed on the basis that, because we declare that we cannot eliminate the possibility of another Shipman, we should have no regard to the findings of the Shipman inquiry?

**Dr Thomas:** The real concern relates to the size of the sample, which is set at around 1 per cent. The Royal College of Pathologists has experience of concerns about pathologists who make diagnostic errors, and there have been cases where pathologists have been reviewed to see whether their practice is up to scratch.

From the samples that we have to take of a pathologist’s practice and his annual workload, we know that a 1 per cent sample will not detect those errors at all. We probably need to get up to around the 10 per cent level to have a realistic chance of picking up errors. You must remember that there will be a lot of noise but not a lot of signal, because the errors that we will see in death certification will be relatively minor. Picking through all that noise to find the signal will be difficult, particularly on a 1 per cent sample.

**Professor Fleming:** It is about more than detecting or deterring a Shipman. As the committee will have seen from my written evidence, many unnatural causes of death are picked up only when the confirmatory medical certificate on the cremation form is filled in. Somewhere in the region of 30 cases a year are picked up at that point. Some of them are road traffic accidents. An old lady dies of bronchial pneumonia and it is only when the doctor who is filling in part C enquires into the circumstances
and mode of death that it becomes apparent that she was in hospital because she was knocked down by a car and was dying as a long-term or later consequence of a road traffic accident. Many unnatural deaths are picked up only because a second doctor scrutinises the cremation certificate.

10:45

Dr Fischbacher: It is important to consider separately the impact of the bill on detecting Shipmans, as against its other purposes, and—

Ross Finnie: I understand that. I am trying to get some balance into the argument as to whether we are entitled to set that aspect aside completely. That is not the impression that I am getting now, but that was rather the steer that we were given last week.

Dr Fischbacher: In my earlier comments, I said that it was possible that the bill might have some effect, but it is important to stress that the impacts would be relatively minor and certainly would not offer any reassurance that we would detect such criminal activity.

Ross Finnie: Would you rather go along with the chairman of the burial and cremation review group, who writes in its “Report and Recommendations” that the unlikely event of another Shipman is simply made marginally less likely if all the measures that are proposed in the bill are enacted? Is that a fair summation?

Dr Fischbacher: That is a fair summary—the bill might make such an instance marginally less likely. We are not saying that there is nothing that can be done about cases like Shipman—far from it. We are just saying that statistical methods are not the way to go, and that there are better approaches, including those that I mentioned: better clinical governance, the regulation of opiate prescribing and the revalidation of doctors. Those measures would be more appropriate.

Professor Fleming: I disagree. I think that the proposed measures make it much less likely that a Shipman-type case would be picked up, compared with the current system.

Ross Finnie: Less likely?

Professor Fleming: They would make it less likely that a Shipman would be detected.

The Convener: Could you develop that point, please?

Professor Fleming: Under the current system, 62 per cent of deaths have three doctors reviewing them, two of whom are not part of the professional practice of the first doctor. Under the bill’s proposals, a doctor looking after a patient will sign a death certificate. That means much less scrutiny. Sampling will not pick up cases like Shipman; statistical analysis will not pick them up; but scrutiny by a second and third doctor, as occurs at the moment for cremation papers, is more likely to pick them up. They might not all be picked up, but it is more likely under those arrangements. If we do away with those arrangements, it will be less likely that we will pick up such cases.

The Convener: Referring to the Shipman inquiry’s third report, the policy memorandum refers to “legislation on the aspects of the report relating to death certification, with the remaining aspects related to burial and cremation to be introduced at a later date.”

Will that deal with the circumstances that you say the bill does not cover?

Professor Fleming: I am uncertain about that, because I do not have the information.

The Convener: That is fine.

Dr Simpson: One of the big problems at the moment, as I see it, is the inaccuracy of death certification. We heard evidence the other day that there had been 600 cases in which the doctor was asked further questions and did not reply, which seems extraordinary. The registrar went back to the doctors in about 3,000 cases, I think—which is 1 per cent—and asked for further information. That is at the same level as the proposed sampling. Answers were obtained in all but 600 cases—in those 600 cases, answers were not received.

My question is: why has it not been considered that we should modernise the system by moving to an electronic certification system, which, given the appropriate software, would allow for entries to be challenged? That would mean that the information that is accrued by ISD Scotland would be electronic, and would not have to be paper entered. In other words, it would mean modernising the system.

My colleague Dr Ian McKee gave the example last week that a doctor might write down “old age” as the cause of death. Procurators fiscal have accepted that as a diagnosis. However, it could be challenged on an electronic form and might have to be qualified in some way, so that the doctor needs to indicate what they thought happened. If accuracy is important, why are we not going for an electronic system?

The Convener: Before Dr Fischbacher responds, I welcome Ishbel Gall, mortuary manager and vice-chair of the Association of Anatomical Pathology Technology, who has fought through the snow to get here. I hope that you will find your journey to be worth while, Ishbel.
Ishbel Gall (Association of Anatomical Pathology Technology): My apologies for being late.

The Convener: You do not need to apologise. It is very good of you to make it through.

Dr Fischbacher: In response to Dr Simpson’s question, I clarify that I am the person who writes to doctors. Last year, I wrote around 2,000 letters to doctors for two purposes. I asked for further information resulting from post mortems and for clarification of the cause of death where we did not think that it was clear. Doctors have no obligation to respond to those letters, and a substantial minority of them do not do so, as Richard Simpson said.

At the moment, registrars transfer information electronically from registration offices to the General Register Office for Scotland, where I provide medical advice in the review process. Causes of death are coded using software and are then manually reviewed, so there is already a software check. The software will say that the sequence of events that led to a death does not seem to make sense and is not clear, and the certificate will then be manually reviewed. The coding staff at the GROS will ask for my advice if they are still uncertain.

Dr Simpson: So we already have a system at the back end, beyond the registrar’s office, but not at the front end. Why do we not have a system at the front end, so that the doctor is given drop-down menus and choices about what he can enter, rather than doing something that has been around since 18 something or other? He has to enter things that then require data to be put out. Such a system would also mean that there would be much more accuracy. Questions that are not being asked about the 54,000 deaths that are accepted could be asked, and we could have much more information about things such as ethnicity, which is not being picked up. That is important epidemiologically. There are many other issues that it would be quite simple for a doctor to deal with electronically that are much more difficult to deal with on a handwritten form.

Dr Fischbacher: I understand the value of your proposal, but I would need more information on its feasibility.

Dr Simpson: Yes. Understood. My question is whether such a system has been considered.

Dr Fischbacher: Not to my knowledge.

Professor Fleming: I strongly support that suggestion. We have a number of front-end systems like that. In my clinical job, I am a renal and transplant pathologist. We have a Scottish renal biopsy registry where we register diagnoses. There are subtle wording differences for describing things, and there are prompts to qualify the answer if it does not match the coding system. The software is available, but obviously quite a bit of work would need to be done. However, I strongly support the principle of the suggestion.

Mary Scanlon (Highlands and Islands) (Con): For the record, we are here today in response to the Shipman case. Following the publication of the Shipman inquiry in June 2003, the previous Scottish Executive set up a review group that made recommendations on the law relating to burial, cremation and death. That is the background to the bill. Let us be honest: we are here as a result of Shipman and to try to correct things.

Professor Fleming said that the three aims of the certification process are to confirm the fact of death, its medical cause, and to detect and investigate unnatural deaths. From his evidence, it appears to me that he is not satisfied that the bill addresses those three issues in an effective manner. Ishbel Gall said:

“the bill will do nothing to improve”—

The Convener: Would Professor Fleming deal directly with the first question before we move on?

Mary Scanlon: I have not got to a question yet.

The Convener: Professor Fleming can talk about the evidence that he has given.

Professor Fleming: Mary Scanlon’s summary is correct. I think that the bill will meet the first need—it will confirm the fact of death—but I am not convinced that it will necessarily improve accuracy on the medical causes of death. I am even less convinced that unnatural deaths will be identified as a result of it.

Mary Scanlon: When you say that it will confirm the fact of death but not improve the accuracy on the causes, you are saying that it will prove whether a person is dead or alive.

Professor Fleming: Yes. Those are the three parts of the medical certification process. The death must be certified in order to be registered—there are all sorts of legal consequences of that. The bill will clearly do that, but I am less certain that it will give us an accurate cause of death and I am even less certain that it will pick up all the unnatural deaths that are detected by the current system.

Mary Scanlon: The process will confirm whether someone is dead or alive.

Professor Fleming: Yes.

Mary Scanlon: We have been quite good at doing that for a few centuries now, have we not? I am sorry, I do not mean to be flippant, but—
The Convener: It is more complex than that, but we will leave that to the committee members who were general practitioners.

Mary Scanlon: Okay. I will go to the main points of the evidence. Ishbel Gall, in your written evidence you say that the bill will do nothing to improve the accuracy of death certification. You also say that it will be possible for people to be cremated without examination, but your main point is that you think that the changes proposed in the bill will not improve the quality of medical certification.

Professor Fleming, you say that the existing system is superior to the proposed system. You refer to the 30 cases a year in which unnatural causes of death—including suicide, industrial disease and medical mishap—would not be picked up in the proposed system. You go on to refer to the cause of death, misdiagnosis and so on, and the fact that a doctor would be checked on every five to 10 years.

Although both of you say that you agree with parts of the bill, your evidence raises serious concerns about it. In particular, Ishbel Gall, you say that it is a "retrograde step" and that the system that we have in place at present is superior to what is proposed. Can you elaborate on that?

The Convener: Ms Gall, I ask you to deal with the broader question of whether the bill is a retrograde step. I think that some of those questions have probably been answered already by Professor Fleming.

Ishbel Gall: Under the current system, a registered medical practitioner can issue a death certificate without examining the deceased. Once the death is registered, the deceased can be cremated without being examined. In order for cremation to take place, at least two doctors have to examine the body of the deceased, then the paperwork goes to the medical referee at the crematorium who will approve the cremation. The process is clear just now, but it is more complex than that. Furthermore, in about 15 per cent of cases someone has been very ill at home for a long time, rather than just taking somebody's word that life is extinct—it would be prudent to insist that a medical practitioner examine the body before issuing a certificate.

The Convener: Before I move on, do any of our GPs want to come in on that? You had quite a lot to say last week about the system being retrograde. Rather than giving evidence, you can just ask a question.

Ishbel Gall raises a couple of points of the evidence. Ishbel Gall raises a couple of points about human error and misdiagnosis make me think about the evidence that we heard last week, for example, about cases in which someone may die in a coronary care unit, but the main contributory factor could be that they had had diabetes for 30 years, or cases in which people die of pneumonia but had a serious hospital-acquired infection. Will there be more thorough or more accurate information on the death certificate as a result of the bill?

11:00

Professor Fleming: I do not believe so. At the moment, in 62 per cent of deaths, the disposal of the body is by cremation. There is a separate cremation form, a second doctor and a confirmatory medical certificate. We know from our local experience and the nationwide crematoria experience that in about 15 per cent of cases—the figure is somewhere in that ballpark—there is a fine tuning or even an alteration of the diagnosis by the confirmatory medical certificate. That involves someone standing back, looking at the bigger picture and inquiring into the circumstances and mode of death. A system that does away with that will be inherently less accurate.

The Convener: Those are the sort of circumstances that you may wish to examine. If somebody has been very ill at home for a long time, rather than just taking somebody's word that life is extinct—that the person has died—it would be prudent to insist that a medical practitioner examine the body before issuing a certificate.

Ishbel Gall: Some GPs do not view the body when they issue a death certificate; that is legally allowed.

Mary Scanlon: Professor Fleming's points about human error and misdiagnosis make me think about the evidence that we heard last week, for example, about cases in which someone may die in a coronary care unit, but the main contributory factor could be that they had had diabetes for 30 years, or cases in which people die of pneumonia but had a serious hospital-acquired infection. Will there be more thorough or more accurate information on the death certificate as a result of the bill?

Mary Scanlon: Ishbel Gall raises a couple of issues that have not been covered yet. It is unclear what provision the bill makes for tissue or organ donation. The process is clear just now, but under the bill it will be an offence to dispose of body parts. Will the bill make it more complex for medical practitioners to consider tissue and organ
donation? Will it be more difficult as a result of the bill, or is the information simply not there? I am not sure.

Ishbel Gall: At the moment the procurator fiscal is involved in many of those cases, because unfortunately some sort of traumatic event will have led to the person being considered as an organ donor.

Most of the organ retrieval that I perform takes place in the mortuary once the patient has died, and usually involves corneas and things like that. We also retrieve tissue for medical research when the person has indicated in life that they wish that to happen.

If there is a chance that the death certificate may have to be reviewed, many people would feel uncomfortable going ahead and retrieving tissue. In much the same way as we need permission from the procurator fiscal, we would expect to have permission from the medical reviewer to proceed. Unfortunately the medical reviewer will not be a 24/7 operation, so we may have difficulty getting that tissue and therefore lose some of the valuable donations that we currently get.

Mary Scanlon: That is really the point that I am making. On page 2 of your submission, you note that there is an overlap with the work of procurators fiscal, who have the power to instruct a post mortem, which the medical reviewer does not have.

You are saying that the presence of the medical reviewer could make retrieval more difficult, or could delay potential organ or tissue donations. Is that right?

Ishbel Gall: Yes, that is correct.

Ross Finnie: The removal of the requirement for the triple signature, which will affect 60 per cent of cases, has been defended by the Government. The bill team leader, in his evidence to us last week, said:

“A number of people have commented on how, in many cases, the signing is done in a relatively perfunctory manner and does not really deliver a robust check.”—[Official Report, Health and Sport Committee, 24 November 2010; c 3712.]

That observation is supported by the burial and cremation review group, and we have to accept it, but it appears to raise at least two options. On the one hand, you may decide that secondary checks—not necessarily triple signatures—can play a role, and if you find the present system to be perfunctory, you can seek to address that by changing the system. On the other hand, you can adopt the Government’s approach—as represented in the bill—and say, “Oh well, the triple check is entirely perfunctory and does not appear to be working, so we will simply abolish it.”

Which of those approaches do you believe to be the more satisfactory and likely to inspire public confidence in the system as a whole?

Professor Fleming: We got the same feedback from the bill team, but it does not reflect my professional experience. The doctor who completes the confirmatory certificate has to speak to the doctor who has filled in the first part and to other individuals who are named on the certificate, such as nursing staff, family members, or other doctors involved in the person’s care, and then they have to complete the certificate. In hospitals such as Ninewells and those in Fife, a relatively small number of individuals carry out that task.

I have already said that on approximately 15 per cent of occasions the diagnosis is fine-tuned or changed. In Scotland as a whole, between 20 and 30 cases a year end up with a full procurator fiscal investigation for an unnatural death. Some of those cases are suicides and some are industrial diseases, and they have just slipped through the net; no malice is intended. A 15 per cent improvement in accuracy and picking up on dozens of unnatural deaths does not seem to me to be perfunctory.

I would much rather that the approach had been to look for the flaws in the system and to improve it, rather than do away with it completely.

Dr Fischbacher: I do not want to disagree with Professor Fleming on that point, but I have a couple of other points. Two important weaknesses of the current system are that there is no systematic method of feeding back the problems that are detected by the form C doctor or others in the process, and my understanding is that there has been little or no improvement in the accuracy of death certification in Scotland in the past 10 years. The present system is therefore not delivering any improvement and it is not completing the feedback loop.

Some of the discussions that we have had with the Scottish Government have suggested that a stronger element of quality improvement should be built into the system so that we get feedback and systematically monitor the quality of certification to show that it is improving.

Ishbel Gall: I agree with Professor Fleming that the confirmatory certificate C is far from perfunctory. It picks up quite a few anomalies that are usually ironed out before the cremation papers go to the medical referee at the crematorium.

Professor Fleming: I have one brief additional point. There is no mechanism for information on a cremation form, which might be altered, being fed back to the medical cause of death certificate. I think that that would be a relatively simple thing to do that would improve accuracy.
Dr Thomas: It is also about the seniority of the two practitioners who are involved in the signatory process. It is proposed that an FY2, which is a doctor who has been qualified for just one year, will be the person in hospitals who will normally sign the only certificate to allow a burial or cremation to proceed. The current system requires a second doctor who has been registered for five years.

I accept the Scottish Government’s assertion that the quality of the current system is patchy—I am sure that it is—but the principles are sound.

Ian McKee: I ask my questions from the background of many years of signing death certificates and parts 1 and 2 of cremation forms. I want to ask about the educational functions of the six medical reviewers who are to be appointed. Apart from collating and analysing information, they are to provide training, guidance and support to persons who are required to complete medical certificates of cause of death. At least 5,000 GPs perform that function and I do not know how many other people can sign certificates, nor did the Government’s bill team last week. How realistic is it to expect the medical reviewers to be able to carry out their education role, for which they have been allowed two and a half days a week? The other two and a half days is for them to spend on following up individual death certificates. Do you think that that aspect of the bill is likely to improve the accuracy of MCCDs to any great extent?

Professor Fleming: I will answer that with my university hat on. It is clear that six medical reviewers will not be able to deliver an education programme to around 12,000 doctors and 1,000 new graduates every year. That work will have to be outsourced, probably through the medical schools. Programmes will have to be developed with the medical schools and the medical royal colleges. Neither the bill nor the associated documentation contains detail on how that will be done, but it will have to be done through other organisations.

Ian McKee: Does anyone else want to reply?

The Convener: I am letting the witnesses self-nominate, and it seems that no one else wants to respond.

Ian McKee: From my experience of signing death certificates, I know that, in many cases, it is impossible to be accurate unless a post mortem is requested. There are plenty of people who are found dead in bed at an old age and everyone says how wonderful it was that they did not suffer. When a doctor is called on to sign the death certificate, it often seems to be the luck of the draw whether the cause of death is deemed to be a coronary thrombosis or a stroke, when it might have been something such as a pulmonary embolism. The only way that I can see of getting more accurate MCCDs is by having more post mortems. I do not see how another doctor reviewing the first certificate could give any more accurate a guess than the first doctor. What do you think about that assertion?

Professor Fleming: What you say is correct. We know from research-based studies that, in cases in which a post mortem was performed after a death certificate had been completed, the inaccuracy rate was about 20 to 30 per cent. That is the ballpark figure.

We do not advocate a return to the post mortem rates of the 1970s or 1980s, but there are some circumstances in which a second doctor who has come to a case fresh and who reviews it from more of a distance and inquires into the circumstances and the mode of the death may suggest an altered diagnosis. That is what happens with the confirmatory medical certificates at the moment.

I fully agree that we will not get anywhere near 100 per cent accuracy with death certificates, but I think that we can improve on the present accuracy rate. I am concerned that the bill’s proposals will make it less likely that we improve accuracy.

Ishbel Gall: I was going to say pretty much the same thing. A post mortem is the ultimate audit, but it is probably not possible or feasible, given the number of pathologists we have in the country at the moment, to go back to the number of post mortems that we carried out 20 or 30 years ago.

I do think that having a second doctor from a hospital setting, who is usually more qualified, adds something to death certification, because of their depth and breadth of experience. When they read through the case notes, they quite often pick up on something that a more junior, newly qualified doctor did not pick up on.

Dr Thomas: In my experience of the process of carrying out a post mortem, scrutiny of the case notes usually takes you a long way towards the correct diagnosis. If a second doctor reviews the case notes carefully, he can usually get a long way towards the correct diagnosis. The post mortem does not usually throw up that many surprises. I believe that taking a little bit of time to review the medical records—that does not have to be done by a pathologist; a senior practitioner could do it—can do an awful lot to improve the accuracy of death certification.

11:15

Dr Fischbacher: I wonder whether it would be helpful to clarify some of the advice that the Information Services Division provided about the process. The work that Professor Fleming has
done on Tayside indicates that about 15 to 30 per cent of death certificates might be changed as a result of a second review. However, I think that he would agree that we do not have a good estimate for Scotland as a whole and that we do not know whether the situation is improving. The likelihood is that it is not improving.

ISD proposed to the Government that there should be a national sample of around 500, which would allow us to estimate the error rate for Scotland. Repeated on a regular basis, that would tell us whether things are getting better or worse. That would be the purpose of that sample. Using ISD’s experience of national audits—for example, we audit surgical mortality and run other national audits—we would start a programme of focused sampling, looking at specific areas with a link to quality improvement, setting standards and investigating unexplained variation. There would be a focused checking of death certificates in a particular area with the aim of making improvements, which would be monitored through the national sample. That is what we have suggested and discussed.

Ian McKee: I have one final question on a slightly different topic. In practice, I was always under the impression that the reason why so much attention is paid to someone being cremated is that it is burning the evidence whereas, if someone is buried, the body can be exhumed and further tests can be done. The new proposal treats people who have been buried in exactly the same way as people who have been cremated. Was I wrong in my assertion? Is it not reasonable to assume that, if someone is buried, evidence can be found later that cannot be detected if someone has been cremated?

Ishbel Gall: Yes. I agree that the evidence can be destroyed by cremation. When somebody has been buried, whether the body would be exhumed would depend on how long afterwards the death was to be reviewed and whether there would be any valuable forensic evidence. Obviously, the longer the body had been buried, the more deterioration there would be. If the body had been embalmed, that might have destroyed any toxicology that would have been useful prior to the embalming process. Once a body is cremated, there is very little that can be gleaned from the ashes.

Ian McKee: Do you think that there is still a case for double treatment, rather than the proposal to treat every body in the same way, irrespective of whether it is going to be cremated or buried?

Ishbel Gall: I certainly do. If the bill is passed, the body will not have to be examined by even one doctor before the medical certificate of cause of death is issued. That is rather worrying.

Dr Thomas: The concern is that the whole system is being dumbed down. At the moment, the system requires two signatories to safeguard against the concerns that have been raised by Dr McKee. We are moving away from that, and that appears to me to be a backward step. It is a dangerous move.

Dr Fischbacher: We must bear in mind the purpose of the reviews. If the purpose is to address concerns about criminal activity, we must bear in mind the reservations that I spoke about earlier and remember that cremation certificates did not prevent the activities of Dr Shipman. If the purpose is to improve accuracy, we should note that the present system does not do enough to monitor accuracy or to ensure that problems are dealt with and fed back and that there is systematic improvement.

Professor Fleming: The premise of your question is that burial and cremation are handled differently because of forensic evidence and so on. I support the move to a single process for both burial and cremation, but I would move to one that is similar to the process for cremation rather than, as the bill suggests, one that is similar to the process for burial.

The Convener: Rhoda Grant will ask the next question, followed by Mary Scanlon, then Richard Simpson.

Rhoda Grant: Can I ask a couple of questions?

The Convener: You can do that, as you are a nice person.

Ross Finnie: I do not like the implication of that statement.

The Convener: You are all nice people. I cannot say anything without a ton of bricks landing on me. I try to be kind but, hey, why bother?

Rhoda Grant: Ishbel Gall’s submission talks about the logistics of moving bodies, storing bodies for long periods of time and so on. Last week, Government officials told us that it was possible to apply to have the review waived, so bodies would not have to be stored for an overly long time. Do you still think that there is a problem, despite that provision?

Ishbel Gall: Yes. I have spoken to quite a lot of the funeral directors in my area and, although they are based in Aberdeen, they deal with a lot of deaths from Aberdeenshire, the Highlands and Islands and Orkney and Shetland. Most of the undertakers in those areas do not have refrigerated accommodation, which is part of the reason why burials in those areas go ahead quickly—in many cases, they take place within two or three days of death.
The funeral directors to whom I spoke said that they would do nothing until the family had successfully registered the death, which is different from the way in which things happen at the moment. Often, in the case of deaths that are some distance from Aberdeen, the funeral director will collect the deceased and will also pick up any personal effects and the certificate of cause of death, which he will convey to the family to save them having to travel to pick up the certificate themselves. However, they have stated that, now, they would definitely not be going to collect the deceased and the death certificate, because they would then be responsible for the deceased until such time as the funeral arrangements were made, and they just do not have the facilities. In this kind of weather, it is not such a problem but, in summer, storage of the deceased is often a problem.

Usually, the funeral director takes the deceased to their premises and puts them in a coffin and then, perhaps, takes the coffin to the family’s home before, on the night before the funeral, moving the body to the church. That process takes two to three days. Under the proposals, therefore, the undertakers would be expecting that the deceased would stay with us for an extra two to three days, in most cases, which would cause major problems for us at certain times of the year, especially if the medical reviewer were working 9 to 5, Monday to Friday, and taking all the public holidays.

Rhoda Grant: It would cause stress to the families, too.

Ishbel Gall: Yes. They are used to the way that things currently are. To be handed a certificate of death for the expected death of a loved one and then be told that that would be subject to a review would be terribly upsetting for many people.

Rhoda Grant: My understanding is that many people feel that the bill that is going forward south of the border is better than the one that we have. Concerns have been expressed about the fact that, because all bodies would need to be reviewed in England, which would not be the case in Scotland, issues might arise for families when someone died in Scotland but was to be buried in England.

Ishbel Gall: I think that that will be quite a regular problem for people in the Borders and in Dumfries and Galloway, where cross-border burials are common. Many of our members have expressed concern about the extra delays that might be incurred in such situations.

Professor Fleming: The Royal College of Pathologists is a United Kingdom-wide royal medical college so I have some insight into the proposals in England and Wales through the college council. I am not sure that they are better, but they are different.

The Convener: Let us hear from Richard Simpson, who has a supplementary question, and then Mary Scanlon. Get the whole lot in at once, Richard.

Dr Simpson: I found very helpful the examples in Ms Gall’s submission about the delays that are likely to occur. My question is a technical one: if there are so many delays, do we have the mortuary capacity to manage the extensions that you cite in your examples? Also, how would the panel members feel if one of their cases was selected for review? Would you not be thinking, “Oh there must be something wrong here,” or “Have I missed something?” I am not saying that the random selection process is wrong but, thinking about it from the patient’s or family’s point of view, I wonder how they will feel when a case that appeared to be straightforward is selected for review? What is the basis of that selection—is it completely random, focused or geographical? It has been suggested that there might be pressure on an area at some point if all cases are reviewed there. I am just trying to get a handle on the situation.

Ishbel Gall: Currently, the mortuary at Foresterhill hospital in Aberdeen is the busiest by ratio of space to the number of people passing through it. We see ourselves as being relatively efficient because we have quite a lot of burials and people spend as little time as possible in the hospital mortuary. We also have a duty of cooperation under the Public Health etc (Scotland) Act 2008 to work with the local authority on its body storage, which is also woefully inadequate. My concern is that the proposals will be a major issue not just in our area. We already have a problem in that there are no out-of-hours GPs and most of the services are run by an out-of-hours service, which is not particularly good at issuing certificates out of hours because the circumstances surrounding the death are not always known. It is common for the deceased to be moved to the public mortuary because no certificate is forthcoming until such time as a GP can be contacted. If the death occurs on a Friday night, that might happen on Monday morning and, if there is a public holiday, it might take even longer. We already have pressures on the available space and the proposed review would exacerbate the problem.

Professor Fleming: Colin Fischbacher and I were talking about this matter before we came in. If, as is probably the case, the primary purpose of the review is to benchmark the error rate rather than anything else, it is not clear to us why that cannot be done as a post-registration event. It is
not there to pick up flaws that would block registration, so why block registration?

Dr Simpson: That is the answer that I was hoping for.

Ross Finnie: I will not ask such a leading question.

Dr Simpson: Never ask a question unless you know the answer that you want.

The Convener: Putting that in the Official Report will come back to haunt you, Richard. One day, you will get an answer that you do not want.

Mary Scanlon: According to the policy memorandum, it is estimated that about 250 Scots a year die outside Scotland. It is also estimated that in around 10 per cent of those cases the cause of death will not have been established. Quite a lot of people who have given written evidence, panel members excepted, say that the proposed system is less robust than the existing one. One person stated that it was “inappropriate that this responsibility should be placed on a medically-unqualified member of staff, bearing in mind the penalties to be introduced for disposing of a body without authorisation.”

Mr Thomas spoke about the seniority of practitioners and case notes; we are talking about someone who might have lived abroad for some time and whose case notes might not be as robust as they could be. There seems to be some concern about deaths occurring outside Scotland. I have tried to read sections 17 and 18 of the bill, but I am not sure that I totally understand them. Does any of the witnesses have concerns that what is being proposed is less robust than the present system?

Dr Thomas: I have been advised that the proposed system is in fact more robust for deaths abroad than the current one. At the moment, the signatory for the body’s disposal is the secretary of state’s office and, under the legislation, responsibility will now move to the medical reviewer’s office. I would view that as progress.

11:30

Mary Scanlon: In its submission, though, Edinburgh Crematorium Ltd says that it is inappropriate for the responsibility for registering the death to fall on a medically unqualified member of staff.

Dr Thomas: I was not aware that that would be the case.

The Convener: We can put that question to the funeral directors, who are giving evidence next.

I have a couple of supplements for clarification. Ms Gall mentioned difficulties with organ or tissue donation if a certificate is under review, but I wonder whether that issue is dealt with under section 6, “Request for review not to stay registration”, which refers to someone called the “qualified informant”. As I understand it, that person makes a statement to the reviewer, saying, in effect, “Can I just get on with this? This person’s got a donor card.” I believe that the provision is to be inserted into the Registration of Births, Deaths and Marriages (Scotland) Act 1965, but I do not know how the term “qualified informant” is defined under that legislation. Nevertheless, would that deal with any problems that might arise?

Ishbel Gall: The qualified informant is the person who usually registers the death and is therefore usually a family member. If the registrar is open within 24 hours of the death taking place, it is possible to ask for a stay of the review; however, if the death occurs, say, on a Friday, we might not be able to contact the medical reviewer or get the death registered until the Monday morning. At the moment, if we have an adequate cause of death and there is no procurator fiscal involvement, we go ahead with the retrieval.

The Convener: That is very helpful.

Secondly, on a more sensitive and delicate issue, paragraph 95 of the policy memorandum says:

“It has been agreed with COPFS that, in future, where no doctor or midwife is present at a stillbirth, such cases should be referred directly to the PF.”

What is the current procedure if no doctor or midwife is present at a stillbirth? I imagine that, if the smell of suspicion hangs over such an incident, the people involved will find it quite distressing. [Interruption.]

Dr Simpson: There is a buzz coming from somewhere.

The Convener: Indeed. It is not just your ears, Richard. Some naughty person has left their electronic equipment on—and I am looking around for a red face. I hope that it is not keeping someone’s heart going. It would be really bad if I had to ask them to switch it off, but at least we have the right people in the room.

Do you want to respond to that question about stillbirths, Ms Gall?

Ishbel Gall: Depending on the circumstances, certain changes happen in a baby that can help to determine whether it died in the womb prior to its birth or died during birth—I do not want to get too technical. In many cases, the mother and baby will present at the maternity hospital, where qualified staff decide whether what has happened is a stillbirth with no suspicious circumstances or whether there might be merit in reporting it to the procurator fiscal. At the moment, it is determined
on a case-by-case interpretation of the circumstances.

The Convener: Is it a good idea, then, to apply the provision in all such cases where, for example, the mother simply turns up in an ambulance?

Ishbel Gall: In certain cases it is obvious that what has happened is a stillbirth with no suspicious circumstances. If, for example, maceration is quite well developed, there will be no need for an inquiry. Moreover, in most cases, the parents will authorise a hospital post mortem to establish what has happened.

The Convener: But is this a change? The policy memorandum says that “such cases should be referred”—not “must be referred”—“directly to the PF”.

Do you read that as being mandatory?

Ishbel Gall: It sounds more mandatory than the current procedure.

The Convener: Obviously we are talking in the abstract about individuals at a very sensitive time in their lives but I was wondering whether such a provision was necessary. Thank you for your comments—I will leave the matter there.

Dr Simpson: This morning’s evidence has been very helpful, but I wonder whether Dr Fischbacher could set out in writing on half a side of A4 the current review procedure for certificates that he receives from the registrar and could indicate whether, for example, the software highlights particular cases to him or whether someone manually goes through the certificates.

Dr Fischbacher: I will do that.

Dr Simpson: Thank you. That will be very helpful.

The Convener: I thank the witnesses for their evidence.

11:36

Meeting suspended.

12:04

On resuming—

The Convener: I reconvene the meeting. Elizabeth Allan will join us shortly. We have delayed the meeting for at least 30 minutes, so we will proceed.

William Stanley is cemeteries manager from the Institute of Cemetery and Crematorium Management—I beg your pardon, he is not coming today. Jim Nickerson is chairman of the Scottish sub-committee of the Federation of Burial and Cremation Authorities and Gerard Boyle is the immediate past president of the National Association of Funeral Directors. Thank you very much for coming. I know that you sat through the previous evidence session. We will move straight to questions.

Mary Scanlon: I have two questions. My first question is for Gerry Boyle. We hear so much about medical reviewers, pathologists and so on, but I want to put it on the record that it was not a doctor who picked up the Shipman case. Am I right in saying that it was a funeral director?

Gerard Boyle (National Association of Funeral Directors): Yes, that is right.

Mary Scanlon: I wanted that on the record.

Ian McKee referred to training and so on. Should we look further at training and at better integration with funeral directors, given that the bill is all about addressing the Shipman experience?

Gerard Boyle: Fortunately, doctors do not go into medicine to do what Harold Shipman did, and it was a funeral director who pointed the case out.

The funeral directors’ issue with the bill is that the system it would introduce is not as robust as the current one. We welcome any improvement to the medical certification for statistical analysis, but we feel that, for cremation, going from a two-doctor system plus a medical referee at the crematorium down to one doctor is, as was said in the previous session, a bit of a backward step.

I think that we have missed an opportunity to get cross-border issues sorted out. We have missed an opportunity to maybe adopt the same sort of systems that they use in the rest of the UK. Although we welcome any changes to the medical cause of death certification, the proposed system is definitely not as robust as the current one.

The Convener: If we seem to have settled that the bill will not prevent a Shipman—a determined, cunning murderer—and it is not really intended to do that, what difference does it make if one medical practitioner signs the certificate and authorises cremation, rather than two?

Gerard Boyle: It primarily comes down to safeguards and the fact that it is in the public interest that proper checks are done for everybody who is to be cremated. At the moment, only one doctor signs a certificate for a burial, but the system is different for cremation. Fortunately, we have not had any incidents like Harold Shipman—I do not think that we can legislate for that sort of occurrence anyway. If people set out to carry out that sort of crime, legislation will not prevent them from doing so, but we are moving from something that is quite robust to something that is not.
Jim Nickerson (Federation of Burial and Cremation Authorities): I will expand on Gerard Boyle’s comments. I do not know whether it will be helpful if I outline the current procedure with the cremation papers, so that members understand the situation.

What happens now with the cremation papers is that they come into the cremation office and the office staff check that they are consistent. They will check that the name is right, the address is right, the age is right, the date of death is right and that all questions are filled in. The start of form B states that it is a statutory form and that all questions must be answered. That is the form that asks who was present at the time of death, what the cause of death is and so on. In about 20 per cent of cases not all the questions are answered. What concerns us is the accuracy of the MCCD. If the existing system, which is not entirely accurate, is swept away, how accurate will the replacement system be?

At present, we check the forms in 100 per cent of cases so we can go back to the doctor and say, “You’ve missed that question. What is the answer?” In that way, we ensure that all the forms are properly filled in and, when they go to the medical referee, they can review properly filled in forms. If the medical referee did not get properly filled in forms, he would be at it for days. Without 100 per cent review, there would be no confidence in the papers.

Mary Scanlon: That is interesting. I want to come back on the points that Gerry Boyle and Mr Nickerson made. Gerry Boyle said that the bill is a backward step, that the proposed system is less robust and that we have missed an opportunity to adopt the new system that is being brought in in England and Wales. First, why do the funeral directors believe that the proposed system is a backward step? Secondly, what is being done in England and Wales that we should be doing here?

Gerard Boyle: From the funeral directors’ point of view, it is important that the certification is right before we carry on with any funeral arrangements. The bill proposes a 1 or 2 per cent review of cases with six medical reviewers. Our concern is that that would add undue delay to all funerals.

As the previous panel said, the system in England and Wales is not better than what is being proposed in Scotland; it is just different. Scotland has a separate legal system from England. The bill just seemed an ideal opportunity to harmonise the arrangements for death throughout the country. What they do in England and Wales is not necessarily better than what is proposed here, although, as Jim Nickerson said, the proposal is certainly less robust in terms of the review of certificates.

Mary Scanlon: If I can talk for Mr Stanley of the Institute of Cemetery and Crematorium Management, who is not here today, he and various others—

The Convener: I do not think that you can do that, actually. However, you can remark on his evidence.

Mary Scanlon: I cannot put a question to him, but I can quote from his written evidence, which raises serious concerns about the procedure for deaths that occur outside Scotland. The policy memorandum states that, on average, about 250 people a year die abroad who have expressed a wish to be repatriated to Scotland. The Institute of Cemetery and Crematorium Management’s submission states:

“Under the proposed system,”

registration

“will fall on the person having charge of the cemetery or crematorium. The Branch feel that it is inappropriate that this responsibility should be placed on a medically-不合格 member of staff, bearing in mind the penalties to be introduced for disposing of a body without authorisation.”

Will you comment on that? It would seem to be a concern, given what we heard from the previous panel, that such a responsibility would fall to a medically unqualified member of staff—particularly if someone has lived abroad for a few years.

Jim Nickerson: Many of the people who die abroad have gone on holiday and died, so they might have been out of the country for only a couple of weeks. At present, if they are to be buried, nothing happens. If they are to be cremated, the paperwork goes to the Scottish Government, which gives an authority to cremate to the medical referee, who then decides, with all the paperwork, whether to give an authority to cremate to the crematorium.

The Government envisages that the medical reviewer will review the medical notes from Britain to determine whether the person had an implant or something else that is likely to explode or be hazardous when it cremates. If there is not, they will say to the crematorium, “It is safe to cremate.” However, that system would rely on the crematorium staff ensuring that they have the equivalent of the death certificate and the registration of death from whatever country the person died in. We would have totally unqualified people making decisions on whether a document is a death certificate.

I run two crematoria. Between them we have done 12 to 15 deaths from abroad in the past year. In only one case out of the last three was there a proper registration of death from the country where the death occurred—Spain. The death certificate stated in Spanish at the top that it was a
death certificate, and the registration of death also stated what it was in Spanish at the top, so that was okay.

One of the others was in Malta—it was somebody who died on a cruise ship. We got permission from the Government to go ahead, and the paperwork that came to us consisted of an unheaded note that looked as if it had come from the ship, saying what the person died from. It had been stamped at the bottom by a police sergeant in Malta. Presumably, that is a registration.

The other one concerned somebody who died in Turkey. The local consul had done a translation of the death certificate, but there was nothing about registration.

12:15
Things might be vague just now, but at least someone in the Scottish Government has the authority to make a decision. In future, it would be somebody in a crematorium or cemetery. There are many cemeteries in Scotland, some of which do only one or two burials a year. The people at those places might come across such paperwork only once every 10 years and they would have to make a decision on the matter. A part-time elder, for example, would have to decide whether the paperwork was correct.

The paperwork is to be distributed throughout the whole of Scotland and it is to be kept, but there is to be no review of it whatever. As far as I know there is no such review now, but at least all the paperwork is held by the Scottish Government so that if somebody wishes to do a review of how many people have died on a particular cruise ship, or in Turkey, for instance, the paperwork is available for that review to be carried out. The proposal is for the paperwork to be dispersed throughout the whole of Scotland, and unqualified people—hundreds of them—are to be asked to make the necessary decisions.

Mary Scanlon: That is very worrying. I wonder if I might ask Elizabeth Allan about this.

The Convener: First, I welcome Elizabeth Allan to the meeting. Thank you for struggling through the weather.

Elizabeth Allan (City of Edinburgh Council): Thank you for inviting me.

Mary Scanlon: Is that correct?

Elizabeth Allan: That is correct. At the moment there is no fee for registering a death. People have the option to buy a certificate, but when they do they are basically just handed something. That is the only fee that people have to pay, if they make that choice.

If the procedure of registrars taking a fee is introduced, it might be perceived as a fee for registering a death, and that might deter people from coming in. That could cause problems for people who are not relatives and who might not benefit from the estate of the person.

Mary Scanlon: Who do you think should collect that fee?

Elizabeth Allan: That is the difficult part.

Mary Scanlon: You are the president of the Association of Registrars of Scotland.

Elizabeth Allan: Yes.

Mary Scanlon: Am I right in saying that it is the view of registrars throughout Scotland that you do not think that you should collect a fee at the time of registering the death?

Elizabeth Allan: It is certainly the view of the members of the association, which represents the whole of Scotland, that the fee should not come to the registrars. We are more for keeping the status quo, whereby the funeral directors collect it. I know that they have an issue with that, however.

The Convener: Are all registrars in the Association of Registrars?

Elizabeth Allan: No.

The Convener: What percentage of registrars do you represent?

Elizabeth Allan: We cover all the councils, and each council has at least somebody in the association; 15 councils are represented on the executive of the association. It is the same as for many other associations: there are members who speak for everyone else. From the 15 members on the executive, it is a unanimous view that registrars do not wish to count the fee.

The Convener: But there are registrars who are not in your association?

Elizabeth Allan: Yes.

The Convener: Do you know how many, or what percentage, are in your association and how many are not in your association?
Elizabeth Allan: I think that there are about 280 in the association; there are about 520 registrars altogether.

Mary Scanlon: It is a serious matter to claim that, on the basis of such a fee, people in Scotland would not register a death. What background information is there? On what basis do you make that claim?

Elizabeth Allan: Personally, I make it on the basis of registering deaths for 33 years. I have seen people come in and I have seen how upset they have been. People do not understand what they are being told—it must be broken into bite-sized chunks for them. People have also complained about having to pay £8 or £9 for a death certificate. That has been when they have been physically given something. If we have to say to them that they will be liable to pay a fee, they will say, “What’s that for?” It would have to be explained to them when their relative has just died that they will be liable to pay it so that they can get a better service from the national health service. That will not be easy to sell to the public.

Gerard Boyle: I disagree with Elizabeth Allan on who should collect the fee. If there is to be a fee for issuing a death certificate, it will be a statutory fee. Where funeral directors currently collect fees for doctors for cremation certificates, most funeral directors will have entered into a contract or agreement with the doctors to supply those certificates. We would pay the fees for that. We do not enter into contracts for doctors at hospitals to sign death certificates. There were recommendations in the “Burial and Cremation Review Group: Report and Recommendations” that suggested that funeral directors were best placed to collect the money because we seem to collect money for everything else, but we do not think that we should be responsible for collecting a statutory fee. It was nice that the report said that we could charge an administration fee, but again we disagree with that. Why should we charge a fee for collecting a fee that is not ours? Registrars are the constant in everything. Not every family has to use a funeral director.

On accountability and the management of the funds that are collected, it seems to me that every death must be registered. If a person does not register a death—I understand why they might have difficulties doing that—that is an offence. The law of the land is that a death must be registered within eight days. If it is not, the person must have a pretty good reason for not doing so.

We have said that all deaths have to be registered anyway. The funeral directors thought that if the fee is not to be collected at the time of death from the hospital on the production of the certificate for the family, it should not be our responsibility to collect the fee on the Government’s behalf.

The Convener: I am going to let in Ian McKee to ask his questions, as I know that he has an obligation to be somewhere else shortly.

Ian McKee: Thank you.

Some questions that I was going to ask the witnesses were answered during the first session, but I have a question that is mainly for Mr Boyle, I suppose, on the current system for signing the second part of the cremation form. When I was in practice, I thought that it was valuable that the doctor who signed the second part of that form had five years of experience, questioned the doctor who signed the first part of the form and the relatives, and looked over the papers. I cannot recall a situation in which having to examine the body was of any great benefit. The funeral director would no doubt have told me if there had been a dagger in the body’s back when it was being prepared. In your experience as a funeral director, can you think of occasions when the doctor who examined the body and signed the second part of the form discovered something in examining the body?

Gerard Boyle: There have occasionally been marks or bruises on bodies that cannot be explained from the doctor’s first signing of the form. The doctor who signed the death certificate might not have been aware that the person had had a fall in the previous weeks, and the second doctor might find unexplained bruising on the body. The second doctor will examine the remains if they want to do so. Doctors certify on soul and conscience that they have examined the remains, and they must see and identify the body after death. On the proposal to move to a system in which just one doctor does that, secondary checks are not done just because it is nice to do them; there are valid reasons for doing them.

I understand the reasons that were given in the previous session why a second doctor is valuable in cremation cases whereas one doctor is used for burials. As one of the doctors said, if we are going to change the system, perhaps we should move to a system in which two doctors look at the deceased on every occasion, although I understand that there would be difficulties with that as well—for people who live on islands, for example.

Ian McKee: I have taken on board that recommendation from the previous session. I was trying to separate things into their component parts. I appreciate that not everyone has to go through a funeral director but, by and large, I would have thought that someone who is preparing a body in a funeral director’s premises would notice bruises, for example, and would draw
Gerard Boyle: Off the top of my head I cannot think of any case in which a funeral director or an embalmer who was preparing the deceased noticed something that both the first and second doctor had missed, although I can think of occasions when the second doctor has seen something.

Ian McKee: You can.

Gerard Boyle: Yes, although I do not have specific details. I have been a funeral director for 24 years. Elizabeth Allan spoke about her experience. In my experience, that has happened. I would have thought that, by the time an embalmer comes to prepare the person’s remains for cremation and two doctors have already seen the person, they would expect that anything that was to be seen would have been seen.

Dr Simpson: I would like to clarify something that my colleague Mary Scanlon asked about. Mr Nickerson, in your evidence you talked about there being no definitive list of burial grounds in Scotland, so the number of cemetery staff is unknown. Those staff will be asked to bury people and do the checks without appropriate training, and they may commit an offence if they bury parts without authorisation. Where is the authorisation now in the system?

Jim Nickerson: There is not any authorisation for burial at the moment. That is a weakness in the current system.

Dr Simpson: Right. Okay.

My other question is more technical. Does everybody get a death grant at the moment?

Gerard Boyle: No.

Dr Simpson: There is no universal death grant?

Gerard Boyle: There is no death grant at all now.

Dr Simpson: There is no death grant of any sort?

Gerard Boyle: No. There used to be a death grant of around £30, but that was done away with and the social fund was brought in. In order to claim benefits from that fund, a person has to receive certain benefits, such as housing benefit or income tax or council tax rebates.

Dr Simpson: So there is means testing. I was thinking that if there was still a universal grant the £30 could be taken off it. That would solve both of your problems, but that is not practical.

Gerard Boyle: No.

Dr Simpson: Okay. That is fine.
Coding of causes of death - Note for the Health and Sport Committee

1. This note is in response to a request from Dr Richard Simpson MSP at the committee meeting on 1st December 2010. It provides further information on how the work of the medical adviser to the General Register Office for Scotland (GROS) contributes to improving coding quality, how software is used to automate coding and how this might help detect inaccuracies.

2. The current flow of information is as follows. Information from the medical certificate of the cause of death is transferred electronically from Registrars to the GROS. Automatic coding software (provided by the US National Centre for Health Statistics) is used at GROS to assign codes from the International Classification of Diseases (ICD) to each cause of death and to identify the underlying cause of death. The codes assigned by the software for each death are briefly reviewed by coding staff (more complex causes are considered more carefully), and in some cases may be corrected by them (as the software does not code correctly certain types of case). Where there are still queries about coding particularly unusual or difficult cases, further advice is provided by the medical adviser to GROS.

3. The coding software may identify apparent errors in the completion of certificates if it is unable to assign a code to a particular cause recorded by the doctor. This may happen because of spelling errors or because the term used is vague or not standard. The software may also identify errors where the durations of the reported medical conditions are not consistent. These errors require manual checking by coding staff.

4. Checks by coding staff may also identify cases where the reported sequence of events leading to death is unclear or implausible. In some cases these may be resolved by contacting the registrar or discussion with the medical adviser, and in other cases the medical adviser may write to the doctor concerned asking for clarification.

5. Where there are queries, letters are sent by the medical adviser to the certifying doctor asking for further information. Around 1,625 such letters were sent in 2009 and 1,145 replies (70%) were received. The medical adviser also writes to doctors when the certifying doctor has indicated that further information from a post-mortem may be available. Around 767 such letters were sent in 2009 and 610 replies (79%) were received. The medical adviser's letters request further information to assist in the statistical classification of the cause of death, and state that it will not lead to the amendment of the death certificate or the public record. (NB: coding staff can change only the copy of the cause of death that is held in GROS's statistical database. The cause of death in the publicly-available register is changed only at the request of an authorised doctor or Procurator Fiscal: if that happens before GROS has finalised its figures for the year, the statistical data will be updated as well.)

6. The coding of particular causes of deaths (such as drug related deaths, or deaths involving healthcare associated infections) is checked more carefully on a regular (usually quarterly) basis.

7. It should be noted that GROS can check only the information that it receives. GROS cannot detect an error if the cause of death information appears in the appropriate format and seems to be complete and consistent. With no access to medical case notes, GROS cannot know if something relevant was omitted from, or something irrelevant was included among, the causes of death that were listed on the medical certificate.
8. Some further information is available from GROS's web site - e.g. material on "death certificates and coding the causes of death", "sources of information for coding the cause of death" and "quality of GROS data on deaths" which is available via:


Dr Colin Fischbacher
Information Services Division, NHS National Services Scotland.
December 2010
Certification of Death (Scotland) Bill

Scottish Council of Jewish Communities

The Scottish Council of Jewish Communities welcomes the opportunity to comment on the Certification of Death (Scotland) Bill.

*Halachah* (Jewish Law) regards the human body – including all body parts and tissue – as sacrosanct, and requires that it should always be treated with dignity. Once death has occurred, there should be as little interference with the body as possible. Ideally, it should not be left unattended, and burial should take place as early as possible, preferably before sunset on the day death occurred. Although Liberal Judaism (of which there is a small Scottish community in Edinburgh) places less emphasis on this, and the funeral may occasionally be delayed to enable distant family to attend, in the vast majority of cases, delay or procedures such as a post-mortem examination are likely to be particularly distressing to the family of the deceased. In addition, the *shivah* (initial period of mourning) cannot begin until after the burial has taken place, and consequently any postponement will delay the grieving process and inevitably cause great psychological distress to the bereaved. When we recently met the Solicitor General and his officials, they assured us that COPFS recognise their obligations to the bereaved, but we do not think the Bill takes this sufficiently into account.

**Do you agree or disagree with the general principles of the Bill?**

We support the principle of effective scrutiny, and agree that the system must be “*proportionate and ... not impose undue delays on bereaved families arranging a funeral.*”\(^1\) Although we agree that accuracy is important in recording the cause of death, this should not be an overriding consideration if no significant issues depend upon it such as legal proceedings. We are aware of many cases in which a post-mortem has been ordered simply because the deceased’s own GP was unavailable, and a locum was not prepared to certify a death that was entirely expected in accordance with the medical history of the deceased. In other cases a post-mortem has been ordered to determine the immediate cause of death, when the underlying condition was never in dispute. This is simply no necessity for this to happen, as it is likely to cause additional distress to families at what is already a very difficult time.

**Do you agree with the proposed changes to the system of death certification in Scotland?**

We are very concerned at the likely delay between death and release of the body for disposal. Although the Policy Memorandum states that the average length of time before a funeral is 7 days\(^2\), the vast majority of Jewish burials in

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1. Policy Memorandum, paragraph 18
2. Policy Memorandum, paragraph 65
Glasgow, where most of the Scottish Jewish community live, currently take place no later than early afternoon on the day after death. As we have already stated, it is of great importance to the bereaved, and the vast majority of the Scottish Jewish community, that Jewish burials take place as soon as possible after death, if possible before sunset on the same day. We are assured by senior forensic pathologists that there is no reason why this should not currently be achievable.

**Request for registration and scrutiny to proceed in parallel**

Although we welcome the possibility of an expedited procedure, we remain concerned that some funerals may still be delayed.

Moreover, we are concerned that the decision as to whether registration may proceed before the review has been completed is left entirely at the discretion of the medical reviewer. Our concern is that this will give rise to a similar situation as currently obtains whereby the personal preference on the part of some senior staff for surgical post-mortem has led to only 1% of cases being conducted according to the ‘view and grant’ system in Glasgow, whereas in Dundee and the Lothians it is used in 30-35% of cases.

We urge that care should be taken to ensure that this legislation does not result in similar discrepancies, resulting in difficulties and distress to families. We therefore urge that section 7 of the Bill should, at least, be amended to require a presumption that registration may, on request, proceed in parallel with scrutiny unless there are sufficiently compelling counterarguments in any individual case.

Such amendment would not, however, address all our concerns, since the vast majority of bereaved families, whether or not they have a religious faith, will find it extremely distressing to be informed at the point of registration that registration may not proceed. We therefore suggest that the Bill should be amended to permit parallel registration and review in all cases. The issuing of a provisional registration certificate would enable arrangements for the funeral to proceed pending satisfactory scrutiny, after which a confirmatory registration certificate would be issued.

In addition, we urge that the Bill should be amended to include an expedited procedure for disposal. The Equality Impact Assessment (step 5) states that the current proposals will “address the concerns that religious and belief groups raised during the consultation process [since] The Medical Reviewer will make the decision on whether quick disposal can take place alongside the random scrutiny”. This, however, is seriously misleading since the Bill currently provides only for parallel registration, and not for parallel disposal.

We recognise the importance of effective scrutiny but contend that it will be rare for the Medical Reviewer to require a post-mortem examination of the body after a full scrutiny of the medical records. We therefore suggest that, in the situations listed in paragraph 72 of the Policy Memorandum, the Bill
should permit applications for parallel scrutiny and disposal, as stated in the Equality Impact Assessment, provided only that disposal is by means of burial, since in this case the body would still be available in the rare circumstances when a post-mortem examination might be required.

Deaths outwith “office hours”

We welcome the acknowledgement\(^3\) that some registrars open their offices to register deaths that take place at the weekend or on bank holidays, and are grateful to the staff who make it possible for these burials to proceed in a timely fashion. However, the availability of an out-of-hours service varies widely from area to area, and in practice often depends on the family happening to have contacts who happen to have the personal contact details of the Registrar. This is clearly unsatisfactory and potentially discriminatory, and we suggest that the opportunity should be taken to introduce a Scotland-wide system of out-of-hours registration of deaths.

Do you agree with the proposed creation of a system of Medical Reviewers?

Although we hope that the medical reviewer system would be a deterrent to criminal activity and malpractice, it is clearly the case that “no system of death certification can prevent all criminal activity of the type carried out by Shipman”\(^4\). We are therefore concerned that there should not be a misplaced reliance on the new death certification system, in the way that, in some quarters, the ‘Disclosure’ system, similarly introduced in the wake of the Soham murders, is wrongly relied upon as if it were by itself an absolute guarantee that abuse could not happen again.

Do you have any comments on the costs identified in the Financial Memorandum?

No.

Are there any other comments you wish to make on the Bill?

“Fairness”

The Equality Impact Assessment states (p4) that the Bill will introduce a fairer system since “the policy will introduce a uniform process”. We would emphasise that uniformity that ignores relevant differences between groups is not fairness but the reverse. (It is, for example, not unfair for doctors to treat patients with one condition differently from those with another!) Fairness does not mean treating people the same, but must entail considering and reflecting difference – including the different requirements that some faith and cultural groups have for prompt burial.

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\(^3\) Policy Memorandum, paragraph 71

\(^4\) Financial Memorandum, paragraph 75
Monitoring

Step 9 of the Equality Impact Assessment notes that the “Duration of scrutiny and delays to funerals” will be monitored. However, “delay” means different things to different people and communities; for example, whilst a next day burial would be viewed as delayed by many in the Jewish community, to other communities that may appear hasty. We trust therefore that monitoring will not be relative to some arbitrary supposedly acceptable delay, but will record the absolute interval between death and the disposal of the body.

Verification of Death

The consultation paper preceding the Bill pointed out that “Due to changing practices in delivering out-of-hours medical care … it is not always possible or practical for a doctor from the GP practice where the patient is registered to certify death immediately” and requested views as to whether appropriately trained clinical staff, in particular senior nurses and paramedics, should be permitted to verify life extinct. We have already mentioned the difficulties that can sometimes arise if the deceased’s own GP is unavailable, and we believe that this would, as stated in the consultation paper, “minimise distress for family or fellow residents [in nursing or residential homes]” as well as minimising delay. Responses indicated “There was a high level of agreement … that it would be appropriate to enable trained clinical staff, such as nurses and paramedics, to verify life extinct.” Such deaths would, of course, be equally subject to random scrutiny as deaths verified by a doctor, and we therefore recommend that the opportunity provided by the Bill should be used to facilitate this practice.

Summary

We support the need for effective scrutiny in order to deter criminal activity and malpractice, and also promote best practice, but emphasise that the legislation and guidance should not be such as to cause avoidable additional distress to the bereaved, and should recognise, rather than ignore, the specific needs of minority communities.

Note: The Scottish Council of Jewish Communities (SCoJeC) is the representative body of all the Jewish communities in Scotland comprising Glasgow, Edinburgh, Aberdeen, and Dundee as well as the more loosely linked groups of the Jewish Network of Argyll and the Highlands, and of students studying in Scottish Universities and Colleges. SCoJeC is Scottish Charity SC029438, and its aims are to advance public understanding about the Jewish religion, culture and community. It works with others to promote

5 Death Certification, Burial and Cremation

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good relations and understanding among community groups and to promote equality, and represents the Jewish community in Scotland to government and other statutory and official bodies on matters affecting the Jewish community. In preparing this response we have consulted widely among members of the Scottish Jewish community.

Leah Granat
Deputy Director
Scottish Council of Jewish Communities
22 November 2010
Certification of Death (Scotland) Bill

Muslim Council of Scotland

General Points

We generally have a positive view of the main points put forward in the consultation. However some specific points are raised in answer to the last point.

We recognise that the preparation and consultation processes for this Bill have been overreaching and thorough.

Do you agree or disagree with the general principles of the Bill?

Yes, we agree with general principles of the Bill.

As I was a member of the Review Group, I recall that the first item on the summary of recommendations in the report stated: “The procedure for certifying death should be sensitive to the many different faiths and beliefs in Scotland and ensure as short a delay as possible between death and disposal”

While this principle has been considered in drawing the Bill, the wording of the Bill does not mention faith and belief. We suggest a short statement similar to the one mentioned above will be a good idea.

Do you agree with the proposed changes to the system of death certification in Scotland?

We accept the changes as an improvement to the present system, and as a practical balance of the requirement for a safe certification system with minimum delay in issuing the certificate of death. We suggest that the system be reviewed after a few years of application.

Do you agree with the proposed creation of a system of Medical Reviewers?

See above point.

Do you have any comments on the costs identified in the Financial Memorandum?

No, but the fees should be kept to a minimum.

Are there any other comments you wish to make on the Bill?

Yes, the following.
Specific points of concern from Muslim Community

There are two main issues:

- Speed of performing the funeral and burial, same day as death occurs if possible or next day.
- Respect for the deceased body or any human body parts.

To satisfy these issues the following procedures are required:

1. The death certificate is to be issued on the same day as death occurs.
2. Body release to family should be facilitated as soon as possible.
3. Presently, this is not always possible especially at week end and there is a need to make arrangements for certification and release at weekends and public holidays.
4. The new system involves more delays and the arrangements in the Bill under Section7 called “Medical reviewer to determine whether review to stay registration” is welcome. The main text of the Bill does not indicate the link to faith requirements and it would be helpful to indicate this link in the main body of the Bill. It is true though that faith requirements are mentioned in the Policy Memorandum and Explanatory notes. A brief mention in the main text will be helpful.
5. Post mortem examinations should only be carried out when necessary. Surgical post mortem should be used as a last resort and recommendations are to be made to apply alternative non-intrusive inspection methods. Such methods whether existing or new should be investigated and used, such as radiation scanning.

Salah Beltagui
Convenor
Muslim Council of Scotland
18 November 2010
Certification of Death (Scotland) Bill: Stage 1

The Convener: I return to the first item on the agenda, which is stage 1 consideration of the Certification of Death (Scotland) Bill. We will take evidence from two panels of witnesses, first from representatives of faith groups and secondly from the Scottish Government. The committee has also received supplementary evidence from the Government and from Dr Colin Fischbacher of the information services division of NHS National Services Scotland, a letter from the Finance Committee and a report from the Subordinate Legislation Committee.

I welcome Leah Granat, who is deputy director of the Scottish Council of Jewish Communities, and Dr Salah Beltagui, who is convener of the Muslim Council of Scotland. I thank you both for your tolerance in allowing us to deal with other business and keep to our timetable while Ms Granat navigated the traffic to get to the Parliament.

Leah Granat (Scottish Council of Jewish Communities): I thank the committee for accommodating me.

The Convener: Not at all. I think that we should switch to horses—it might be faster. I thank the witnesses for their written evidence and seek questions from members.

You seem to be gathering yourselves. Please do not feel inhibited, Mary—do you want to kick off?

Mary Scanlon (Highlands and Islands) (Con): I have not prepared any questions, but I will ask something just to get the chat flowing.

The Convener: Ian McKee is ready to jump in.

Ian McKee (Lothians) (SNP): In its submission, the Scottish Council of Jewish Communities states:

“We support the principle of effective scrutiny”

but suggests that accuracy

“should not be an overriding consideration if no significant issues depend upon it such as legal proceedings.”

One would hope that there would be no hint of such proceedings in most death certification procedures and that it would simply be a matter of administering the system well and ensuring that death certificates contain the most effective information to allow us to plan our health services accordingly. Do I take from your evidence that you are concerned about burials being delayed just to ensure a more accurate diagnosis for statistical purposes?

Leah Granat: We have to strike a balance between the need for accuracy and information to plan, as you say, appropriate medical provision and the need for communities and—the overriding factor—the need for the bereaved to be able to move to a point at which grieving can begin. In the Jewish community, the seven-day shivah period—in other words, the formal grieving process—begins only after burial. There has been a lot of research in this area and, according to psychologists, when grieving is delayed it becomes a much longer and much more difficult process for the bereaved.

As I say, there has to be a balance. Although we need accurate information, that information might not need to be as detailed as is sometimes sought. For example, it might be enough to know that someone died of a heart attack; knowing the exact mechanism of a particular attack might not be of any particular value to anyone.

Ian McKee: As I understand it, in technical terms the vast majority of deaths will be very expeditiously dealt with under the bill: a death certificate will be issued and that will be that. However, 1 to 2 per cent of deaths will be subject to quite an elaborate review procedure. Leaving aside situations in which relatives express concern—we all know about the legal position in
that respect—I wonder whether the proposal to subject 1 per cent of deaths to more rigorous scrutiny involving a medical reviewer travelling various distances, looking at notes, interviewing the doctor and relatives for the sake of accuracy and so on will cause problems for your religious communities.

Leah Granat: It will, indeed. In the Jewish community, there is a very strong imperative for speedy burial. At the moment, the vast majority of Jewish burials in Scotland take place either on the same day or early the following day and if a review had to be carried out before burial could go ahead it would cause delays and a great deal of distress to a lot of people.

11:15

However, the committee has received evidence that it is unlikely that review would involve post-mortem examination of the body. Professor Fleming suggested:

“it is not clear to us why that cannot be done as a post-registration event. It is not there to pick up flaws that would block registration”. —[Official Report, Health and Sport Committee, 1 December 2010; c 3760-1.]

In that case, why should not registration and subsequent disposal of the body simply go ahead? The review could take place in parallel and continue afterwards. Where the disposal is by means of burial, it will still be available in the extremely rare circumstances in which the body needs to be examined.

Ian McKee: Are all Jewish deaths followed by burial rather than cremation?

Leah Granat: Yes. Very occasionally, the Liberal Jewish community permits cremation, but in Scotland the figure is well below one disposal by cremation every couple of years.

The Convener: I invite Dr Beltagui to comment on the cultural differences that exist.

Dr Salah Beltagui (Muslim Council of Scotland): The experience of burial is important in Islam, too. Burial is supposed to take place on the day of death or the next day, unless there is some necessary delay. The delay that will be caused by the review, which is a paper exercise, could continue after the burial. Muslims do not practise cremation. As Leah Granat indicated, because the body still exists, there is a chance of getting it back, if necessary.

I want to raise the issue not of the review but of the post mortem, which often takes a long time. If the bereaved see no reason for it, it becomes a cause of anxiety for them. It is important to make the point that the burial provides a kind of closure for the bereaved; the recovery process starts after that. If the burial is delayed, it is like starting again after a week. That is the main reason for having the burial take place on the same day. We need to look at the delay that takes place when there is a post mortem, because that happens a lot and sometimes lasts for a week or so. Resources may need to be made available, in some cases.

Ian McKee: Can you give me a rough estimate of the proportion of Scots who are members of your religious communities?

Leah Granat: In the previous census, which is now quite out of date, around 6,000 people identified as being Jewish.

Dr Beltagui: The only source to which I can go is the previous census, which indicated that there were about 60,000 Muslims all over Scotland. Members of ethnic minorities make up about 2 per cent of the total population, and about half of them are Muslims.

The Convener: That is helpful.

Leah Granat: The issue does not affect only the Jewish and Muslim communities or even only ethnic minority communities. Delay to burial is distressing generally. If we establish that there is no reason why registration and disposal—certainly by means of burial—cannot go ahead in parallel with review, that will be of benefit widely across the community.

The Convener: I think that we would accept that, generally.

Dr Richard Simpson (Mid Scotland and Fife) (Lab): I have two questions, one of which follows on from the last comments. Dr Beltagui suggested, in evidence on section 5, alternatives to post mortem, such as scanning. Is that being used at all at the moment?

Dr Beltagui: I think that Leah Granat knows more about that than I do.

Leah Granat: In Scotland there has to date been no post mortem by means of scanning. However, in England it is now recognised in the recent Coroners and Justice Act 2009 that magnetic resonance imaging scanning is an alternative form of post mortem. It has been used as a pilot study for a couple of years in the Manchester area and has been extremely successful. It is very popular there with the coroners as well as the communities who do not want invasive post mortems. One of the reasons why it is very popular is that it can occasionally provide information that cannot be achieved by a surgical post mortem. For example, pneumothorax is very visible on an MRI scan, but as soon as a knife is inserted for a surgical post mortem the air escapes and the evidence no longer exists.

We would also urge the more general use in Scotland of review and grant, which is a particularly
Scottish form of post mortem. Its use is very variable; for example, the figure for view and grant in Glasgow is around 1 per cent and in Dundee it is about 35 per cent. In our submission on the bill we raised that issue of variability, which is due to the individual preference of senior staff in the relevant departments, who either like or dislike the use of view and grant. In the bill, registration could go ahead in parallel with review, but it would be left entirely at the discretion of the reviewer, which could result in the same situation as with view and grant. For example, a reviewer in one area could be happy to go ahead with parallel registration, but in another area the individual reviewer might not be so happy. However, that could change. For example, until a couple of years ago there were no recent cases of view and grant being used in Edinburgh, but somebody new came into post and view and grant began to be used more widely. Therefore, as we suggested—

The Convener: I am sorry. I am listening, but what is view and grant? We have two former general practitioners on the committee who perhaps know what it is, but some of us do not.

Leah Granat: I apologise. View and grant is a form of non-invasive post mortem examination whereby the pathologist will gather together all the available medical records of the deceased person and look initially to see whether they provide evidence of the likely cause of death. There is then a visual but non-invasive inspection of the body, which may sometimes also include, for example, taking small samples for toxicology investigations. However, it is a non-invasive form of post mortem that is highly preferable for the Jewish and Muslim communities.

Dr Simpson: That is very helpful, because we will obviously need to return to such issues. There are two mechanisms in the bill for ensuring that nothing happens that should not happen in relation to a death. One is the random review, and the committee has discussed and taken evidence on whether that is satisfactory. There clearly is a particular problem with delays, to which the witnesses have alluded. I presume that that will include problems at weekends, which are already a difficulty for your faiths.

The other mechanism is that a person with an interest can apply for a review of a certificate. Do you have any comments on that? A person with an interest can be someone who has an interest in the deceased or it could be the person who will be deceased themselves. They can make a statement, and if they have concerns about how they may die or about their care during the last phase of their illness they may desire a review. Do you have any comments on either of those aspects?

The Convener: That is a strange one—people suspecting that there may be suspicious circumstances.

Dr Simpson: It does happen.

The Convener: I never said that it does not happen; it is just strange.

Dr Beltagui: If there is any objection from the deceased, the family or the people interested, it should be followed up. In such a case, they would be asking for the delay, so there would not be an issue with that.

The main thing about the alternative methods and everything else is that we need some more research and training. As Leah Granat explained, the system has been tested in England for a couple of years, and the evidence is conclusive in some cases and inconclusive in others. We need more work in the medical area to find alternative ways to speed up the process and to deal with the other issue, which is respect for the human body—dead or alive. We can reduce anxiety by acting without intrusive methods.

Leah Granat: As Salah Beltagui said, if the request for a review comes from the family, there will clearly not be so much concern about delay to the grieving process. However, there would be a difficulty if there was disagreement between close family members in which one child wanted a review and others did not, or if a partner, husband or wife wanted a review but the children did not. I do not have a solution to that. It is obviously a difficult situation, and it would have to be dealt with case by case.

Dr Simpson: Should the bill refer to a vexatious declaration of interest to deal with someone applying for a review for malicious purposes? I ask in this session because delays are regarded by your faiths as being very important. I hope that it would never happen, but if someone wanted to cause difficulties in the family they could do that by calling for a review.

Dr Beltagui: I think that there is something in the bill already about who deals with the body if there is a conflict in the family. That could be extended to this issue. Different steps can be taken if there is a difference of opinion in the family.

The Convener: There has been no indication that there are further questions, so I ask the witnesses whether there is anything that they have not been asked but which they feel we ought to have asked.

Leah Granat: I want to raise an issue that we raised in evidence. It has been discussed in earlier evidence sessions and we would very much like reassurance about it.
The bill discusses parallel registration and review. It does not talk about parallel disposal and review. In earlier evidence, Frauke Sinclair said fairly explicitly that the Scottish Government view is that in this case “disposal” and “registration” mean exactly the same thing. We would certainly appreciate reassurance that that is the case. Perhaps—thinking about the drafting of the bill—if it means parallel disposal and review, the bill should refer to that rather than simply to registration, which might imply that registration can go ahead but the burial cannot until the review is concluded.

11:30

The Convener: The minister is coming next, so that will be a good point to put to her.

Leah Granat: Section 24 of the bill is about prohibition of disposal without authorisation and—this is looking ahead to secondary legislation—the documents that would be required for disposal to go ahead. The bill’s explanatory note states that the registration certificate would probably be one of the required documents.

The Convener: The certificate ties in.

Leah Granat: Yes. The certificate ties in because if one of the other required documents is a confirmation that any review has ended, that would put a stay on burial. It would be problematic if registration had gone ahead but disposal could not.

The Convener: That is helpful. Dr Beltagui, is there something that you wish we had asked but did not?

Dr Beltagui: I will make one point, although I do not know whether you will agree with it. The review group started about 2005, and the first point in its report summary of recommendations was that “The procedure for certifying deaths should be sensitive to the many different faiths and beliefs in Scotland and ensure as short a delay as possible between death and disposal.”

I would like the word “faith” and consideration of faith to be included in the bill not just for our purpose but for the future. The older bill, from 1850-something, was exclusive of anything except a certain faith. We do not want that to continue.

The Convener: Those are very helpful points.

Leah Granat: I want to follow up on what Salah said about sensitivity to different communities. In the equality impact assessment, there is discussion about the bill being fair because there will be a uniform process for everybody. I just want to emphasise that fairness is not the same as uniformity.

The Convener: Exactly: you make that point in your written submission.

Those are two very good points, so I thank you very much. I hope that it was worth your while to struggle through to see us. That concludes the evidence session.

11:32

Meeting suspended.

11:36

On resuming—

The Convener: I welcome our second panel: Shona Robison MSP, Minister for Public Health and Sport; Mike Palmer, deputy director for public health; Dr Mini Mishra, senior medical officer; and Frauke Sinclair, bill team leader. They are all from the Scottish Government.

Before we move to questions, I invite the minister to make a brief opening statement.

The Minister for Public Health and Sport (Shona Robison): Thank you, convener.

There is no doubt that the current arrangements for death certification require reform. Currently, as you know, up to three medical practitioners sign off cremations without that being linked to a systematic quality improvement programme. Families that opt for cremation pay at least £147 to doctors for that service, which I do not believe is fair.

Instead of checking the actions of every doctor, we propose to introduce a systematic quality improvement system through targeted reviews that are linked to existing clinical governance arrangements, and to complement that with a proportionate level of deterrence.

Fundamentally, I believe that an intelligence-led independent medical reviewer system is more effective than a system that is based on a second signature by another certifying doctor, or a non-targeted system such as the one that is being introduced in England, which is likely to cost bereaved families in the region of £170.

I appreciate, from the evidence sessions so far, that the committee has concerns that our proposals may not act as a sufficient deterrent to wrongdoing nor involve sufficient scrutiny. Our proposals deliberately build flexibility into the number of medical reviewers, the sample size for random reviews and the number of additional targeted reviews. Using that flexibility, I propose some significant enhancements that I believe will help to address the committee’s concerns.

First, I propose to double the number of cases in the random sample, which is designed to provide
a benchmark for measuring annual quality improvement, from 500 to 1,000 a year. When that is added to the proposed number of targeted and interested person reviews, it will amount to around 2,000 comprehensive—or level 2—reviews a year.

Secondly, I propose to add to that a larger programme of independent level 1 reviews that are to be applied randomly to around 25 per cent of all deaths. That will capture around 13,500 deaths a year. Level 1 reviews will be conducted by medical reviewers, who will check the medical certificate of the cause of death and discuss it with the certifying doctors before sign-off. If a medical reviewer found cause for concern, a level 2 review could follow.

Furthermore, the legislation has been designed to require an annual report to Parliament on the activities and performance of the reviewers. I would be happy to agree that a report should come back to the committee on the workings of the new system after a suitable period, to review how the system is working before further roll-out. That would take account of stakeholder input, which will feed into the monitoring and evaluation plans that will be developed in due course.

I believe that the package provides robust enough deterrence and reassurance to the public through widespread independent scrutiny of MCCDs, while harnessing the benefits of a targeted quality improvement approach that is proportionate and keeps the financial burden on bereaved families and the Government at a reasonable level. I am happy to take questions.

The Convener: Thank you for that additional information. Ross Finnie will begin.

Ross Finnie (West of Scotland) (LD): Thank you, minister. That was helpful because you have sensed that I and, I think, other committee members have been wrestling with the question of balance. We were a little surprised in our initial session with the bill team. Although we accepted that, if a Harold Shipman sets out to criminally avoid detection, that is what he will do, and no system in the world is likely to pick that up—perhaps we did not express our acceptance of that clearly enough to the bill team—we found it instructive that the burial and cremation review group report of 2007 suggested that, even though the system cannot ultimately pick up a Shipman, it ought to have elements that will act as a deterrent to anyone seeking to defraud or criminally avoid detection. We were surprised because the bill team gave the impression that fraud or criminal activity has no part in the new system. Indeed, the bill team leader answered in such terms. I am therefore pleased that you have proposed an enhanced level of scrutiny that seeks to address that.

We are getting into what Professor Fleming and Dr Fischbacher talked about in their evidence about relying on statistical probabilities to give us confidence. Has the decision to double the number of cases to be scrutinised from 500 to 1,000 and to increase the proportion of level 1 reviews to 25 per cent been made on any statistical basis, or have you simply had to apply a reasonableness test in arriving at that figure?

Shona Robison: A reasonableness test has been applied, with the recognition that, when the test sites have been in operation for a year, that should begin to give us some ability to judge whether there are any concerns about the new system. That is why the test sites are so important. As the figure of 25 per cent will be under ministerial direction to the registrar, it can be changed upwards or downwards in light of the evidence that we gather from the practice of the new system.

What is proposed is a reasonable compromise, and it is proportionate cost-wise. The proposed system is affordable and it will increase the Government’s contribution by around £600,000. I feel strongly that I do not want to increase the level of fee to be paid by members of the public; I want to hold that at the £30 that we have proposed. We therefore propose that Government expenditure will cover the additional cost of having level 1 reviews in 25 per cent of cases.

That is the rationale, and it can be tested during the test site period.

11:45

Ross Finnie: In earlier evidence, the Government seemed to take the position that the previous system of checking was “perfunctory”, although that claim was very much challenged by Professor Fleming, who said:

“A 15 per cent improvement in accuracy and picking up on dozens of unnatural deaths does not seem to me to be perfunctory.”—[Official Report, Health and Sport Committee, 1 December 2010; c 3754.]

I do not want to play with words, but I want to get some sense that what we are about to embark on has some foundation. You might well direct my attention to the pilots or test sites and suggest that, as a result of those, a more rigorous statistical analysis could well be applied to provide the degree of comfort that the committee has been searching for over the past few weeks of evidence taking.

Shona Robison: Doubling from 500 to 1,000 the number of comprehensive reviews is itself a significant step. After all, those level 2 reviews will be fairly in-depth and will involve checking not only the paperwork associated with the death but the appropriate medical records and the results of any
medical investigations; discussions with the certifying doctor, other relevant staff and the deceased’s family or informal carers; and consideration of any other evidence including, if necessary, arranging to view the body.

The test sites will allow us to reflect on whether the system is working not just with regard to level 1 and level 2 reviews but in a number of areas. For example, communication with families will be important and we will be able to find out whether we need to do more in any area in response to feedback from stakeholders on the test sites. I regard that as very important, and I want to involve the committee in this work. Indeed, I have committed to reporting back to you on what stakeholders are saying and reflecting on whether any changes need to be made before the new model is rolled out.

The Convener: Cabinet secretary—I am sorry; I mean minister. I was promoting you there. Can you give the committee any steer on the location for the two test sites, one of which will be urban and the other rural?

Shona Robison: We have not really reached that stage. Our commitment is to have one urban and one rural test site, but we have not yet identified any locations.

That said, we have decided to locate one of the test sites in a rural area to ensure that issues such as rurality and remoteness do not impact on the system and lead to concerns over, for example, delays. As soon as we have identified the areas, we will come back to the committee.

The Convener: I might challenge that comment by pointing out that rurality and remoteness are not one and the same thing. Rural areas, such as the one that I represent, and remoter parts such as the Shetland Islands might have separate issues and very localised difficulties. Moreover, the evidence from the faith groups that we have just taken, which I am sure the minister heard, raised a number of issues that I think should be considered with regard to the urban test site.

Helen Eadie (Dunfermline East) (Lab): I welcome the minister’s comments about increasing the number of level 1 checks by 25 per cent, because the committee has felt some unease in that respect. We will certainly need time to reflect on the matter.

In response to Ross Finnie, you touched on an issue that I was going to ask about. In their written submissions, the Convention of Scottish Local Authorities and the City of Edinburgh Council suggest that the wider public will deem the £30 charge to the registry office as a “death tax”. Those are their words, not mine. The preference in the submissions from a variety of people—not only the City of Edinburgh Council and COSLA—was for the money to continue to be paid to funeral directors, not the registrar, as that would help to remove the perception that this is a £30 death tax. At the moment, the charge for the basic certificate is £9 and the public would view an increase from £9 to £30 as a big jump, although we know from others that some people end up paying £30 because they want a full certificate. What is your comment on all of that?

Shona Robison: At the moment, the vast majority of people pay £147, because there are more cremations than burials. There is a real inequity in that—it has been described as the ash cash issue. The proposed new charge will deal with that, as everyone will pay £30. For the vast majority who currently pay £147, it will be a vast improvement. You also have to consider the cost of some of the alternative systems. For example, in the English medical examiner model, the cost will be £100 plus £70 to £80 for the inspection of the body, so bereaved families in England face a bill of £170 to £180. You have to put the matter in context.

The question of who collects the fee has been an issue for the committee. The truth of the matter is that representations have been made on behalf of registrars that they do not want to collect the fee, for a number of reasons, and, similarly, the funeral directors have said that they do not want to collect it. Nobody is exactly falling over themselves to volunteer, so a choice has to be made and we need to look at the arguments for and against. I will not go to the wall on this one; the judgment is for the committee. There are a number of reasons why our preference is for the registrar. All deaths have to be registered. Registrars are used to dealing with the bereaved. There are registrars in all 32 local authorities, so there is a system in place. It is not necessary to use a funeral director to arrange a funeral, so there will always be some cases that fall outwith the funeral director. It also seems odd that a statutory fee for a public service should be collected by a commercial organisation. Funeral directors do not want to collect an admin charge for a service that they are not providing—I am sure that they have expressed that view strongly. There is also the danger of significant additional bureaucracy. Hundreds of funeral homes across Scotland would have to be registered and brought into some kind of monitoring and audit scheme. We would probably have to legislate to force them to collect the fee.

Having heard all the disadvantages, I was put into the position of having to choose between two reluctant fee collectors. In the end, I came down on the side of the registrars. The list of disadvantages for a system where funeral directors are the collectors is longer than the list of disadvantages for registrars doing that.
The Convener: It is certainly a long list.

Helen Eadie: That was a helpful explanation. I have a final question on registrars. We have heard evidence, including from Jewish and other faiths this morning, about the problem of contacting a registrar, for example when a death falls at the weekend. We have heard that people at times resolve these issues only through local knowledge in having home numbers. People of faith for whom the burial has to take place on the same day as the death have told us that the issue needs to be addressed. Legislation may not be required to do that. What is your thinking on the issue?

Shona Robison: These issues are very important. We need to reassure faith communities that there would not be a delay, because that is a significant issue for them. The main thing to understand is that the review can happen concurrently with the registration at the discretion of the medical reviewer. We want to ensure that that happens. We would also highlight to the General Register Office for Scotland the need to ensure that there are no delays in the system. The test sites will be important because they will give us an opportunity to monitor and, if required, to make adjustments at that stage, before further roll-out. We recognise the sensitivities and we would certainly not want to create difficulties for our faith communities.

The Convener: As a supplementary to that, I would like to clarify something while it is fresh in my mind. Somebody else might have asked about the point that Leah Granat raised about registration and disposal being talked about as if they were one and the same thing. In the bill and the explanatory notes, that is not the case. Can you address the issue of parallel registration and review? We have issues about registration being timeous, but we also have issues about definition.

Shona Robison: Frauke Sinclair will respond to that.

Frauke Sinclair (Scottish Government Chief Medical Officer and Public Health Directorate): When registration is complete, disposal can take place and form 14, which is the disposal certificate, can be issued. The bill does not need to be changed in that regard, but I take the point that the faith groups made earlier. We can make the position clearer in the accompanying documents, but the bill does not need to be changed. That is already taken care of.

The Convener: You are satisfied that we do not need anything in the bill—

Frauke Sinclair: Absolutely. We discussed that situation when we drafted the bill.

The Convener: Hmm—I am making my “hmm” noise because I will have to think about that one. I am not sure about it. I do not say that I disagree, but I will have to think about it a little bit more because I do not know whether what you said resolves the question. What does the committee feel?

Michael Matheson (Falkirk West) (SNP): Is it entirely clear that the disposal of the body can take place while the medical reviewer is still carrying out a review?

Frauke Sinclair: No. The point that we are making is that, once registration is complete, they want disposal to take place, and the concern was that that is not the same thing. However, I made the point the last time that I gave evidence that they are the same thing in effect because—

Michael Matheson: No. Let us be clear here. The concern that has been raised is that the bill refers to the fact that the review can take place while the registration is occurring, but that registration is not the same as disposal of the body. Under the bill, if registration has occurred but the review is still taking place, can the disposal of the body occur?

Frauke Sinclair: Once the review is complete, registration can be completed.

Dr Simpson: The answer to Michael Matheson’s question is no.

Michael Matheson: The answer must be no, then.

Dr Mini Mishra (Scottish Government Primary and Community Care Directorate): In the expedited procedure, when somebody makes an application, the MR, apart from screening out the vexatious requests, will communicate with the registrar after cursory, superficial scrutiny to say that, in his view, there will be no need to retain the body and that registration and disposal can go ahead while he deals with the more detailed aspects of the certification process. Another point that was made was that the disposal documents might require an MCCD and that that could tie in while the funeral arrangements are being made in the expedited procedure, bearing it in mind that getting the notes and doing about a three-hour review should all tie into an expedited burial as well. In the expedited scenario, there is provision for the MR to say that registration and disposal can go ahead while they carry out a concurrent review.

Shona Robison: But it would only be at the stage where the medical reviewer had satisfied himself or herself that there were no outstanding issues. It would not happen automatically but would have to be at the say-so of the medical reviewer. In effect, it would be a judgment made by the medical reviewer. If the committee is uncomfortable with that, we can certainly explore it.
further. We felt that it was important for the discretion to be kept.

12:00

Michael Matheson: We are just trying to respect the position of different faith groups, particularly the Jewish and Muslim faiths. We want to ensure that the system does not unduly delay disposal of the body and that that is clear in the bill. From the discussion that we have had, I have been left a little uncomfortable about whether it is entirely clear on that. We need to ensure that the expedited process reflects the faith needs of certain groups in society.

Shona Robison: We had envisaged that being in the guidance, but we can certainly consider the committee’s concerns if you feel that we need to do more than that.

The Convener: What happens just now when there is a faith burial within 24 hours of death? Must registration of death take place before disposal if it has to be within 24 hours?

Mike Palmer (Scottish Government Chief Medical Officer and Public Health Directorate): Yes, registration must take place before disposal.

The Convener: Is that in any circumstance?

Mike Palmer: Yes.

The Convener: So we are back to the same thing, except that we have the problem that, if we were trying to do a parallel review and registration, that might delay it. That is the point that is being made.

Mike Palmer: As the minister said, we can make that crystal clear in guidance and the secondary legislation. Section 24 of the bill says:

“The Scottish Ministers may by regulations made by statutory instrument—

(a) specify the certificates or other documentation required for the interment, cremation or other disposal of the body”.

That gives ministers discretion to lay out exactly in the secondary legislation which forms and certificates would be necessary. We envisage that, under the expedited procedure, simple confirmation of registration would be required. That is form 14, which the registrar issues. We can make that absolutely clear in the relevant set of regulations so that we can reassure the faith groups about the ambiguity over disposal versus registration. [Interruption.]

The Convener: I think that a counter discussion or sub-discussion is taking place between Helen Eadie and Mary Scanlon. Are you ready, ladies? It is you now, Mary. Is it a collaborative question?

Mary Scanlon: I welcome what the minister said about doubling the random sample of cases from 500 to 1,000 and the level 1 reviews on 15,500 deaths—I think that that is what she said—each year. I ask her to put that in the context of Stewart Fleming’s evidence. He said:

“Each doctor in Scotland would only have on average one certificate reviewed every 5-10 years.”

Given the changes that you announced today, how often on average would each doctor in Scotland have a review? Would it be once every four years?

Shona Robison: I am not sure that we will be able to answer that today. We can certainly try to work that out and come back to you.

Mary Scanlon: Given that the random sample will be doubled, instead of saying:

“Each doctor in Scotland would only have on average one certificate reviewed every 5-10 years”,

we are now saying that it would be every two and a half to five years. Would it, therefore, be accurate to say that a doctor would have one certificate reviewed every four years?

Dr Mishra: It really depends on the number of certificates that a doctor signs. It is difficult to make an average because a doctor in a remote area might sign few certificates, whereas a doctor who looks after a care home might sign many. We can categorically say that one certificate in four will be reviewed, but the link between the certificate and the doctor is quite tenuous.

Mary Scanlon: Professor Fleming was able to come up with that figure in his written evidence before seeing you and I wonder what impact your announcement will have on the average that he was able to come up with.

It would be helpful to know that, because paragraph 2 of the policy memorandum—I take what Ross Finnie said—says that the bill is

“to examine the processes governing death certification following the inquiry into the case of Dr Harold Shipman.”

That means more robust reviews than each doctor having one certificate reviewed every eight years, on average. Could you write to us to say how the changes that you have just announced will impact on the average that Stewart Fleming came up with?

Shona Robison: We can do that, although the whole raison d’être of the review system, including both level 1 reviews and level 2 reviews, is to drive up the quality of MCCDs in general, so that every certifying doctor is ensuring that the quality improves—unlike in too many cases at the moment. That is a very important part of the new system.
The issue is not just how many certificates each doctor might end up having scrutinised; it is more about driving up the general quality of those certificates across the board.

Mary Scanlon: I appreciate that, and you mentioned the quality improvement system.

Many of our witnesses were less than impressed with the bill. For example, Ishbel Gall of the Association of Anatomical Pathology Technology wrote:

“AAPT do not think that the proposed changes to Death Certification proposed in the Bill ... will work in practice and that there will be no improvement to ... quality”.

Is there anything that you have announced today that would provide some assurance that you have improved the quality of death certification?

Shona Robison: The system that we propose to introduce is about doing exactly that: ensuring, through the system of level 1 and level 2 reviews, that quality remains very much a part of what goes down on the certificate. In addition, it will be possible to take an in-depth look at practice in certain areas of Scotland—for example, groups of care homes, GPs or hospitals—and consider whether there are statistical anomalies that require to be further investigated. Furthermore, there is an education and training element, in which medical reviewers will play an important part.

Looking at the package, quality improvement comes through all that. The quality of the completion of the certificates should improve—I very much believe that it will—because of all the elements of the system.

Mary Scanlon: My final question is on false certification and the underlying causes of death. The matter has been raised by many witnesses in both written and oral evidence. I return again to Stewart Fleming’s evidence. He pointed out that in cases in which patients die of liver failure, it is only upon further examination that it might “become evident that these were cases of suicidal paracetamol poisoning” or of mesothelioma. There could be false certification merely through human error. Professor Fleming said that such cases “would not be detected by the systems proposed.”

He goes on to ask:

“Would the public be reassured by a process which allows hundreds of unnatural deaths to pass undetected?”

I have also raised a point about underlying causes in relation to diabetes. Someone could die of a heart attack, but it might not be recorded that one of the main contributory factors was diabetes or, for example, hospital-acquired infection. Will quality be improved? Will there be more information? Will more focus be given to contributory factors? Will the information be more accurate?

Shona Robison: I believe so, as quality will be driven up. Unfortunately, at the moment some death certificates still say that a person died of old age. That is completely unacceptable in this day and age.

The Convener: Our GPs are wincing—they will intervene.

Shona Robison: We must recognise that the current system does not detect the issues that Mary Scanlon has outlined and ask ourselves what we are trying to do. We are trying to drive up quality. The level 1 and level 2 checks will drive up the quality of completion.

The nub of Mary Scanlon’s question is whether there is any system that we could put in place that would detect some of the issues that have been mentioned. That would be a difficult task. Unless a post mortem is conducted and a toxicology report is produced for every one of the 50,000-plus deaths in Scotland each year, we will not necessarily be able to get at some of the issues that she raised. However, we can have the best and most proportionate system that includes a sufficient level of deterrence. There has been widespread recognition that it would be difficult to put together a system that was completely foolproof and that could always detect a Shipman-type scenario. The best that we can do is ensure that the level of deterrence is strong enough, that any statistical issues that arise are detected—the national statistician has a hugely important role—and that the quality of completion of death certificates improves. I believe that the system that we propose will do that. That is the best and most proportionate approach—affordability is an issue. The bill establishes the best system for doing all the things that we want to do.

Mary Scanlon: The points that I am making are not my own—they are taken from the evidence of learned professors and others.

Can you give me one example to assure people that, once the bill is passed, there will be less false certification and that, where appropriate, more factors that underlie and contribute to death will be mentioned on death certificates? Most of the written submissions that we have received have suggested that certificates will become more vague, rather than providing better quality information.

Shona Robison: I will give you an example of how the position will be strengthened. Under the new system, families will be able to raise with the medical reviewer concerns about the cause of death, which is not the case at the moment. You mentioned health care acquired infection. At the moment, families have no mechanism to say in an
easy way that they are concerned that something about the cause of death has been omitted from a death certificate. Under the new proposals, a family will be able easily to contact the medical reviewer to say that they are not happy, which will allow the reviewer to look into the case. At the moment, that mechanism does not exist, but it will be part of the medical reviewer’s role. That is an important additional element for families that will enable them to raise their concerns.

Mary Scanlon: If the family initiates the process, is there anything in the medical profession that will lead to the information being provided?

The Convener: An interested person may initiate the process.

Shona Robison: Yes, it does not have to be the family—any interested person can raise concerns. I was referring to the fact that the family may not be happy. The proposed arrangements really strengthen their position.

The Convener: I was thinking of whistleblowers who want to raise issues.

Dr Simpson: I have some quick questions. First, I take it that we will get a new financial memorandum. Clearly, the costs will now go up, and the charge has not been included; I presume that we will get that.

Shona Robison: Yes.

12:15

Dr Simpson: Secondly, Professor Fleming gave a ballpark figure for the current system, saying that in 20 to 30 per cent of post mortems the initial determination of death was inaccurate. No one is suggesting that we go back to having massive numbers of post mortems—although it has been suggested today that we should consider the alternative scanning methods that are being piloted in England. Even if not today, it would be good to hear the minister’s and the department’s reflections on that suggestion.

My main concern is quality. The public have to be confident in the system, and the minister has gone a long way towards answering that point today with the 25 per cent level 1 review. That helps enormously. However, certificates are often signed by junior doctors. For cremations, a doctor cannot sign a death certificate unless they have been qualified for X years and unless they have gone through a module of training. The minister has repeatedly referred to the need for training. If a junior doctor has the experience and has completed a module of training in death certification, that will drive up quality. Did you consider specifying a level of experience and training?

Electronic processes are used in part of the system at the moment: once the registrar has registered the death, it will be electronically transmitted to the medical adviser—currently Colin Fischbacher—in ISD Scotland, who then undertakes checks and writes to the doctors. We have heard about the number of letters and about the poor response rate—about 70 per cent. Have you considered an electronic system? Such a system would tighten your data set considerably. If you have only drop-down menus on which to operate, you can devise software to ask questions—and Professor Fleming referred to that in terms of the renal review register. That allows you to get to nuances in the certification process that you cannot get to at the moment.

If you feel that death by old age is something that we elderly GPs are wrong to write—

The Convener: You asked for that on your death certificate—“old age”—which is a long way away.

Dr Simpson: Thank you. I know I did. I hope I do die of old age, and that a revolutionary doctor will put it down as “old age”. However, if that is not acceptable—and I understand the need for epidemiology and so on—we will need a system that will prompt the doctor. Any modern system that does not have an electronic approach to take this out from the back end, where it is at the moment, and put it in at the front end, is losing a massive opportunity.

A change to the bill may not be required; it may be that regulations will have to be developed. However, I would like an assurance that nothing in the bill will confine us to the old-fashioned paper system that has served us so badly over the years, and that we will have the opportunity to move forward.

Shona Robison: I will write to the committee about scanning methods; that would be the best way of answering that question.

Dr Simpson raises a number of important points about quality. I will ask Frauke Sinclair to respond on the training and certification of doctors. At the moment, the requirement for who may certify death is any registered doctor supervised by an educational supervisor consultant. I will pass to my colleagues the question whether consideration was given to whether it should be specified that a doctor has a certain level of training or qualifications.

Dr Mishra: The question was considered. Any registered doctor who is beyond F1—that is, who is in F2 onwards—can certify death. If we are restricted to people who have more than a certain amount of experience, two issues arise. One is that doctors in training do not get that training, and the other is that we will not have enough doctors...
do the certification, which would lead to delays and other problems.

We spoke to educationists, who feel strongly that junior doctors should have a role in certifying deaths, but that they should be supervised by their seniors, which is what is meant to happen. That is also relevant to general practice, where GP registrars should be supervised by their trainers.

That is the way that deaneries would like us to go. They would like us to emphasise the educational supervisors’ role in death certification, just as in other activities, such as operations.

Dr Simpson: I am interested that you use operations as a parallel—I would use something else. Supervision is extremely patchy—people are left to do death certification at weekends when no consultants are in. If we genuinely want to drive up quality, we must have an experience qualification—or—if we accept your argument about delays, which are important—junior doctors should have to do a training module. Postgraduate training is now all about modules. Junior doctors should not be allowed to sign a death certificate unless they have been signed off by the deanery as having undertaken a module.

Shona Robison: We will certainly reflect on that.

You have previously raised the issue of an electronic system, which we have examined in detail. I reassure you that nothing in the bill confines practice to a paper-based system. My only note of caution is that introducing new information technology systems is costly.

We will certainly continue to consider the suggestion. I suspect that it might be difficult to have a system up and running for the test sites, but we would always consider where IT solutions could help. On your main point, I reassure you that nothing in the bill requires the system to be paper based, so it is future proof.

Ian McKee: I congratulate the minister on the excellent level 2 proposals and especially on giving interested parties and relatives a formal way to have a death investigated further. However, I have concerns about the new level 1, which you can perhaps help me with. I gather that the proposal is that 25 per cent of deaths—or perhaps 23 per cent, if we leave out the 2 per cent—

Shona Robison: That would be additional.

Ian McKee: For 25 per cent, a telephone conversation will take place between the reviewer and the doctor who signed the certificate.

Shona Robison: The medical reviewer will check the MCCD and will then speak to the certifying doctor by phone to obtain background clinical information. If the reviewer becomes concerned at any point and for whatever reason, they will be able to escalate the review to a level 2 comprehensive review.

I do not claim that a level 1 review will be at the same level as a level 2 review, because it will not be, but the system will be designed to cast the net wider, so that a check—albeit a fairly straightforward one—is done. Should any alarm bells ring, that check could be escalated. Through the test sites, it will be interesting to monitor how many cases are escalated. That should begin to paint a picture for us of whether issues are being picked up and escalated from level 1 and, if so, to what extent. I am keen to examine that once we have that real-time information.

Ian McKee: I return to what happens today. I am a bit confused about information that Dr Mishra gave me yesterday, which she can put on the record now, about the statutory basis of the certificate that is given for cremation forms. Will she expand on that?

Dr Mishra: The cremation forms are specified in legislation—a statutory requirement applies. On top of that, crematoria place conditions in bold or in red—they have local variations on the statutory forms. Crematoria insist on doctors filling in some parts, but those extra requirements have no statutory basis.

Ian McKee: What information is required in statute?

Dr Mishra: Statute requires five questions to be asked, but none of those questions needs to be answered in the affirmative.

Ian McKee: So doctors can be asked whether they have done a post mortem, whether they have spoken to the relatives, whether they have spoken to the doctor who signed the certificate and so on, put no to all those questions and have fulfilled their statutory obligation?

Dr Mishra: Yes, on form C, at the moment. However, those are the current cremation regulations.

Ian McKee: I have in front of me the form that is used by the City of Edinburgh Council at Mortonhall crematorium. It says that the certificates are statutory and that all questions must be answered fully.

Dr Mishra: I have that Edinburgh form as well. It says, in red ink, that one question should be answered in the affirmative. Glasgow asks for two questions to be answered in the affirmative. Each area has different requirements.

Ian McKee: Does any cremation body say that none of the questions need be answered in the affirmative?
Dr Mishra: I have not trawled the whole system, but I went through Edinburgh’s forms and I have them here. I also found out from Glasgow, the other of the two biggest cities, what its custom is. There are areas on the forms that are highlighted in bold or red. They are not specified in statute, but they are required by local authorities.

Ian McKee: Taking practice as it exists rather than concentrating on the theoretical, you probably agree that most doctors who get a form that says a certificate is statutory and that the questions must be fully answered will, according to custom and practice, answer at least one of the questions in the affirmative—if that is what they are asked to do. Do you agree with that?

Dr Mishra: Yes I am sure they will, otherwise the form will be rejected.

Ian McKee: So, the system at the moment is that 60 per cent of all deaths in Scotland require the completion of a two-part cremation form. In practice, part 2 is signed by a doctor—not the doctor who signed the first part—who questions the first doctor and either another doctor who was involved or the relatives or people nursing the deceased at the time of death. Is that right?

Dr Mishra: That is what they affirm.

Ian McKee: Minister, do you think that the public will be convinced that we have a better procedure when, instead of 60 per cent of all deaths requiring the first doctor to be interrogated by a doctor who has no financial or professional interest in the workings of the first doctor and the relatives or people who were nursing the deceased having to be questioned, 25 per cent of all death certifications require a telephone conversation between a central doctor and the doctor who is to sign the certificate?

Shona Robison: The question is really about the purpose of what we are trying to achieve. The review group, which debated those issues for two years, concluded that there was little to be gained for the public purse or for public reassurance from the current system. That is why we are sitting here debating a new system to replace it. The old system was seen as out of date and unnecessary.

Two options were proposed for our consideration. We are talking about one of them. The other, which represented more of a minority view in the review group, was for a medical examiner model. We have chosen to take the route that we are discussing. The system will not be the same. I would not claim that it is the same. We are having this discussion because the old system was not found to be fulfilling any particular purpose and it was extremely costly to the bereaved family. We could not continue to justify the ash cash issue, which has caught the public’s attention, and times and understanding have moved on from when that system was established medical practice.

Ian McKee: You have doubled the number of level 2 investigations. What effect will that have on the number of medical reviewers who will be appointed?

12:30

Shona Robison: We estimate that the number of medical reviewers will rise to 10. That is not set in stone, so we can make adjustments if required, but we estimate that there will be 10 full-time equivalents—there might be some part-time people. However, they will have administrative assistance to help with some of the paperwork, so it is not as if they will have to do all the paperwork themselves. We believe that that will be adequate but, again, we will be able to find out for sure through the test-site model.

Ian McKee: My next question is on education. You kindly provided us with figures that show that approaching 20,000 doctors in Scotland are able to sign certificates. It was explained to us that the medical reviewers will spend half their time on an education function. I mentioned in a previous evidence-taking session that a few medical reviewers educating 20,000 doctors in a part-time capacity seems a huge task. Obviously, the deans and the postgraduate organisations will be involved and, as my colleague Richard Simpson says, it would be good to have a module, but how exactly do you envisage the medical reviewers fulfilling their education function as opposed to that function being part of ordinary postgraduate training?

Shona Robison: Both will be important. The medical reviewers will have the opportunity to have some strong local links with the professionals in their areas. I envisage that they will take the opportunity, particularly in the early stages of the new system, to hold educational sessions locally. However, the most important aspect will be the ongoing relationship. The medical reviewer should develop a relationship with the doctors in their area so that they can lift the phone, for example, should anything require to be clarified, particularly in the early stages of the new system. Some of the work might indeed involve formal input—obviously, that will have to be manageable time-wise—but some of it might be more informal, such as doctors checking on the phone with the MR that they understand the system correctly.

Frauke, do you want to say anything more about education?

Frauke Sinclair: Yes. We do not expect the medical reviewers personally to undertake the training of, as you rightly said, nearly 20,000 certifying doctors. That would not be feasible. We
have had initial talks with educational bodies and, for example, the postgraduate deans. Their view is that the education supervisors have a responsibility to ensure that there is quality in this area.

The medical reviewers will carry out their education and training functions in a number of ways. We will particularly look for the senior medical reviewer to take a leading role in the area. For example, they will be expected to contribute to training through seminars, making links with the deans and talking to boards. The regional medical reviewers will have one day a week, not half their time, in which to carry out their training and education role. They will mainly focus on the scrutiny and review role. I just wanted to clarify that.

Ian McKee: Oh, right. Sorry—I thought we were told it would be half their time.

Finally, I have a question on the diagnosis of old age on death certificates. The convener has prompted me several times to raise the issue. In defence, the fact is that lots of people die when they are old and it is often not easy to establish a specific cause of death. One of my friends died in that situation last week. I appreciate that it would look a lot more accurate if we could put down “heart attack”, “stroke” or some other diagnosis that makes total medical sense, but it is debatable whether it is good to push doctors into putting down a diagnosis to fit some coding when they are not in the slightest bit certain that it caused the death. In many cases it is not obvious what the cause of death is but there is nothing suspicious about the death. If someone who is 97 goes to bed and they are dead when they are found in the morning, how do we get over that? Are you really just wanting the diagnosis of the week to be chosen, which you will vary, or what? What your statistics show will depend on what you choose. If you choose myocardial infarction every time, there is nothing suspicious. My concern is that every mother in that situation will now find that the death was nothing suspicious. My understanding is that many GPs can tell that there was nothing suspicious. My concern is that every mother in that situation will now find that the death was reported to the procurator fiscal. That could be extremely distressing. Is it not too big a step? Should the death not be referred to the procurator fiscal only when it is reasonable to do so? Why make it mandatory?

Shona Robison: I certainly understand the sensitivities you are referring to.

Frauke Sinclair: That relates to a form that currently applies only when no doctor or midwife was present at the birth. It is applicable in less than 1 per cent of cases; it hardly ever applies. We are not really changing many circumstances here. The number of stillbirths in Scotland in 2009 was 317, so we are talking about a couple of cases. Referral of stillbirths to a procurator fiscal is very rare.

The Convener: From my point of view, a couple of cases is a couple of cases too many if there is no reason for referral. I do not know why it is necessary. I appreciate that we are talking about a few people, but these are people who find out that their baby is dead, there was nothing suspicious about it and yet, I presume, they are told that the diagnoses are appropriate and not appropriate.
death is being reported to the procurator fiscal. I have concerns about that.

Dr Mishra: Any doctor who is asked to certify a stillbirth will always say, if they were not present at the death, that it was a sudden death. On that basis, they would refer the stillbirth. If it was a death in utero, the mother would in most cases deliver in a hospital setting. In that case, somebody would be present at the birth. What we are really looking at is sudden deaths where a young girl delivers a baby—a concealed pregnancy or whatever—and the baby is found dead. In those circumstances I think that the doctor would be required to refer to the procurator fiscal, because the cause of death is uncertain.

The Convener: I am not totally satisfied by that. I think that the professional would exercise his or her professional judgment and discretion and say, “I am concerned about this, so I’ll refer it.” My concern is that the whole thing is now mandatory and, in those circumstances, one such case is one too many in my book.

Frauke Sinclair: We have consulted the Royal College of Midwives and the Royal College of Obstetricians and Gynaecologists, which are content with the proposals.

The Convener: And what about procurators fiscal?

Frauke Sinclair: And the procurators fiscal, too.

The Convener: I do not know. I think I would also have asked mothers who had had stillbirths about their feelings about such a proposal.

Shona Robison: We will certainly reflect on that, convener.

The Convener: Thank you very much. That concludes the evidence session. There will be a pause to allow for a changeover of witnesses for the next item of business, which is consideration of subordinate legislation, but we will all stay nailed to our chairs.
December 2010

Dear Christine

HEALTH & SPORT COMMITTEE – MINISTERIAL EVIDENCE SESSION CERTIFICATION OF DEATH (SCOTLAND) BILL

I am writing to provide the further information requested by the Committee following the evidence session held on 15 December 2010 as part of the Stage 1 deliberations of the above Bill.

Test sites

Firstly, you asked for further information on the two test sites planned for the new system, one urban and one rural, and where will they be. You specifically wanted to know how the differences between a rural site and a remote site, and in particular issues of remoteness, will be dealt with. In relation to urban sites, you asked how issues raised by faith groups regarding speedy burial and contacting a registrar at short notice will be dealt with.

The purpose of the test sites will be to pilot the administrative elements of the new system such as the retrieval and transmission of medical documents, any delays in the system and implications for families. Test sites are not envisaged to start until 2012 and we will engage closely with stakeholders to develop detailed monitoring plans next year. We will also be taking forward discussions about the location of the test sites early next year with relevant local authorities and health boards, and in doing so we will consider carefully how rural and remote dimensions can be effectively covered. Similarly, we will ensure that testing is carried out in a local authority area with a sufficient number of ethnic minority groups to cover faith issues. The test sites will be run in such a way that no funerals will be delayed.

Parallel review and registration and disposal

Secondly, you asked for clarification regarding a point raised by faith groups regarding the expedited review procedure and the distinction between completion of registration of the death (which may occur in parallel with an expedited review) and the disposal of the body.
Specifically you wanted to know if it would be possible to proceed to dispose of the body before the expedited review was complete, so as to ensure no undue delay occurs.

Under the expedited procedure it will be possible to proceed to dispose of the body before the review is complete. When a case is selected for review, an application may be made directly to the medical reviewer who will confirm to the registrar as soon as possible whether the expedited procedure can be used.

Where a case proceeds using the expedited procedure, registrars will be able to register the death right away and will not need to wait until the review has been completed. Registrars will be able to issue a Form 14 certificate there and then, confirming that the death has been registered. In such cases, this confirmation certificate is all that will be required to dispose of the body (this will be set out in regulations to be made under the new section 27A of the Registration of Births, Deaths and Marriages Act 1965, inserted by section 24 of the Bill). Accordingly, families will be able to proceed directly to funeral, whilst the review is ongoing.

I also want to correct a piece of information given to the Committee in recent oral evidence. We indicated that registration must always take place before a body is disposed of. In fact, it is technically possible for burial (but not cremation) to take place prior to registration, although this is unusual. I can confirm that the Bill will introduce provisions so that no funeral can take place without prior registration of death (section 24).

**Frequency by which a doctor would be reviewed**

Thirdly, you asked for information on how often a doctor would be reviewed and the impact of Level 1 reviews on the averages provided by Professor Fleming in his evidence to the Committee.

For each Medical Certificate of Cause of Death (MCCD) a doctor certifies, he or she has a 1 in 4 chance of the case being selected for Level 1 review (cases will be selected at random). Each doctor in Scotland could on average expect to have one certificate reviewed once a year. This compares to Professor Fleming’s evidence in relation to the previous proposals: “Each doctor in Scotland would only have on average one certificate reviewed every 5-10 years” (both averages relate to GPs).

**Level 1 reviews: supplementary cost information**

Fourthly, you asked for supplementary information to the Financial Memorandum regarding the costs of additional medical reviewers to provide Level 1 reviews.

There are 3 elements to additional costs arising from the Level 1 reviews:

i. costs to conduct the 25% of Level 1 reviews
ii. costs to conduct any Level 2 reviews arising from the 25% Level 1 reviews
iii. costs to expand the test sites to take account of 25% Level 1 reviews.

The additional costs for (i) are £640k per annum, to pay for additional medical reviewers and assistants (there will also be an additional one-off £10k to the start-up costs.)

The additional costs for (ii) depend on the number of Level 2 reviews arising from Level 1 reviews - these are currently unknown but we will use the test sites to estimate them. Numbers would be expected to decrease over time as quality improves. Costs would be as follows:
• if 5% of Level 1 reviews resulted in comprehensive Level 2 reviews, the additional costs - over and above (i) - would be £310k;
• if 10% resulted in further Level 2 reviews the additional costs would be £480k;
• if 25% resulted in further Level 2 reviews the additional costs would be £1,140k.

The additional Level 1 reviews also have implications for the test site costs - the additional one-off costs for this third element will be £65k to cover additional staff and evaluation costs.

All additional costs for (i), (ii) and (iii) will be borne by the Scottish Government.

We will provide a revised Financial Memorandum early in 2011.

Non-invasive post mortems

Fifthly, you asked for information on the use of new modern scanning techniques, such as CT scans, as a means of non-invasive post-mortem examinations and whether they will be used in Scotland.

Current research shows that MRI scans are additional tools in a post mortem examination and cannot replace an autopsy. Trained staff and appropriate equipment are not currently available apart from in research settings. However, this is a developing area, and pathologists and radiologists will keep abreast of developments. Investigations should not be a part of legislation but part of professional best practice and guidance, as this area of medial investigation is a rapidly changing one.

Stillbirths and Procurator Fiscal

It may also be helpful to provide clarity on the issue the Convener raised at the end of the meeting relating to stillbirth cases which may require to be referred to the Procurator Fiscal, and the resultant distress this could place on grieving parents.

COPFS currently requires all sudden and unexplained deaths to be reported to the procurator fiscal (PF). While a sudden or unexplained death may not be suspicious, there is a requirement to report it, just as suspicious deaths have to be reported to the PF. If a baby has died in utero and is diagnosed, then the delivery will usually occur in a hospital, where clinical staff will be available at delivery. If a baby dies during birth, and a midwife or a doctor is present, they may be able to establish a cause of death and sign a stillbirth certificate. If the cause of death is not known or death is sudden or unexpected, the doctor or midwife cannot offer a cause of death if they have not witnessed the event, i.e. delivery, or examined the body. The COPFS currently expect the doctor or midwife to discuss the case with the PF. There will be no change to this practice as a result of this Bill.

In investigating non-criminal deaths all PFs are expected to act with sensitivity in dealing with nearest relatives. Where the deceased is a child (perhaps a sudden unexpected death in infancy) or where stillbirth has occurred this duty of sensitivity is particularly acute. It is paramount that parents are informed that the involvement of a PF is not an indication of wrongdoing but rather that the PF is exercising his/her “other” role as deaths investigator.

The only change being made by the Bill is to remove the current requirement in section 21(2)(b) of the Registration of Births, Deaths and Marriages (Scotland) Act 1965; this requires a qualified informant (usually a family member) seeking to register the stillbirth to complete a declaration to the effect that the child was not born alive and that there was no
doctor or midwife present at the birth. As the PF will, in practice, be involved in such cases, this requirement is unnecessary.

Fees

A further point of clarification I would like to add is that the £9 applicable for the *Full Extract of Death Certificate* currently payable at registrars' offices, is a separate fee to the fee proposed for Level 2 reviews and will remain a separate fee. We have explained this to COSLA, who have confirmed their understanding that these are two distinct fees for distinct purposes.

Quality improvement approach

Finally, I think it may be helpful to clarify the quality improvement approach which we are seeking to take through this legislation.

Our proposals seek to apply in the area of death certification the improvement approach already employed through the patient safety approach to quality - as outlined in the NHS Quality Strategy. A key principle underpinning this approach is a reduction in variation in clinical practice and an increase in consistency allied to high standards. This is done through application of an improvement programme whereby processes and practices requiring improvement are identified, investigated and changed; resulting improvements are measured; work is done to embed them; after which the programme moves on to improve standards elsewhere.

Within this context, the sample Level 2 reviews will provide a national benchmark which will give an all-Scotland measure of the proportion of MCCDs queried by MRs, allowing us to measure year-on-year improvements in the quality of MCCDs (i.e. if, say, 15% of MCCDs are queried in Year One, this sample will show the trend from this baseline in subsequent years).

Our proposed quality improvement programme will be intelligence-led and based on a triangulation of a number of different data sources - including data from the Level 1 and Level 2 random reviews (covering over 25% of all deaths); Interested Person reviews raised by any one of a number of stakeholders involved in any death; Hospital Standardised Mortality Ratios (comparing expected mortality rates from hospitals with actual mortality rates); queried MCCDs reported by registrars to GROS; and any unusual patterns identified by the national statistician. Acting on this data, MRs will be able to carry out targeted quality improvement programmes in specific geographical areas and/or circumstances and measure resulting improvement through the year-on-year random sampling. This element of systematic continuous improvement is missing from the current system of second and third doctor checks.

I hope that this information is helpful and clarifies matters. If the Committee requires any further information on any aspects, I would be happy to provide this to you.

[Signature]

SHONA ROBISON
3 January 2011

Dear Christine

CERTIFICATION OF DEATH (SCOTLAND) BILL - SUPPLEMENTARY FINANCIAL INFORMATION

Following the proposals I set out during the evidence session on 15 December 2010 as part of the Stage 1 deliberations of the above Bill, I now attach a document containing supplementary financial information with revised projected costs. A supplementary Financial Memorandum will be put forward after stage 2.

To reiterate, the proposals I outlined at Committee are:

- the introduction of a new level of real-time scrutiny - to be called Level 1 reviews - to be applied to 25% of deaths in Scotland, selected randomly by the GROS computer system; and

- an increase of random real-time Level 2 reviews (i.e. comprehensive scrutinies) from 500 to 1,000 cases annually.

These enhancements will be complemented by targeted reviews initiated by medical reviewers (MRs) and interested person reviews (the sum of targeted and interested person reviews is estimated at around 1,000 cases annually).

Level 1 reviews will be conducted by medical reviewers (MRs) and will involve checking the MCCD and speaking to the certifying doctor to obtain background clinical information. The MR will discuss any concerns with the certifying doctor (or another doctor in the team) by phone and will be covered by the procedure as currently set out in the Bill (sections 10 & 11). This will allow the MR to check quality and cause of death and to query anything unusual. It will allow discrepancies to be picked up and can act as a trigger for a comprehensive Level 2 review if considered necessary or where there is any disagreement.
The random sample of Level 2 reviews will be increased to 1,000 cases and this increased sample size will provide a benchmark for the proportion of queried MCCDs to within a 2% margin of error; the key purpose of this sample is to provide a quality benchmark at an all Scotland level and to measure improvements. Data from reviews (random Level 1 and Level 2 reviews, targeted reviews and interested person reviews) will feed into a comprehensive audit and quality improvement programme based on triangulating a number of data sources - including Hospital Standardised Mortality Ratios, coding checks from GROS and statistical analysis from the national statistician.

Level 1 reviews are likely to take 30 minutes per case. The MCCD can be faxed by the registrar to the MR's office to limit delays. It will be countersigned following review if the MR is content and then faxed back. The Bill's expedited procedure (included for circumstances requiring an accelerated process, including for reasons of faith) can be applied for in relation to Level 1 and Level 2 reviews. Administrative implementation issues will be tested including any specific issues relating to rural communities.

The additional Level 1 reviews and the 50% increase in random Level 2 reviews will provide a greater degree of deterrence and reassurance to the public and a greater level of independent scrutiny. These additional reviews will also enhance the quality assurance aspects of our approach via the links in the new system to education and training and clinical governance.

I believe these proposals maintain a balance between the need to keep costs to the public purse and families proportionate, the need to minimise undue delay for bereaved families, while providing a death certification system which offers independent, effective scrutiny.

As I mentioned to you before, I would be happy to report back to the Committee on the workings of the proposals after the test sites and before full roll-out.

I trust this information is helpful to the Committee.

Best wishes,

Shona

SHONA ROBISON
CERTIFICATION OF DEATH (SCOTLAND) BILL

SUPPLEMENTARY FINANCIAL INFORMATION

1. This document provides projected costs relating to the proposals outlined to the Health and Sport Committee on 15 December in respect to the Certification of Death (Scotland) Bill introduced in the Scottish Parliament on 7 October 2010. A supplementary Financial Memorandum will be provided after stage 2. The proposals would provide the following enhancements to the medical reviewer (MR) model:

2. Firstly, the introduction of a new level of real-time scrutiny - to be called Level 1 reviews - to be applied to 25% of all deaths in Scotland, selected randomly by the GROS computer system (based on 2009 figures, this would mean around 13,500 Level 1 reviews). Level 1 reviews will be conducted by MRs and will involve checking the MCCD and speaking to the certifying doctor to obtain background clinical information. The MR will discuss any concerns with the certifying doctor (or another doctor in the team) by phone and any disagreements will be covered by the same procedure as currently set out in the Bill. This will allow the MR to check the quality of the certificate and the stated cause of death and to query anything unusual. It will allow discrepancies to be picked up and can act as a trigger for a comprehensive Level 2 review if considered necessary or where there is any ongoing disagreement.

3. Secondly, an increase of random real-time Level 2 reviews (i.e. comprehensive scrutinies) from 500 to 1,000 cases annually. The random sample’s increased size to 1,000 cases will provide a benchmark for the proportion of queried MCCDs to within a 2% margin of error. The key purpose of this sample is to provide a quality benchmark at an all-Scotland level and to measure improvements. Data from all the reviews will feed into a comprehensive audit and quality improvement programme based on triangulating a number of data sources - including Hospital Standardised Mortality Ratios, coding checks from GROS and statistical analysis from the national statistician.

COSTS ON THE SCOTTISH ADMINISTRATION

4. The costings are based on assumptions made of likely workload and tasks initially agreed by an independent Review Group which met between 2005 and 2007. Assuming that 1,000 Level 2 cases are sampled, a further 500 are referred for review by “interested persons” and an estimated 500 cases are selected for targeted reviews, a total of around 2,000 deaths would be subject to Level 2 reviews annually, or around 38-40 cases per week. It is estimated that reviewing one case would take a MR around half a working day (Level 2) and 30 minutes (Level 1). Level 1 reviews would mean 13,464 deaths are reviewed annually (based on 2009 figures).

5. Our consideration of the numbers of MRs that require to be appointed has taken into account these proposed additions to their role. As previously stated, each MR would have around two days a week for: conducting additional targeted reviews; giving more general guidance; and fulfilling an education and training role - the updated financial model assumes

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1 Information about the Burial and Cremation Review Group is available on the Scottish Government website: http://www.scotland.gov.uk/Topics/Health/burialcremation/intro. It submitted a report to the Scottish Government which was published in 2008 which is also available on the Scottish Government website: http://www.scotland.uk/Publications/2008/03/251136210
their time is equally divided between targeted reviews and the other activities (guidance, education and training) i.e. one day each a week. Account has also been taken of absence due to sickness, leave commitments and the time each MR will require to devote to continuing professional development, to duties related to appraisal and revalidation and to reports to/liaison with the senior MR whose key functions will be to provide management of the MRs, a second opinion for reviews, and training and education. As before, each MR will have an assistant.

6. The increase in costs from the Financial Memorandum arise from the proposals which require an increased number of MRs and assistants to conduct both the new Level 1 reviews and the increased number of Level 2 reviews proposed (a total of c. 2,000). At a minimum, 10 whole-time equivalent MRs will now be employed, an increase of 4 from the original model. The annual recurring costs associated with the enhanced model are estimated at £1,830k with a further £110k start-up costs to be incurred in the first year of operation - these costs are detailed in the ‘0% column’ of Table 1 below.2

7. It is possible that MRs may refer a Level 1 review for a more comprehensive Level 2 review. Any additional Level 2 reviews may necessitate the employment of additional MRs and increase costs above the level set out in paragraph 6. The proportion of additional Level 2 reviews arising from Level 1 reviews will not be known until the system is in operation, but information from the test sites will provide good estimates and numbers are expected to decrease over time as quality improves. Table 1 below summarises the estimated costs for different proportions of Level 1 reviews recommended for more comprehensive Level 2 reviews. The recurring costs:

- without any additional Level 2 reviews subsequent to the Level 1 activity would be £1,830k pa;
- if 5% of Level 1 reviews resulted in comprehensive Level 2 reviews, the additional costs would be £310k pa;
- if 10% resulted in further Level 2 reviews, the additional costs would be £470k pa;
- if 25% resulted in further Level 2 reviews, the additional costs would be £1,130k pa.

Table 1 Recurring and start-up costs (excluding test sites) including Level 1 reviews and scenarios for upgrades from Level 1 to Level 2 reviews

<table>
<thead>
<tr>
<th>% upgrade after Level 1</th>
<th>0%</th>
<th>5%</th>
<th>10%</th>
<th>25%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of MRs (FTE)</td>
<td>10</td>
<td>12</td>
<td>13</td>
<td>17</td>
</tr>
<tr>
<td><strong>Recurring costs</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>MR costs (£000)</td>
<td>£1,260</td>
<td>£1,510</td>
<td>£1,630</td>
<td>£2,130</td>
</tr>
<tr>
<td>Total medical staff (£000)</td>
<td>£1,410</td>
<td>£1,660</td>
<td>£1,780</td>
<td>£2,280</td>
</tr>
<tr>
<td>Analytical staff (£000)</td>
<td>£70</td>
<td>£70</td>
<td>£70</td>
<td>£70</td>
</tr>
<tr>
<td>Support staff (£000)</td>
<td>£240</td>
<td>£280</td>
<td>£300</td>
<td>£380</td>
</tr>
<tr>
<td><strong>Total staff costs (£000)</strong></td>
<td>£1,720</td>
<td>£2,010</td>
<td>£2,150</td>
<td>£2,730</td>
</tr>
<tr>
<td>Total running costs* (£000)</td>
<td>£110</td>
<td>£130</td>
<td>£150</td>
<td>£230</td>
</tr>
<tr>
<td><strong>Start-up costs</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total start-up costs (£000)</td>
<td>£100</td>
<td>£110</td>
<td>£110</td>
<td>£120</td>
</tr>
<tr>
<td><strong>Total costs (£000)</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>£1,930</td>
<td>£2,250</td>
<td>£2,410</td>
<td>£3,080</td>
</tr>
</tbody>
</table>

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2 The estimated financial costs are at 2010-11 price levels.
Total running costs include employee IT and telephony costs, document transit and expense claims.

Total start-up costs include initial accommodation, GRO IT changes & support and promotional costs, development of training module. Start-up costs currently do not include recruitment costs. These can be non-linear depending on the number of posts advertised (multiple posts announced in one advertisement) and can range anywhere between £2,000 and £20,000.

All costs are presented at 2010-11 price levels.

8. The number of MRs would not appear in legislation and the proposed test sites will provide further information about the exact number required. These costs are therefore estimates at present and will ultimately depend on the number of MRs appointed.

9. The associated costs would not necessarily rise linearly with sample size due to the flexibility between review and training time incorporated into the model, due to non-linear changes in the travel costs and transport charges, and due to possible economies of scale arising from conducting more than the currently assumed number of reviews per week. Each added MR post (including an additional medical assistant) would increase the start-up costs by approximately £2,500 and the annual costs by c. £150,000, made up of salary and on-costs for the MR and the medical assistant, as well as IT and telephony running costs.

Staff, Accommodation, IT Changes Etc. Costs

10. The cost assumptions for staff, accommodation, IT changes, training etc. costs are unchanged.

Test Sites

11. Provided that primary legislation is completed in the 2010-11 legislative session, secondary legislation may be consulted on and go through the Scottish Parliament in 2011-12. Following that, a further transitional period of at least one year will be required for test sites to trial the new system, before full implementation in 2013-14. Two test sites in two different areas of the country are anticipated. These would offer a comparison between rural and urban populations, including remote rural and faith group issues. To include the enhancements we propose to extend the test sites to run for nine months, with monitoring and evaluation running in parallel.

12. Table 2 below summarises the revised estimated costs associated with the test sites.

<table>
<thead>
<tr>
<th>Staff costs</th>
<th>£110,200</th>
</tr>
</thead>
<tbody>
<tr>
<td>Promotional costs</td>
<td>£1,000</td>
</tr>
<tr>
<td>Evaluation costs</td>
<td>£40,000</td>
</tr>
<tr>
<td>Running costs*</td>
<td>£11,900</td>
</tr>
<tr>
<td>Initial accommodation costs</td>
<td>£5,000</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td><strong>£168,100</strong></td>
</tr>
</tbody>
</table>

*Running costs include transport costs; travel expenses; IT and telephone charges for staff.

13. The cost estimates for the test sites are made up as follows: staff costs for two part-time (0.5 FTE) MRs and two assistants for nine months; promotional costs for initially affected...
registrar offices (£1,000); evaluation (£20,000 for each test site, based on previous evaluation expenditure for commissioned work); running costs including document transit / transport, with the remainder available for incidental costs including administrative and running costs; and accommodation costs.

Recouping the Costs of the new System

14. The initial set-up costs of the new enhanced system, estimated at c. £110,000, will be paid by the Scottish Government.

15. The Financial Memorandum proposed that the new arrangements would be self-funding through charging a fee to the public. Ministers have undertaken to meet the additional recurring costs attached to the additional proposals from within existing Health and Wellbeing budgets. The proposed level of public fee is intended to remain at £22.08 plus an estimated handling charge of £8-10. The costs set out in Table 1 do not include handling charges which will be incurred in collecting the fee, although these will be met by the public and so lead to a direct increase in the proposed fee. The method for collecting the proposed fee is yet to be agreed and this will influence the level of handling charge.

16. The costs for the test sites will be paid by the Scottish Government from existing budgets and will not be recouped through the fee.

Total Estimated Costs

17. Table 3 below shows when individual costs will be incurred, with the national statistician costs being incurred first, followed by the costs of the test sites (the running costs comprise of transport and administrative costs), before full introduction from 2013-14. The fee is set to cover the annual costs from 2013-14 onwards excluding the costs of the enhanced reviews detailed in this document. Nor will the proposed fee offset any costs incurred during 2011-2013.

Table 3 Year-on-year costs (inc test sites and Level 1 reviews without upgrades)

<table>
<thead>
<tr>
<th></th>
<th>2011-12 Inception</th>
<th>2012-13 Test sites</th>
<th>2013-14 Year one</th>
<th>2014-15 onwards</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical &amp; support staff</td>
<td>£0</td>
<td>£94,000</td>
<td>£1,410,000</td>
<td>£1,410,000</td>
</tr>
<tr>
<td>Support staff</td>
<td>£0</td>
<td>£16,000</td>
<td>£240,000</td>
<td>£240,000</td>
</tr>
<tr>
<td>Analytical staff</td>
<td>£70,000</td>
<td>£70,000</td>
<td>£70,000</td>
<td>£70,000</td>
</tr>
<tr>
<td><strong>Total staff costs</strong></td>
<td><strong>£70,000</strong></td>
<td><strong>£180,000</strong></td>
<td><strong>£1,720,000</strong></td>
<td><strong>£1,720,000</strong></td>
</tr>
<tr>
<td>Total running costs*</td>
<td>£4,200</td>
<td>£16,100</td>
<td>£110,000</td>
<td>£110,000</td>
</tr>
<tr>
<td>Test sites costs</td>
<td>£0</td>
<td>£40,000</td>
<td>£0</td>
<td>£0</td>
</tr>
<tr>
<td>Initial accommodation</td>
<td>£5,000</td>
<td>£5,000</td>
<td>£30,000</td>
<td>£0</td>
</tr>
<tr>
<td>IT changes &amp; supports</td>
<td>£0</td>
<td>£0</td>
<td>£7,000</td>
<td>£0</td>
</tr>
<tr>
<td>GRO promotional costs</td>
<td>£0</td>
<td>£1,000</td>
<td>£10,000</td>
<td>£0</td>
</tr>
<tr>
<td>e-Learning modules costs</td>
<td>£0</td>
<td>£57,500</td>
<td>£0</td>
<td>£0</td>
</tr>
<tr>
<td><strong>Total costs</strong></td>
<td><strong>£79,200</strong></td>
<td><strong>£298,600</strong></td>
<td><strong>£1,877,000</strong></td>
<td><strong>£1,830,000</strong></td>
</tr>
</tbody>
</table>

18. Assuming the annual number of deaths remains at a similar level to recent years, total fee income of c. £1,200k will be available towards the recurring costs of the model from 2013-14.
onwards. The remaining annual recurring costs will be met by the Scottish Government. These will be at least £640k, assuming 0% upgrades from Level 1 to Level 2 reviews. The costs met by the Scottish Government will increase, depending on the proportion of Level 1 reviews referred for Level 2 review. Table 4 shows the level of recurring costs increases associated with the proportion of cases proceeding to Level 2 for which the SG would be responsible with the level of fee proposed held constant at £22.08.

Table 4 Possible recurring costs to SG associated with Level 2 reviews following Level 1

<table>
<thead>
<tr>
<th>% upgrade to Level 2 arising from Level 1</th>
<th>0%</th>
<th>5%</th>
<th>10%</th>
<th>25%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Recurring costs to SG</td>
<td>£640,000</td>
<td>£950,000</td>
<td>£1,120,000</td>
<td>£1,780,000</td>
</tr>
<tr>
<td>arising from Level 1 reviews</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

19. Table 5 below summarises the year-on-year costs including the costs of the test sites to the Scottish Government.

Table 5 Year-on-year costs (inc test sites and Level 1 reviews assuming 0% upgrades) to the SG, local authorities, other bodies, individuals and businesses

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Costs to SG</td>
<td>£79,200</td>
<td>£298,600</td>
<td>£1,877,000</td>
<td>£1,830,000</td>
</tr>
<tr>
<td>Costs to LAs, other bodies, individuals and businesses</td>
<td>£0</td>
<td>£0</td>
<td>£0</td>
<td>£0</td>
</tr>
</tbody>
</table>

COSTS ON OTHER BODIES, INDIVIDUALS AND BUSINESSES

20. There are no changes anticipated to the costs on local authorities, other bodies individual and business as a result of these proposals.

SAVINGS

21. There are no changes anticipated to the savings to the public as a result of these proposals.
ANNEXE C: OTHER WRITTEN EVIDENCE

Academy of Medical Royal Colleges and Faculties in Scotland
Argyll and Bute Council Registration Service
British Medical Association Scotland
Consumer Focus Scotland
COSLA
Cruse Bereavement Care Scotland
Diabetes UK Scotland
East Ayrshire Council
Edinburgh Crematorium Ltd
Faculty of Forensic and Legal Medicine
Gall, I (Vice Chair, Association of Anatomical Pathology Technology)
General Medical Council Scotland
Glasgow City Council
Institute of Cemetery and Crematorium Management (Scotland & Northern Ireland Branch)
Jones, C (NHS Health Scotland)
Medical Protection Society
Munro, N (Company Secretary, Edinburgh Crematorium Ltd)
NHS Borders
NHS Greater Glasgow and Clyde
NHS Lothian
NHS Orkney
North Lanarkshire Muslim Women and Family Alliance
Royal College of Nursing Scotland
Royal College of Pathologists Scottish Council
Royal College of Physicians and Surgeons of Glasgow
Royal College of Physicians of Edinburgh
Scotland Patients Association
Scottish Public Services Ombudsman
South Lanarkshire Council
Stanley, W (Cemeteries Manager, South Lanarkshire Council)
Strathcarron Hospice
Certification of Death (Scotland) Bill

Academy of Medical Royal Colleges and Faculties in Scotland

The Academy of Medical Royal Colleges and Faculties in Scotland thanks the Scottish Parliament for the opportunity for involvement in this consultation.

The Scottish Academy welcomes the general principle of the Bill but has concerns about some of the content. We would like to highlight the comments submitted by our members from the Scottish Regional Council of the Royal College of Pathologists, the Royal College of Physicians and Surgeons of Glasgow, the Royal College of Physicians of Edinburgh as a general consensus of opinion. We have also had discussions with our members from the Royal College of General Practitioners who have concerns and agree with the comments submitted by the Scottish Regional Council of the Royal College of Pathologists.

We are happy for the comments of the Scottish Academy to be included within the final report.

Dr John Colvin
Chairman
Academy of Medical Royal Colleges and Faculties in Scotland
17 November 2010
Certification of Death (Scotland) Bill

Argyll and Bute Council Registration Service

On behalf of Argyll and Bute Council Registration Service, I wish to present the following comments on the proposed Certification of (Scotland) Bill (SP Bill 58).

1. The general principles of the Bill are acceptable and indeed seen as a positive way forward.

2. We agree that the proposed changes to the system of death certification in Scotland are necessary and would be a suitable replacement for the present system.

3. We agree that the creation of a Medical Reviewer would be a welcome initiative and certainly think that the introduction of a system allowing for a small (perhaps 1%) random selection of the “Medical Certificate of cause of Death” in addition to referrals from interested persons, would be preferable to proposals for a 100% review which we believe would have been too intense, laborious and unnecessary. This system allows for referrals from interested parties to the Medical Reviewer which is an added benefit as it will ensure that particular cases are examined where there are concerns. It is important that suitable time limits for such referrals are included in the proposed Bill, and that this whole process does not hold up registration of death.

As part of the review it may be necessary for the Medical Reviewer to examine health records of the deceased, seek the views of the medical practitioner who attested the certificate or make other enquires – it would be a concern to us this should become a lengthy a process which would delay funeral arrangements and therefore cause distress to the bereaved.

It would be hoped that should a Registrar require contact with a Medical Reviewer, that this would happen without delay.

The information detailing the other functions of the Medical Reviewer including training of persons who are required to complete Medical Certificates of Cause of Death can only be positive and would certainly be welcomed by this Authority.

An Annual Report, as proposed, would ensure that this system remained open and transparent to all concerned.

4. We understand and concur with the proposal to charge a modest fee to cover the costs of the proposed system. It would be a requirement that any proposed fee be set at a reasonable rate and allowances made for certain categories of persons who would have difficulty in paying. We are concerned that the income from this should not be outweighed by costs of following up non-payers. In many cases there are few/ no assets in an estate, and it could
be a disincentive for friends and neighbours to register a death if they felt that there would be a fee attached to this process. All literature should make it very clear that there is to be no fee for registering a death. Any such fee is for the system of medical reviewers. Furthermore arrangements for collection of these fees will require further more detailed consideration. We understand that one option may be for registrars to collect these fees. Whilst registrars are used to collecting fees for extracts and marriages etc, and have the mechanism for doing this, we are concerned that this would then appear to be a fee for registering a death even though this is not the stated policy intention. Additionally all fees normally payable to registrars are paid up front and do not involve requirements to subsequently follow-up non-payers, so this would be a wholly new administrative burden. It might be preferable to consider other options such as collection via funeral directors, crematoria etc.

I trust these comments are useful to you. Please do hesitate to contact me if you would like to discuss any of these matters raised in more detail.

Judy Orr
Head of Customer and Support Services
Argyll and Bute Council
17 November 2010
Certification of Death (Scotland) Bill

British Medical Association Scotland

The British Medical Association is a registered trade union and professional association representing doctors from all branches of medicine. The BMA has a total membership of around 140,000 doctors representing 70% of all practising doctors in the UK. In Scotland, the BMA represents around 15,500 doctors.

BMA Scotland is grateful for the opportunity to provide comment on the Certification of Death (Scotland) Bill. The BMA supports attempts to improve death certification and provide reassurance to the public, however, we question whether either of these would be achieved with this Bill.

Do you agree or disagree with the general principles of the Bill?

The BMA supports the general principles of the Bill. In particular, we support the introduction of a new system for the scrutiny of medical certificates of cause of death. However, we believe that the measures included in this Bill are inadequate and in some respects actually make the certification of death less robust than the current system. These measures are significantly less robust than the system being introduced in England and Wales.

As doctors in Scotland, we have concerns about the proposed medical review system. While it has benefits in terms of raising standards and education, there does not appear to be a credible deterrent to any potential abuse of the system, and while this does remain very unlikely, and there can never be a guarantee that such abuse would be detected, there are proportionate ways to increase the likelihood of doing so.

Do you agree with the proposed changes to the system of death certification in Scotland?

No. The BMA does support a new system for the scrutiny of medical certificates of cause of death, however, we do not support the measures detailed in this Bill. We believe the proposed Bill actually makes the certification of death less robust than current arrangements.

Under the proposals in the Bill, only 2% of death certificates will be examined by two doctors, whereas, under the current system, two doctors independently check the cause of death for all cremations, which account for two thirds of all deaths in Scotland. Should this Bill be passed, 98% of death certificates will be seen by only one doctor. We are by no means questioning the ability or professionalism of doctors, however, we recognise that the public require a degree of independent oversight for the sake of public confidence, and we are not convinced that the public would be reassured to know that 98% of certificates will have no further check.
Do you agree with the proposed creation of a system of Medical Reviewers?

No. The BMA does not object to the concept of a medical reviewer per se, but believes that this medical review system is not sufficiently robust or transparent. Rather than leaving 98% of death certificates to be seen by only one doctor, we would prefer a system similar to that of England and Wales, where all deaths are scrutinised. It is for the Scottish Government to decide what is affordable given today’s economic climate. We are particularly concerned that were there anything untoward in any given death certificate, there would be no prospect whatsoever under these proposals of detecting it in 98% of cases.

Do you have any comments on the costs identified in the Financial Memorandum?

Although the system detailed in the Bill may appear to be reasonably priced, we believe it does not provide the best value for money since it does not offer adequate or effective protection levels to society.

We also have concerns that the level of costs detailed in the Financial Memorandum is seriously underestimated. This could have severe implications as any lack of funding or staff shortages could cause delays to funerals causing distress to families at a particularly difficult time. Any pilots taking place should be examined carefully to provide more accurate costs and Scotland’s rural nature should also be taken into consideration when considering costs.

Are there any other comments you wish to make on the Bill?

The BMA has specific concerns regarding Section 15 (documents: offences). According to the Bill, the medical reviewer would provide a notice to a person to produce relevant documents (including health records). The notice would specify the documents required and the date by which the person is required to produce them. Doctors in Scotland would, of course, be willing to provide the relevant documentation when requested or provide views to the medical reviewer (as detailed in section 8 (2) (b)). However, would this timescale be standardised or would it be liable to be determined at the discretion of different medical reviewers across Scotland? Additionally, given the short timescale for each review, which we appreciate is required to avoid delays to funerals, we have concerns regarding the additional workload for doctors.

We acknowledge that all reviews can be suspended during times of an epidemic, however doctors in primary and secondary care settings constantly work under very tight timescales juggling patients in both planned and emergency situations. If an unrealistic timescale is set, or an emergency arises, or due to pressures from staff absence, a doctor will be required to decide whether to let patient care suffer or to be imprisoned.
Given the nature of retribution, how will the notice be given, how can the reviewer be sure that the doctors have received the notice to avoid any delays. How will the doctor be sure the reviewer has received the information sent to avoid any possible misunderstandings?

Finally, with regard to providing the information to the medical reviewer, confidentiality is paramount in preserving trust between patients and doctors. Doctors must have guarantees that all documents provided to the medical reviewer are secure in transit, be that electronically or by other means, to avoid any distress to relatives and preserve the dignity of the dead.

On a positive note, we entirely support the section relating to where a person has died outwith Scotland and the section making it an offence to dispose of a body or body parts without authorisation. With regard to other parts of the Bill, we hope to be closely involved in any changes to the medical certificates of cause of death and welcome the pledge of training for those who are required to complete them.

**Conclusion**

The BMA has real concerns regarding whether this Bill would provide improved public protection given the lack of real-time scrutiny, and the minimal level of that scrutiny. Furthermore, we have doubts regarding costs and would question the decision to remove two doctors’ signatures from about 67% of death certificates, where the deceased is to be cremated, despite the fact that one aim of the Bill is to provide improved safeguards and increased public confidence in the system.

We believe the medical reviewer system is less robust and not as comprehensive as the current system or the scheme being introduced in England and Wales. Indeed, there will in fact be a two tier system in the UK, and it is doubtful that this would reassure the Scottish public. We are by no means saying the current system is perfect, however we should take this chance to change the certification of death for the better and not implement inadequate and unsafe changes to save money.

Please do not hesitate to contact us if you should require any further information.

Dr Charles Saunders  
Deputy Chairman  
BMA Scotland  
12 November 2010
Certification of Death (Scotland) Bill

Consumer Focus Scotland

General comments

Consumer Focus Scotland welcomes the opportunity to submit evidence on the Certification of Death (Scotland) Bill. Our former Director, Martyn Evans, was a member of the Burial and Cremation Review Group and we are pleased that the Bill is now taking the Group’s recommendations forward. We agree with the general principles of changing the legislation in order to meet the needs of the people of Scotland in the 21st century, removing some of the burden of costs that are currently incurred, and facilitating the availability of affordable local burial or cremation.

Consumer Focus Scotland also believes that any new Scottish legislation should align with policies across the rest of the UK so that no cross border difficulties are created.

As a consumer organisation, we have a particular interest in ensuring users are at the heart of public services and we have a commitment to work on behalf of vulnerable consumers. The consumers of death certification, burial and cremation services, i.e. the families of the deceased persons, may be considered vulnerable by the very nature of the circumstances in which they find themselves. During what is inevitably a time of considerable emotional difficulty and stress, it is vital that services operate in a clear and consistent way and that these consumers’ needs are given paramount importance. We have therefore limited our comments to the provisions in the Bill which are most likely to have a direct impact on consumers.

Policy objectives and aims of the Bill

We agree with the proposed changes to the system of death certification in Scotland. This system will be more financially sustainable, proportionate, and will avoid undue delays being experienced by bereaved families arranging a funeral.

Consumer Focus Scotland is supportive of a new system that will ensure a single system of independent, effective scrutiny applicable to deaths that do not require a investigation by the procurator fiscal. A common method of certification and review regardless of the method chosen for disposal (i.e. burial or cremation) will remove the differential treatment of burials compared to cremations, and people who have traditionally paid for cremation forms to be signed will no longer be charged this levy. We believe that this corrects the potentially unfair situation currently in existence.

Sarah O’Neill
Head of Policy
Consumer Focus Scotland
18 November 2010
Certification of Death (Scotland) Bill

COSLA

General Principles

1. COSLA supports the general principles of the Death Certification (Scotland) Bill and recognises the need to ensure that appropriate measures are in place to safeguard the public through improving the quality and accuracy of cause of death forms and ensure appropriate scrutiny of deaths in Scotland. To that end, the move to renew the process and scrutiny of death certification through legislation is welcome.

2. The proposals for changes to death certification, in particular the channel through which fees are to be collected, have been discussed by COSLA’s Health and Well-being Executive Group, which is comprised of an elected member from each of Scotland’s councils.

3. Although the group is generally supportive of the protection the new legislation intends to provide, serious concerns were expressed on the specific issue of the Death Certification Fee and there are a number of details concerning the proposal to require a separate charge for death certification and the suggestion that collection of this charge be done by local authority registrars, which we are unable to support.

4. However, it is our view that the Bill, if passed, is unlikely to generate significant financial pressures for local Government, because local authority practices will not be radically altered by the terms of the proposed legislation. If this analysis proves to be incorrect, COSLA and the Scottish Government will work together, within the terms of the concordat, to assess how any significant new pressures arising from the proposed legislation might best be accommodated.

5. In view of the extremely short timetable scheduled for this bill we would like to reserve the option to make further comment if, as our understanding of the Bill develops further, significant additional implications for local authorities become apparent.

Implications for Local Government Registrars

6. Death Certification – Fee Collection
   Since registration became compulsory in 1855 one of the founding principals on which the statutory requirement to register all deaths has been based is that registration should be free of charge. Whilst technically the monies being discussed herein are termed ‘certification’ fees, if collected through the registrar function of the council it will inevitably be perceived as the fee for registering a death and may discourage people from doing so.

7. At present registration of a death adheres to this founding principle and is free. This means that the ‘informant’ is issued with an abbreviated death certificate, a form to allow the funeral to take place, and a form for social security purposes all at no cost.

8. The term ‘certification fee’ is slightly misleading as it implies a charge to cover administrative costs rather than to pay for the process of scrutiny
and ensure it is self funded. The scrutiny function itself is a function of local health boards. It seems questionable to expect local authority registrars to take on the additional work required to collect this fee particularly at a time when economic constraints mean that local government is far from being in a position to have the additional capacity to take on further administrative functions on behalf of the Scottish government.

9. Currently a small fee of £9 is charged only if the informant requires a ‘full extract death certificate’. Introducing a requirement to collect a compulsory fee as part of this process is likely to cause difficulties, particularly among those clients unable to afford to pay the fee. It is also unclear how payment of the fee will be handled in cases where a non-relative (e.g. police officers, nursing home administrators etc) is required to register a death.

10. There are also concerns associated with non-payment and expediting debts of such small amounts and the negative perceptions and consequences such work would have on registrars. Whilst initial suggestions indicate that any short-fall in the cost of collecting the fees compared with the administration element of the fee collected would be reimbursed by the government it is not clear if this would include the overall cost of recovering un-paid fees.

11. There is also concern about a lack of detail about addressing the practical issue regarding the release of a cadaver in the event of non-payment of the fee if no certificate is issued due to non-payment of fee.

12. We understand that the Association of Registrars of Scotland (whose elected Executive Council comprise 12 local authorities) have indicated that they do not welcome this additional role, not least due to the fact that this will not be popular with the public and will be seen as a ‘death tax’ being collected by local authorities.

13. Scrutiny – Costs & Funding
We appreciate the desire that the proposed new system should be self funding but note that at an estimated £1.2m, the overall costs of running the new scrutiny and certification system will be lower than for the existing system; which currently costs £4.9m; a saving of £3.7m.

14. We are informed that individual transactions will comprise a fee of £30 which is a significant increase on the £9 currently charged for a full extract. From the £30 collected the Scottish Government will pay local authorities an administration fee of £11 per transaction and that there will be a fund of £85,000 for start-up and training.

15. We also note the requirement for six new Scottish Government posts to perform the statistical element of the scrutiny function and that there would no-longer be a need to employ medical ‘referees’ which are required to allow cremation since the system will be uniform regardless of the method of interment; the creation of new posts might be a delicate matter during this post recession period.

16. Currently, when a cremation is planned, the death certification fee is collected by undertakers, as part of the overall cost of funeral arrangements. The certification fee element is then passed to the relevant health board. We see no reason why this existing structure cannot be used to collecting the fees required to fund the new system.

17. We would urge the Health & Sport Committee to consider alternative approaches to funding the new scrutiny system rather than asking the
general public to pay up front at the point of registration during these times of economic constraint. There are alternative options which could be used to fund the new scrutiny system including direct funding from the Scottish Government.

Conclusion

18. Whilst no one would deny the need for a scrutiny system for death certification which provides adequate safe-guards to protect the public, the funding required for such a system could be provided through direct funding from the Scottish Government.

19. It might appear convenient that fees be collected through the registrar function of local councils but there are a number of difficulties which would arise concerning principles, practicalities and perceptions – listed above.

20. COSLA has considered the issues and wishes to resist any move which would require local authority registrars to collect death certification fees.

Garrick Smyth
Policy Manager
Health & Social Care Team
COSLA
19 November 2010
Certification of Death (Scotland) Bill

Cruse Bereavement Care Scotland (CBCS)

Background

CBCS is the national voluntary organisation whose focus is the wellbeing of bereaved people in Scotland. It has nearly 400 trained volunteers. Last year they provided around 40,000 hours of service, including over 8000 hours of one to one support to 3000 bereaved people across the country and a national phone line (0845 600 22 27).

CBCS Response

CBCS welcomes a number of key aspects of the current Bill, including its potential for increased responsiveness to the needs of bereaved people, who may seek the review of medical certificates of cause of death, and for the potential reduction in delay involved in opting for cremation. CBCS believes the Bill offers the bereaved greater clarity and confidence in the certification of cause of death.

CBCS also welcomes the specific responsibility for training placed on the medical reviewers. CBCS believes it will be important that those involved in the review process – doctors and registrars - should have suitable training in dealing with the bereaved. CBCS has considerable experience of training its volunteers and others in this area, and would be very willing to assist further.

CBCS seeks reassurance that the Scottish Government will ensure sensitive delivery of proposals in the Bill. The provisions for selective review on a random basis, and for the medical reviewer to select other cases for review, could potentially result in delay in a funeral, which could be very distressing for the bereaved. CBCS asks that they be administered so as to cause no more delay than strictly necessary and suggests specified time limits should apply in all but exceptional circumstances.

CBCS believes it is important that in developing the administrative processes around what is inevitably a distressing event, an awareness of and sensitivity to the needs of the bereaved should remain a primary consideration in the Government’s approach.

Alan Fraser
Chairman
Cruse Bereavement Care Scotland (CBCS)
4 November 2010
Diabetes UK Scotland

Diabetes UK Scotland is one of Scotland’s largest patient organisations. Our mission is to improve the lives of people with diabetes and to work towards a future without diabetes through care, research and campaigning. With a membership of over 11,000, including over 600 health care professionals, Diabetes UK Scotland is an active and representative voice of people living with diabetes in Scotland. We welcome the opportunity to submit evidence to the Health & Sport Committee on the Certification of Death (Scotland) Bill.

What is diabetes?

Diabetes is a common life-long health condition. There are 228,000 people diagnosed with diabetes in Scotland and an estimated 60,000 people who have the condition but don’t know it.

Diabetes is a condition where the amount of glucose in your blood is too high because the body cannot use it properly. This is because your pancreas does not produce any insulin, or not enough, to help glucose enter your body’s cells – or the insulin that is produced does not work properly (known as insulin resistance). If you have diabetes, your body cannot make proper use of this glucose so it builds up in the blood and isn’t able to be used as fuel.

Diabetes is a serious condition that, if not treated properly, can lead to some very serious complications, such as heart disease, stroke, kidney disease, blindness and amputation.

Summary of main points

- statistics based on death certificate data seriously underestimate mortality from diabetes
- recording diabetes on the cause of death certificate is low in Scotland compared, for example, to Sweden and New Zealand
- excess global mortality attributable to diabetes is three times higher than suggested by international statistical reports mostly based on death certificates

General principles of the Bill

Our comments are focused solely on the principles of the Bill and, in this context, we welcome the Bill as an opportunity to reflect the impact of diabetes on mortality in Scotland and to help drive diabetes-related health policy and provision.

Diabetes was the underlying cause of 730 deaths in Scotland in 2008 and contributed to a total of 4,052 deaths\(^1\). However, statistics based on death
certificate data seriously underestimate mortality from diabetes, because the ultimate cause of death is usually from complications that are not uniquely related to diabetes.

The impact of diabetes on mortality is well known. Despite this it is difficult to achieve an accurate picture of the number of deaths that can be attributed to diabetes, owing to poor death certification recording. We, therefore, welcome the Certification of Death (Scotland) Bill as an opportunity to address this issue through its aim to improve quality and accuracy of ‘medical certificates of cause of death’ forms in order to: improve public health information; and help ensure that public health resources can be directed where needed.

We know life expectancy can be reduced by more than 20 years in people with Type 1 diabetes and up to 10 in people with Type 2 diabetes. We also know the long term complications of the condition have a major impact on mortality:

- Kidney disease accounts for 21 per cent of deaths in people with Type 1 diabetes and 11 per cent in people with Type 2 diabetes
- Within five years of an amputation as a result of diabetes up to 70 per cent of people will die
- Cardiovascular disease accounts for 44 per cent of fatalities in people with Type 1 diabetes and 52 per cent in people with Type 2.
- Patients with diabetes have an increased risk of all-cause and a higher risk of cardiovascular mortality in every age/sex group, evident after only 2 years of diagnosis, compared with patients without diabetes (Type 2 DM, Tayside).

Despite this, poor death certification recording means that it is difficult to achieve an accurate picture of the number of deaths that can be attributed to diabetes. The Yorkshire and Humberside Public Health Observatory states: “clinical coding practice means that only a minority of deaths among people with diabetes from causes that can be associated with the disease have diabetes identified as the primary cause of death.”

The UK prospective diabetes study found that diabetes was reported on 42% of all death certificates and on 46% of those with underlying cardiovascular disease causes (considered still low). This recording was associated with social class, age, underlying cause and it may be lower in certain ethnic groups. The study called for a need to raise awareness in clinical practice of the importance of diabetes as a risk factor for cardiovascular death.

In 2008, researchers examined the death certificates of 1,872 people with type 2 diabetes in Tayside. This study showed that less than half (42.8%) of the patients with type 2 diabetes had any mention of diabetes on their certificate, even among people with cardiovascular disease as the underlying cause of death. The authors suggest that diabetes is under-recorded.
The rate of recording diabetes on the cause of death certificate is low in comparison to Sweden\(^i\) (57\%), and New Zealand\(^ii\) (55.1\%).

Other research has highlighted endocrinologists may be more likely to report diabetes mellitus as underlying cause of death than cardiologists and nephrologists\(^vii\).

Complex methods have been developed for estimating cause-specific mortality for some conditions - AIDS, tuberculosis - but not for diabetes. The World Health Organisation Global Burden of Disease Project modelled worldwide data from 2000\(^viii\). This estimated that the excess global mortality attributable to diabetes is three times higher than suggested by international statistical reports mostly based on death certificates. This moves diabetes from the eighth to the fifth place in cause of death ranking. The number of excess deaths attributable to diabetes is similar in magnitude to numbers reported for HIV/AIDS in the year 2000.

The British Heart Foundation (2009)\(^ix\) estimates that five times as many deaths are indirectly attributable to diabetes as directly attributable; about 35,000 deaths a year in the UK attributable to diabetes – about one in twenty of all deaths.

**Conclusion**

Diabetes is a growing public health issue in Scotland. The number of people with type 2 diabetes has doubled over the past 10 years and is expected to grow to near 400,000 by 2030. Capturing accurate data on diabetes-related mortality improve public health information and help ensure that public health resources can be directed where needed.

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East Ayrshire Council have considered the Certification of Death (Scotland) Bill and would like to comment as follows.

1. **Do you agree or disagree with the general principles of the Bill?**

   East Ayrshire Council supports the introduction of the new Bill and the principles of the Bill. This Bill was brought about as part of a wider review on burial and cremation in Scotland which was discussed by a review group from 2005 – 2007. This Council welcomes the improvements made in this Bill relating to the certification process, however, it would also like to remind Ministers that it is equally important to ensure that other recommendations relating to burial and cremation as contained within the Review Group’s findings identified in the Scottish Government Death Certification Burial and Cremation analysis of consultation findings Phase 2 report 2010 are brought forward at the earliest opportunity as these would bring a modern service to Scotland. The burial law at present dates back to 1855 and it is important to update all aspects not only certification of death.

2. **Do you agree with the proposed changes to the system of death certification in Scotland?**

   Yes because disposal of the body cannot go ahead without authorisation. The introduction of a medical review team is to be welcomed and will go some way towards addressing the concerns of the public and practitioners which came to light after the Shipman case. The changes will bring about a robust checking system that will be delivered by way of random checks across the country as well as monitoring for patterns of death within the health service either in hospitals or GP practices. We would suggest that Ministers continue to monitor the work of the medical review team and that results are routinely analysed. This would increase confidence in the system and would ensure best use of resources. We support the introduction of a harmonised certification system that is in place to cover burial and cremation.

3. **Do you agree with the proposed creation of a system of Medical Reviewers?**

   Yes.

4. **Do you have any comments on the costs identified in the Financial Memorandum?**

   We would expect there would be additional costs in identifying, forwarding and processing documents for random sampling and for
training staff. There is also going to be an increased burden and responsibility on registration staff. We would recommend that a fee be set by the Scottish Government for each local authority to charge in respect of an administration fee so that the same level of fee would be applied throughout Scotland.

5. Are there any other comments you wish to make on the Bill?

We would comment on specific sections of the Bill as follows.

- Section 2 – We would recommend there should be specified areas of possible concern highlighted in the guidance or regulations which would serve as a checklist for registrars to assist registrars in identifying which Certificates to refer for review. We would also recommend that steps be taken to amend the Medical Certificate Cause of Death to include a Section whereby the Medical Practitioner would confirm having advised the family of the deceased/informant of the review process, random check and the registration fee.

- In relation to Section 5 it appears there may be some confusion for registrars on whether or not to register a death. There may also be issues with requesting a review not to stay a Registration. Registrars should be given specific guidance about the circumstances in which a request to review a stay of registration may be made by a qualified informant.

- In relation to Sections 11(8)(b) and 11(9)(b) – If the matter is referred to the Procurator Fiscal for investigation we would suggest the Registrar should also be informed of this step and this should be specified in the legislation.

- In relation to Section 19 – We would recommend that there be specific provision for training for Registrars. This could also be provided by the medical reviewer.

- In relation to Section 23 – We understand there is ongoing debate about who would collect the fee. Consideration has been given to collection by the Burial Authority. From our perspective this would raise issues where a death is reviewed in Scotland but the body cremated or interred elsewhere. There would therefore be no fee collected. Also, there may be a lack of co-operation where private cemeteries and cremation companies are concerned because of the additional time and cost burden on collection. Careful consideration would then need to be given to permit a consistent charge across the country. We would recommend the appropriate method of collection of this type of fee is by the Registrar. This would ensure all fees are paid in Scotland as everyone will be required to register the death in this country. We would also recommend that no fee be chargeable in cases of stillbirth or children of sixteen years or under. We would strongly support Scottish Government imposing the level of fee and administration fee to be recovered by the Local Authorities. We would recommend the administration fee be set at a level which reflects the true cost to the Local Authority of carrying out this work.
Response prepared on behalf of East Ayrshire Council by Robert McCulloch, Outdoor Amenities Manager with responsibility for Bereavement Services; Catherine Dunlop, Senior Registrar and Avril Forrest, Solicitor all East Ayrshire Council, Council Headquarters, London Road, Kilmarnock.

Avril Forrest
Solicitor
Legal Services
East Ayrshire Council
16 November 2010
Certification of Death (Scotland) Bill

Edinburgh Crematorium Ltd

Edinburgh Crematorium Ltd agrees in principal with the Scottish Government’s decision to overhaul the certification of death legislation; however we disagree with the current proposals on two issues:

1. One of the stated aims of the proposed method of Death Certification is to provide a "single system of independent, effective scrutiny of deaths that do not require Procurator Fiscal investigation". One of the Procurator Fiscals’ sources of information for investigation of deaths is from the medical profession, who are required to notify him in specified instances. A second stated aim of the proposed method of Death Certification is to "deter criminal activity/malpractice (indirectly)".

   Under the current system Cremation Form B asks whether or not the Procurator Fiscal has been notified of a reportable death. All Form B's are scrutinised and in the process of doing so it is common to come across reportable deaths that have not been notified to the Procurator Fiscal. The doctor responsible is then contacted and advised that the death must be reported. The Medical Referee will not authorise cremation until this has been done.

   It does not seem credible that the proposed system can act as a deterrent to malpractice of this type when the planned level of scrutiny is 1-2%.

2. Under the current system, when a person dies abroad and the body is to be cremated, the Scottish Government give written authority to the Medical Referee, at the relevant crematorium, to authorise the cremation.

   Under the proposed scheme, when cremation is required, the Medical Reviewers determine whether it is safe to cremate the body. Deciding on the validity of the paperwork accompanying the deceased for both burial and cremation is to be the responsibility of those in charge of the place of burial or cremation. The policy memorandum that relates to the Certification of Death (Scotland) Bill states that “the disposal is authorised by the correct certification (which for deaths outside Scotland is likely to be certification equivalent to the MCCD and the certificate of registration of Death).”

   There is no definitive list of burial grounds in Scotland and so the exact number of cemetery staff who this responsibility is to be delegated to is unquantifiable. What is certain is that most of these people have no medical training and so are not qualified to make a decision on whether or not they have received the correct certification. It will be an offence to dispose of a body or body parts without authorisation, so these staff are likely to face untenable situations.
To be effective the decision making must remain central and logically be given to the Medical Reviewers. They have ready access to the Senior Medical Reviewer, to discuss and decide on a consistent course of action, for those occasions when the documents do not fully comply with the requirements.

Jim Nickerson
General Manager
Edinburgh Crematorium Ltd
18 November 2010
The Faculty of Forensic and Legal Medicine welcomes the opportunity to respond to the above consultation. The faculty was established in 2006 by the Royal College of Physicians of London and has been founded to achieve the following objectives:

- To promote for the public benefit the advancement of education and knowledge in the field of forensic and legal medicine.
- To develop and maintain for the public benefit the good practice of forensic and legal medicine by ensuring the highest professional standards of competence and ethical integrity.

The faculty includes three different professional groups:

- Forensic physicians
- Medically qualified coroners
- Medico-legal advisers to the medical defence organisations

We are disappointed that more of the original recommendations of the medical members of the working party have not surfaced in the Bill; nevertheless, we are strongly supportive of any measure to make simpler the procedures surrounding death and the disposal of the deceased so long as certain aims are retained:

- The central importance of the cause of death to be stated as accurately as possible; this serves two purposes
  a) the epidemiological needs of public health are satisfied
  b) the family’s insured interests may be settled promptly
- A transparent, reliable system will give some assurance to the family in most instances that care was properly directed by medical staff; where the cause given does not accord with the family’s understanding there is a document founding any inquiries
- Publicity surrounding the new procedure should add new confidence in the reliability of information
- Fees should bear a close relationship to the costs of the system

We believe it likely that many defects in documentation will be venial. Such a belief is strengthened by experience with the new system of authorising cremation in England and Wales; the initial care in certification has been diluted. There is no reason to think that low level error cannot be spotted by a support officer and corrected without reference to the reviewer (such work would, of course, need to be supervised).

The 2% figure for scrutiny seems very small, but statistical advice to the working party suggested that such a low figure was as likely to act as a salutary threat to medical practitioners as several times that level. It is the
view of the faculty that the deterrent effect from this should help reassure the public albeit we do not believe the proposed system is as robust as that which is proposed for England and Wales. We would also recommend that the efficacy of the new system is periodically reviewed to ensure that the desired results are achieved.

We comment on the explanatory notes page 8 §48 [and the related section 16] and page 10 §59 ff [and the related section 24]. It may improve the Bill to make it clear that the responsibility for authorising disposal lies solely with the procurator fiscal (at present, the relevant Form E(1) may be ignored by the medical referee, particularly where the cause of death has not been ascertained at post-mortem). It is not clear from §62 if it to be the registrar’s function to seek further information. If this were deputed to the reviewer s/he would have an opportunity to speak to the delinquent doctor, in the first instance as an educational device, but with admonition if the doctor fails to co-operate.

We would also opine that a primary function of the senior medical reviewer is educational, alongside the role of promoting better clinical governance than presently exists, by improving the accurate certification of death. In addition, active liaison with the Crown Office Procurator Fiscal Service to enhance overall investigation of sudden, unexpected death should be part of the senior medical reviewer’s remit.

The faculty will be happy to provide any further clarification necessary in respect to these comments.

Dr C George M Fernie
Registrar
LLB, MB ChB, MPhil, FFFLM, FRCGP, DFM

Dr W D S Mclay
Fellow
OBE, MB ChB, LLB, FRCS, FFFLM

Faculty of Forensic and Legal Medicine
14 November 2010
Certification of Death (Scotland) Bill

Ishbel Gall

Do you agree or disagree with the general principles of the Bill?

In principal improving the quality of what is written on a Medical Certificate of Cause of Death (MCCD) and being able to identify the registered medical practitioner who has issued said MCCD is a good idea. More information about the deceased would also be welcome.

A more accurate system of death certification would certainly impact positively on planning future healthcare needs and workforce, but it does not appear that this proposed Bill will address these matters and the robustness of the proposals has to be questioned.

Review of such a low number of MCCDs will not improve practice and will impact more on those working within the hospital setting rather than in General Practice.

It appears to create an extra layer of legislation which does not positively enhance the current system.

Do you agree with the proposed changes to the system of death certification in Scotland?

Personally I strongly disagree with the proposed changes as they will delay many funerals whilst not providing any discernable improvement in death certification. Currently there are at least three doctors involved before a deceased can be cremated and it is often when the second doctor examines the deceased that information comes to light which needs further investigation or explanation. Cases which need to be reported to the Procurators fiscal, implants which need to be removed or expected deaths which are not as straightforward as it first seems are common. Often these issues can however be resolved fairly quickly by discussions with a few key people.

If a death is registered then there is no barrier to cremation and unless the death is randomly selected for review prior to registration many people may be cremated without adequate scrutiny of the circumstances or cause of death. Even with review of the MCCD this can never replace an examination of the deceased to exclude anomaly with the given cause of death.

In Grampian region 70% of deaths where the home address is outwith Aberdeen City are burials, and I would anticipate a delay in funeral arrangements being made which at weekends and public holidays will exacerbate storage problems.

If the death requires being successfully registered prior to the deceased being removed by the funeral directors where are all the deceased going to be
stored? Hospital and Local Authority mortuaries will not be able to cope. In rural areas where burial within a few days of death is still commonplace, anticipated delays will cause serious storage issues as well as have an emotional impact on the bereaved.

Those dying at home or in the community will require storage in a suitable facility; will this be a local authority issue? Many funeral directors do not have refrigeration and rely on embalming or similar to delay decomposition but this surely will not be acceptable if there is a possibility the death may be reviewed. Where will these Medical Reviewers be based and how often will they be required to view the deceased? In rural areas the movement of medical notes and possibly the deceased may prove very costly.

It has been suggested the proposed Bill will speed up the release of those deceased who are to be cremated but this will not happen in areas where cremation papers are completed within 24 hours of request.

**Do you agree with the proposed creation of a system of Medical Reviewers?**

In the proposed Bill it is unclear exactly how the Medical Reviewer system fits with current legislation. Currently deaths have to be reported to the Procurator fiscal for a wide variety of reasons and any interested party can do this. The Procurator fiscal will ask for an investigation and after considering the facts will decide whether a post mortem examination is required. The Medical Reviewer has to go through a discussion process if they do not agree with what is written on the MCCD and ultimately they too will report the death to the Procurator fiscal after reporting to the Senior Medical Reviewer if the Registered Medical Practitioner will not amend the MCCD.

The fact that once a death is registered cremation will be able to take place without any further examination of the deceased seems to be a retrograde step and decreases confidence in the system rather than making it more robust.

In the proposals for deaths outwith Scotland it would be more appropriate for a thorough examination of the deceased to be included as well as reviewing of any available medical notes in order to exclude any reason for the cremation not being able to take place. Deaths abroad are sometimes examined by authorised, or hospital, post mortem as the deceased was enrolled in a GP practice in Scotland and the Procurator fiscal has no interest in further examination but the family are keen for a more accurate cause of death. Deceased being repatriated are usually embalmed so toxicology and microbiology often yield little information.

**Do you have any comments on the costs identified in the Financial Memorandum?**

The costs outlined in the financial memorandum are low which suggests that the true costs may be much higher if the proposals are to have any effect.
Associated costs may be much higher than anticipated especially in rural areas where logistics mean greater travelling distances.

The costs to NHS Boards and Local Authorities regarding body storage will impact heavily on their budgets and the biggest factor is probably the monetary and emotional costs to the bereaved who may have travel long distances to collect MCCDs and visit registrars and/or Medical Reviewers. In many cases these people will be elderly and there may be transport issues.

**Are there any other comments you wish to make on the Bill?**

As an example of the impact of proposals the following may illustrate some of the issues regarding delays and body storage:

Mrs X aged 87 years, from *Ruraltown* dies in Aberdeen Royal Infirmary on Thursday afternoon at 1630, the death is not unexpected and a MCCD is issued stating she has died of bronchopneumonia with a background of COPD and left ventricular hypertrophy. There is no reason for the procurator fiscal to be notified and the clinicians have not requested a post mortem examination.

**Under the current legislation:**

Funeral director contacts hospital mortuary at 8am on Friday to confirm MCCD has been issued and asks mortuary staff to collect said MCCD from the ward as family have no transport and are too upset to come into Aberdeen. Funeral director intimates they are coming to collect Mrs X immediately.

Funeral director collects Mrs X at 10am and returns to *Ruraltown* with MCCD for family. Family register the death at 3pm on Friday afternoon and all the arrangements have been made for Mrs X to be buried in *Ruraltown* her funeral taking place at 11am on Monday morning.

Time in mortuary ~ 16 hours

**Under the proposed legislation:**

Funeral director contacts mortuary at 8am on Friday to confirm that the family of Mrs X have been in touch with him and that she is to be buried in *Ruraltown*, no date arranged as they want to wait for successful registration of death and they have no refrigeration at their premises. Husband has to wait until Friday lunchtime for a lift through to Aberdeen to collect the MCCD and he finally arrives back in *Ruraltown* just after 4.30pm. Registrar will not be open until Monday morning. Mr X finally gets to the registrars at 12pm on Monday and registers his wife’s death. He is given the Form 14 by the registrar and he takes this to the funeral director after lunch. It is too late for the funeral director to travel through to Aberdeen on Monday afternoon so they do not collect Mrs X until 10.00am on Tuesday morning. Mrs X is finally buried on Wednesday morning.
Under the proposed legislation, with investigation of death:

Funeral director contacts mortuary at 8am on Friday to confirm that the family of Mrs X have been in touch with him and that she is to be buried in Ruraltown. Husband has to wait until Friday lunchtime for a lift through to Aberdeen to collect the MCCD and he finally arrives back in Ruraltown just after 4.30pm. Registrar will not be open until Monday morning. Mr X finally gets to the registrars at 12pm on Monday and tries to register his wife’s death. He is given the news that this MCCD has been randomly selected for further scrutiny and will need to be submitted to the Medical Reviewer before the death can be registered. (Does the MCCD have to be sent to the Medical Reviewer causing more delay or can this be done electronically?)

Medical Reviewer tries to contact Mrs Xs GP with whom she has been registered for the past 25 years but he is on holiday and his partner has never met the deceased as she didn’t like to cause a fuss by troubling her doctor. Medical Reviewer then gets caught up in another MCCD Review and it is soon 5pm on Monday. Tuesday morning the Medical Reviewer contacts ARI to speak to the doctors who treated Mrs X prior to her death. The junior doctor is on two days leave as she worked the weekend and the Consultant is in a clinic, no-one else is available to speak to the Medical Reviewer. Message is left for the Consultant to speak to the Medical Reviewer when clinic is finished.

The Medical Reviewer finally speaks to the Consultant at 3pm on Tuesday and requests to view Mrs Xs medical notes. Luckily the Medical Reviewer is based in Aberdeen so arrangements are made for the notes to be taken to their office but as it’s now late afternoon they won’t be with the Medical Reviewer until Wednesday morning. After reading the medical notes and speaking to Mr X on the telephone the Medical Reviewer is happy that the MCCD can be accepted by the registrar and the death registered, it is now 3.30pm on Wednesday. The mechanism for the Medical Reviewer signing the MCCD once approved is unclear, but I am assuming this can be done electronically and does not mean more delay; the registrar is then informed the death can be registered.

Mr X returns to the registrar on Thursday morning and is given the Form 14 by the registrar and he takes this to the funeral director after lunch. It is too late for the funeral director to travel through to Aberdeen on Thursday afternoon so they do not collect Mrs X until 10.00am on Friday morning. It was too late to arrange a burial for the Saturday so Mrs X is finally buried on Monday morning 11 days after her death.

Time in mortuary ~ 4 days & 16 hours
Funeral delay ~ 2 days

Time in mortuary ~ 7 days & 16 hours
Funeral delay ~ 7 days
This is an illustration of what may happen if the legislation is brought in as proposed, I don’t think it is an over exaggeration of reality in rural areas. Most of the people from Orkney and Shetland who die on the mainland are sent home accompanied by their MCCDs, how is the proposed legislation going to impact on their relatives; will someone have to travel to the mainland to register the death? Similarly deaths from the Highlands will be affected.

Delays for those people who are being cremated are not that long in some areas as many wards have a policy of trying to complete the forms within 24 hours of request. If the ward knows the patient is to be cremated then often the paperwork is done immediately so no delay at all.

All the deceased that are uncertified because they die out of hours will have to wait in a local authority mortuary until the family have successfully registered the death. In many of these cases the GP writes the MCCD without viewing the patient after they have died as the deceased is in Aberdeen and they are over 50 miles away.

Will an MCCD being accepted for registration still mean the body can be cremated without further examination? That does not appear very robust to me.

Provision of MRs sounds inadequate and what is proposed to cover annual leave and other absences? Periods such as Christmas and New Year where capacity is tight anyway will be even more problematic. Currently storage is freed up as all those for burial can be released, many still going home to rest, cremation papers done quickly so those people can also be released as soon as possible. This year for example we find 25th December is a Saturday so it is likely that a MR would be unavailable from the afternoon of the 24th December through until the 29th December then closed again from the afternoon of the 31st December through until the 5th January. Seeing as how this is often the busiest time of year it would cause many problems with storage.

In response to a previous enquiry I was given the following answer regarding storage:

_Bodies currently can, and are usually, released from hospital mortuaries to the funeral directors whilst the paperwork is being sorted. As the bodies are, in most cases, not being viewed, this practice can continue while the random scrutiny takes place. The National Association of Funeral Directors confirmed that in Aberdeen the average wait between death and funeral taking place is 9.9 days._

I would argue that the deceased are not released without a MCCD being completed; confirmation there is no Procurator fiscal interest, no family complaint or conflict and that if the deceased is to be cremated the appropriate cremation forms. The average length of time for a funeral in Aberdeen may be 9.9 days but this figure must include deaths investigated by the Procurator Fiscal and the delays previously caused by inadequate
cremation facilities. Aberdeen City Crematorium was upgraded earlier this year.

Where toxicology or further investigation is required by the Procurator fiscal a delay of up to 21 days or even longer is possible. Burials take on average 3 - 4 days and burial accounts for a significant number of disposals in rural areas and the Highlands and Islands. Outwith Aberdeen city most funeral directors do not have any refrigeration so would not be removing deceased until they knew when the funeral was to take place. Viewings at NHS facilities would increase if the deceased were staying there for longer. I have spoken to several of the funeral directors in the area and they have indicated that under the new proposal they would not be collecting the deceased until after registration because they themselves do not have facilities for storage and they would not make any arrangements until the family produced the Form 14.

Again in response to a previous query: Will there be a requirement for the Registered Medical Practitioner to examine the deceased prior to issuing the MCCD, currently there isn’t, so if this does not change under these proposals a body could be cremated without ever having been examined?

No, there is nothing in the Bill that requires or empowers the medical practitioner to examine the deceased prior to issuing the MCCD but the certifying doctor is often the person who last attended the deceased during his/her last illness and is aware of the person’s medical history.

It is worrying that the MCCD can be issued without the person issuing the certificate ever having examined the deceased and no further examination required prior to cremation. This system seems much less robust that what we have in place at the moment. In effect someone could PLE and then the body be cremated without a registered medical practitioner having ever examined the deceased. Currently as least two registered medical practitioners examine the deceased prior to a cremation.

Ishbel Gall (personal submission) [Vice Chair AAPT]
18 November 2010
Certification of Death (Scotland) Bill

General Medical Council Scotland

Thank you for your invitation to respond to the Health & Sport Committee’s call for evidence on the Certification of Death (Scotland) Bill. We are pleased to respond.

We have little substantive to add to our response the Government’s initial consultation on the Bill. We are content with the principles of the Bill, with the proposals in respect of the death certification procedure and medical review. We particularly support the strong links to clinical governance structures which are contained in the Bill.

If you have any questions regarding this response please contact me.

Jane Malcolm
Head of Scottish Affairs
General Medical Council Scotland
18 November 2010
Certification of Death (Scotland) Bill

Glasgow City Council

Do you agree or disagree with the general principles of the Bill?

With reference to the above Bill, the Registration Service in Glasgow welcomes the proposals.

Do you agree with the proposed changes to the system of death certification in Scotland?

Changes made to the Form 11 (Medical Certificate of cause of Death) will greatly assist Registrars in carrying out their duties in regard to registering a death. The Doctor’s unique identifying number is a welcome addition and will provide consistency to the Registrar in regard to the Doctor’s details.

Do you agree with the proposed creation of a system of Medical Reviewers?

The proposed creation of a system of Medical Reviewers will provide a scrutiny and safeguard arrangement that does not currently exist.

Do you have any comments on the costs identified in the Financial Memorandum?

Costs to the bereaved relative should be kept to an absolute minimum. There is a danger that if Local Authorities are responsible for collecting the universal fee (currently proposed at £30) that it will be seen as a “death tax”, particularly if collected at the point of registration. The public may well be confused by this and see it as a fee being attributed to registering the death.

Darren Keenan
Corporate Policy Officer
Glasgow City Council
5 November 2010
The Scotland and Northern Ireland Branch of the Institute of Cemetery and Crematorium Management would like to make the following comments:

**Medical Reviewer System**

The members of the branch do not agree with the proposed adoption of the Medical Reviewer model. We feel very strongly that the Scottish Government should opt for the Medical Examiner model [paragraphs 19 & 20 of the Policy Memorandum]. We feel that it is imperative that every death registered in Scotland should be subject to a basic level of scrutiny. Informed by our experience with cremation medical certificates, we believe that only a scrutiny of every MCCD will ensure that these certificates are fully and correctly completed.

We believe that the system as proposed will be less robust than the system it is replacing and less robust than the system in England & Wales [paragraph 107 of the Policy Memorandum]. We wish to express our concern that this latter point could lead to problems where a death is registered in Scotland with disposal to take place in England.

Paragraph 16 of the Policy Memorandum states that the proposed system “should also act as a deterrent to criminal activity or malpractice”. We fail to see how a random sample of around 1 – 2% can have such an effect.

**Deaths Occurring Outside Scotland**

Under the proposed system, the onus of ensuring (a) that a medical certificate equivalent to the MCCD has been produced and (b) that the death has been properly registered will fall on the person having charge of the cemetery or crematorium. The Branch feel that it is inappropriate that this responsibility should be placed on a medically-unqualified member of staff, bearing in mind the penalties to be introduced for disposing of a body without authorisation. This is particularly so in the case of a small cemetery which is rarely used and which will normally be administered by someone whose primary responsibilities lie elsewhere.

Paragraph 16 of the Policy Memorandum states that one of the policy aims of the Bill is “to introduce a single system of independent, effective scrutiny”. We do not see how leaving responsibility to a member of staff of the cemetery/crematorium can accord with this aim.

**Body Parts**

Paragraph 9 of the Explanatory Notes states that it will be an offence to
dispose of a body or body parts without authorisation. It is nowhere stated how or by whom such authorisation may be granted.

Neil Munro
Branch Secretary
Scotland & Northern Ireland Branch
Institute of Cemetery and Crematorium Management
18 November 2010
Thank you for inviting comments on this proposed legislation.

On the issue on whether I agree or disagree with the general principles of the Bill; this will differ regarding one specific issue. The Bill makes it an offence to dispose of body parts without authorisation. I am keen to know if the definitions of body parts includes teeth. This may be an issue for every dentist who undertakes dental extractions, although this is usually from a living patient!

Are teeth excluded from the legislation because the patient is living, or will all dentists, and dental therapists have to be authorised to dispose of extracted teeth. This may also apply to the dental pulp of teeth which are sometimes removed independently during root canal therapy.

I look forward to clarification of this issue.

Thanks in anticipation.

Colwyn Jones
Consultant in Dental Public Health/Honorary Senior Lecturer
NHS Health Scotland
3 November 2010
Certification of Death (Scotland) Bill
Medical Protection Society

General Comments

The Medical Protection Society (MPS) welcomes the opportunity to comment on the Certification of Death (Scotland) Bill (the Bill). Our responses to the questions you have posed are set-out below.

Do you agree or disagree with the general principles of the Bill?

MPS agree with the general principles of the Bill and that the current system of death certification needs to be updated.

Do you agree with the proposed changes to the system of death certification in Scotland?

We feel that the changes being proposed may not be the best ones to improve the current system. We think a revised system should follow the English & Welsh system, which we believe would be more robust and that the changes this would bring about would be more affordable and proportionate.

Do you agree with the proposed creation of a system of Medical Reviewers?

We are concerned that the medical reviewer model is potentially inadequately resourced, particularly with regards to personnel. As such we fear that the proposed system is likely to be considerably less robust than the system that it is replacing.

For example, moving from the current system where three doctors are responsible for cremation to a system where a single doctor is responsible should be a cause for concern.

To scrutinise 60,000 deaths with four full time medical reviewers would be a difficult task, and it is hard to see how this could be done in a meaningful way. We believe that this will lead to a system that will be significantly less effective than that being implemented in England & Wales. This could lead to a lack of support from the medical profession, and a lack of confidence from the public.

Do you have any comments on the costs identified in the Financial Memorandum?

We have no comment on this question.

Are there any other comments you wish to make on the Bill?

We have no further comments.
Further Information

Please do not hesitate to contact me if you require any further information or clarification on the issues raised in this response.

Dr George Fernie
Senior Medico-Legal Adviser
Medical Protection Society
18 November 2010
Certification of Death (Scotland) Bill

Neil Munro

I would like to make the following comments:

Medical Reviewer System

I do not agree with the proposed adoption of the Medical Reviewer model. I feel very strongly that the Scottish Government should opt for the Medical Examiner model [paragraphs 19 & 20 of the Policy Memorandum]. I feel that it is imperative that every death registered in Scotland should be subject to a basic level of scrutiny. Informed by my experience with cremation medical certificates, I believe that only a scrutiny of every MCCD will ensure that these certificates are fully and correctly completed.

I believe that the system as proposed will be less robust than the system it is replacing and less robust than the system in England & Wales [paragraph 107 of the Policy Memorandum]. I am particularly concerned that this latter point could lead to problems where a death is registered in Scotland with disposal to take place in England.

Paragraph 16 of the Policy Memorandum states that the proposed system “should also act as a deterrent to criminal activity or malpractice”. I fail to see how a random sample of around 1 – 2% can have such an effect.

Deaths Occurring Outside Scotland

Under the proposed system, the onus of ensuring (a) that a medical certificate equivalent to the MCCD has been produced and (b) that the death has been properly registered will fall on the person having charge of the cemetery or crematorium. I feel that it is inappropriate that this responsibility should be placed on a medically-unqualified member of staff, bearing in mind the penalties to be introduced for disposing of a body without authorisation. This is particularly so in the case of a small cemetery which is rarely used and which will normally be administered by someone whose primary responsibilities lie elsewhere.

Paragraph 16 of the Policy Memorandum states that one of the policy aims of the Bill is “to introduce a single system of independent, effective scrutiny”. I do not see how leaving responsibility to a member of staff of the cemetery/crematorium can accord with this aim.

Neil Munro
(Company Secretary, Edinburgh Crematorium Ltd)
18 November 2010
Thank you for the opportunity to provide written evidence to the Certification of Death (Scotland) Bill.

We were reassured to note that the issue of those entitled to request investigations outlined in the Burial, Cremation and Death Certification Review (CRESID 1233) has now been addressed. The revised list is more clearly defined and appears to be more appropriate. This allows more confidence about the ability to control the overall numbers of reviews required.

We were also pleased to note that the resourcing issues we raised have been addressed within the Bill and explanatory notes.

However, we would point out that the altered assumptions are partly negated by the changed estimate of time per case. In the initial consultation, costs were based on one case per working day. In the final Bill, Section 82 of the explanatory notes estimates that each case will take a Medical Reviewer only half a working day to complete. It is unclear how this apparent doubling of efficiency has been achieved since the initial review but a change of this magnitude could raise doubts about whether the estimate realistically reflects the actual time required and therefore the overall cost of implementation.

In general, we are supportive of the Bill as a whole.

Dr Ross Cameron
Medical Director
NHS Borders
2 November 2010
Certification of Death (Scotland) Bill
NHS Greater Glasgow and Clyde

Do you agree or disagree with the general principles of the Bill?
Agree.

Do you agree with the proposed changes to the system of death certification in Scotland?
Broadly agree, with comments and caveats below.

Do you agree with the proposed creation of a system of Medical Reviewers?
Broadly agree, with comments and caveats below.

Do you have any comments on the costs identified in the Financial Memorandum?
The financial memorandum clearly assesses the direct costs of the Medical Reviewers and associated support and infrastructure.

However, it does not consider any indirect costs to Boards. We would seek greater clarity on the expectations of boards and the potential implications in relation to:

- Clinical governance systems and follow up of concerns.
- Training and support for staff certifying deaths
- Dealing with any requests for further information
- Training for staff who may be supporting relatives at the time of death.

We feel it is important that the impact on families is fully considered, both in terms of delay and the concern and stress caused by having the death reviewed. It is essential that families understand the reasons for the review, and that the processes and responsibilities for communicating this and allowing full discussion are clear and included in the costs and logistics.

Are there any other comments you wish to make on the Bill?

Any delay which would be introduced by either of the proposed new systems needs to be clearly understood and kept to a minimum.

We agree strongly that it is sensible for the same process to apply to both those being buried or cremated.

We would welcome greater clarity on the methods for identifying deaths for review.
We would welcome greater clarity on the expectations of boards in relation to clinical governance systems, both in response to any concerns raised by individual cases, and around identifying and tackling any concerns raised through statistical review.

Lorna Kelly
Head of Policy
NHS Greater Glasgow and Clyde
19 November 2010
I am responding on behalf of NHS Lothian.

I am supportive of the general principles of the Bill. This is positive response to the improvements required in death certification that were highlighted by the Shipman Inquiry reports.

I support the scrutiny of medical certificates of cause of death for accuracy. The proposed creation of a system for medical reviewers should ensure that this happens.

Care will need to be taken to target the review process appropriately. We would suggest that scrutiny should take place on a number of levels:

- Random selection of all deaths.
- Deaths about which some concern may have been expressed through complaints, Fatal Accident Inquiry, or enquiries by the Procurator Fiscal. Particular attention should be paid to sudden deaths, deaths in children, deaths associated with conditions amenable to healthcare to healthcare intervention, and all deaths associated with complications or misadventures due to healthcare.
- The provisions relating to infection should apply also in respect of biological, chemical, radiological or nuclear contamination. Deaths associated with these should be explicitly described and the enabling regulation to support the Public Health Act and the Death Certification Act should include the Director of Public Health, the Director General of the General Register Office for Scotland, and the Director of the NHS Central Registry in a duty to co-operate.

I support the qualification and experience required for competence as a medical reviewer and would expect to see that detail set out in the enabling regulation. Health Boards, through Directors of Public Health, should be able to charge a fee for these duties unless this is independently funded. I have no further comments to make on the costs in the financial memorandum other than to highlight that no costs appear to have been taken into account with the development of appropriate information systems.

The Bill appears to pay little account of the existing duties and responsibilities of Directors of Public Health. It is important that those are acknowledged and taken into account in the language of this Bill.

Professor Charles Swainson
Medical Director
NHS Lothian
1 November 2010
Certification of Death (Scotland) Bill

NHS Orkney

Do you agree or disagree with the general principles of the Bill?

NHS Orkney agrees with the general principles of scrutiny of death certificates to ensure meets guidelines and adheres to clinical governance and assurance principles.

Do you agree with the proposed changes to the system of death certification in Scotland?

NHS Orkney disagrees with the proposed changes as they will have significant impact on bereaved families and delays in burial processes. It is felt this will impact on the ethnic communities in particular where there are required timelines for burial and bereavement. We are also concerned about the impact on the mental health and well being of the family where the death is that of a child. Whilst we recognise the population health benefit of scrutiny of the death certificates we are concerned that the negative health impacts on the families of the deceased individuals have not been adequately addressed.

Do you agree with the proposed creation of a system of Medical Reviewers?

We disagree with proposed appointment of national medical reviewers as we believe this will result in delays and distress to the bereaved families and feel instead a local solution should be established that could reduce delays and financial impact to bereaved families. The proposed system does not adequately address the needs of the remote and rural communities and would introduce further rural/urban inequity.

Do you have any comments on the costs identified in the Financial Memorandum?

At a time where costs are being stripped out of the NHS it is inappropriate to divert costs to establishing a new nationally based system. Options for establishing local reviews systems should be explored instead.

Are there any other comments you wish to make on the Bill?

A review of mortuary provision will need to be made as any delays in the burial of deceased will require additional facilities.

Of special note are remote and rural areas where the cultural practice tends to be that of keeping the deceased in their own homes until burial is arranged and there are no neighbouring mortuary facilities. It is totally inappropriate to enforce delays in this situation as they will have significant impact on already distressed families, potentially introduce health and hygiene risks associated
with a decaying body or necessitate transportation of the body off outer islands to the mainland for refrigeration with associated costs and family disruption. It appears that the practicalities of remote and rural living and local cultural expectations are inadequately addressed with significant negative mental health and wellbeing impact on individuals already made vulnerable by a bereavement.

Mrs Rhoda Walker
Director of AHP & Nursing
NHS Orkney
18 November 2010
I am writing from North Lanarkshire Muslim Women and Family alliance regarding the above.

Where we agree with the proposed creation of a system of Medical Reviewers.

This Bill is also of specific interest to Muslims, particularly the need for a more speedy release of Death Certificate. We therefore request any review must consider the Muslim religious requirement i.e. the speedy release of Death Certificate and deceased body in this regard. It is the believe of the Muslim Community that the delay in the burial causes a deceased suffering therefore speedy burial is required.

We sincerely hope that our request will be considered in the proposed Bill.

Bushra Iqbal
Chair person
North Lanarkshire Muslim Women and Family Alliance
22 October 2010
The Royal College of Nursing (RCN) is the UK’s largest professional association and union for nurses with around 395,000 members, of which over 38,500 are in Scotland. Nurses and health care support workers make up the majority of those working in health services and their contribution is vital to delivery of the Scottish Government’s health policy objectives.

The RCN welcomes the opportunity to comment on the general principles of the Certification of Death (Scotland) Bill. We have confined our comments to the issue of death certification. In particular, we have made comment on the potential role for nurses in certifying death in order to better serve the needs of the people of Scotland.

Whilst we support the introduction of a new Certification of Death Bill, we have a specific concern regarding death certification about which we have already spoken to the Scottish Government. We are raising the issue in our Stage 1 evidence to the Health and Sport Committee as we feel this is of sufficient significance as to impact on the general principles of the Bill.

For many years nurses have been confirming or verifying death. The Nursing and Midwifery Council (NMC) guidance on confirmation of death was updated in 2008 and states:

“In the event of death, a registered nurse may confirm or verify death has occurred, providing there is an explicit local protocol in place to allow such an action, which includes guidance on when other authorities, e.g. the police or the coroner, should be informed prior to removal of the body.

"Nurses undertaking this responsibility must only do so providing they have received appropriate education and training and have been assessed as competent."

Given that nurses have been confirming death or verifying life extinct for some years we consider that the current Bill is lacking in its broader consideration of death certification. This Bill provides an opportunity for the Scottish Parliament to consider whether there would be benefits of extending certification of death to other healthcare professions.

The current requirement that the Medical Certificate of Cause of Death (MCCD) can only be completed by a registered medical practitioner is contrary to the wider policy principles of current Scottish Government policy, which is to value the professional judgement of nurses and nurture the

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This proposal needs to be seen against a background of developing nursing roles. Many registered nurses lead multi-disciplinary delivery teams, and work independently in community and clinic settings. Nurses have for many years been taking on new areas of practice including those trained as advanced nurse practitioners who have undertaken a specific course of study to assess, diagnose, and treat. Nurse prescribers are able to prescribe a range of drugs from the British National Formulary and use these skills within their areas of clinical expertise. In many cases, particularly as more care is delivered in the home, nurses are likely to be the most appropriate person to certify a death.

The RCN is therefore calling for the Health and Sport Committee to consider whether in future, appropriately prepared, experienced nurses could certify death in the following circumstances:

- The nurse had been supervising the care of the deceased during his/her last illness.
- The death was expected and the deterioration in health clearly documented in the healthcare record.

The reason for this proposed change is to improve the final part of the care journey for the deceased and their families. The major benefit would be to minimise delays in certification of death and to enhance person-centred care so that this final part of the care journey can be undertaken by the most appropriate member of the team in any given situation. Out of core hours, awaiting certification can involve for extended periods whether in hospital or at home. This can be distressing to bereaved relatives, particularly for those for whom this may involve travelling significant distances to return to a hospital/hospice the next day to collect MCCD.

RCN members shared many instances when certifying death would enhance care both by avoiding delays and by enabling the most appropriate health professional to support families by certifying death - someone who had been involved in the final care of their loved one. This applies equally to inpatient settings and care in the home, when families are not comfortable with the body of the deceased remaining for a long time. There is no question that, if appropriately prepared, nurses would have the clinical skills to take on the role of certifying expected death.

Often, the nursing team is well known to a family and this final duty being undertaken by a familiar professional would provide a continuity of care. This role could enhance the process of support and care to the bereaved, allowing nurses to complete the journey of care for the deceased. The RCN believes that the flexibility afforded by nurses being able to certify death would enhance the dignity of end of life care, minimising unnecessary and distressing delays.
There are particular challenges in remote areas where increasing numbers of health services are delivered by nurses who may not have easy access to a registered medical practitioner. Nurse-only island services are one example of this. We ask the committee to consider how timely death certification by a registered medical practitioner could be ensured on an island community with nurse-led services during poor weather.

We are aware that Scottish Government has enquired of the Royal College of Physicians, Faculty of Forensic and Legal Medicine as to the recommended external post-mortem examination that doctors should perform and we would expect any nursing staff involved in the future to be working to these same requirements. Any regulated healthcare professionals undertaking this work should have the necessary skills and competence and their regulated status brings with it the professional accountability that comes with the role.

We were pleased that the Health and Sport Committee recognised the evolving role of nursing and has left the way open for nurses to hold GMS contracts in the future by amending the Tobacco and Primary Medical Services Bill. In recognition of the increasing role that nurses have, we ask you to consider amending this Bill to allow potential regulation in the future that would enable nurses and other appropriate healthcare professionals to certify death. In order to improve end of life care for the families of Scotland, it would be undesirable for this Bill to close off the opportunity for nurses and others to certify death in the future.

Clare Mayo
Policy Adviser
Royal College of Nursing Scotland
18 November 2010
Certification of Death (Scotland) Bill

Scottish Regional Council of the Royal College of Pathologists (SRC)

We welcome the opportunity to respond to this document at this stage. While there have been many issues that we have disagreed with during the progression of this Bill, we realise that we will require to work with the final legislature. We would therefore wish to express our willingness to liaise with Scottish Government and other stakeholders during implementation and beyond.

The questions posed by the committee in its Call for Evidence Summary are given responses as follows:

1. Do you agree or disagree with the general principles of the Bill?

The SRC welcome several matters within the proposed Bill, notably the removal of cremation fees, the improved monitoring of deaths abroad and the possibility of further examination if requested by any interested party including the family. Also, there is a clear commitment to education and training around death certification which has been inadequate in recent years.

It is understood that the general principle of the Bill is to revise some aspects of Death Certification in Scotland by scrutinising a small proportion (1-2%) of Medical Certificates of Cause of Death (MCCD) by an appointed medical reviewer. The SRC fully accepts that accurate Death Certification is important for the generation of statistical data that may be used in disease prevention and health care planning. However, from the evidence presented in the Bill, it is clear from the proposed system that it will be inadequate for the intended task.

The medical reviewer role as it is currently outlined in the Bill will not be independent of the NHS as the proposed system advocates such individual(s) being employed by Health Improvement Scotland. The Bill has been presented in its current form as being flexible to the request of politicians. Such a role should be outwith such direct influence although it is agreed that such a system should be transparent and open to scrutiny. An annual report should be sufficient unless an anomalous event occurs that is in the public interest to be reported to Parliament at another time.

The SRC would disagree with any aspect of this Bill being put forward as a preventative measure against another “Shipman” from occurring in the future. The numbers of MCCDs proposed for review would not generate statistically significant data or be sufficient to “red flag” such a doctor’s behaviour and the SRC calls for references to Shipman to be removed from any subsequent press notice or notes concerning the Bill.

The benefit of such a system is limited and will cause further distress to families of the deceased due to time delays and will not change or enhance the quality of Death Certification. Although it is cost neutral to the government,
there is a cost to all families with regard to the certification process, and the benefits are limited for an investment of 1.2 million pounds.

There is no definition of “quality of death certification” and a clearer statement regarding the measurable outcomes from the proposed changes would be welcome, quality measures such as legibility, data items, and certificates which require telephone contact with the certifying doctor are some, but the quality of the actual cause of death and the medical terminology used are the most important but most difficult to measure.

2. Do you agree with the proposed changes to the system of death certification in Scotland?

The information outlined in the Bill gives little weight to advocate the proposed changes in Death Certification. For the vast majority of people completing an MCCD, there will be no impact on their practice. A 1% random audit of death certificates means that in practice a GP might be expected to be reviewed once every 8-10 years. The possibility of a 1% review is unlikely to affect the care and consideration given to the writing of a death certificate and is equally unlikely to help identify unsatisfactory performance.

The change in the system will however impact on the general public, particularly the relatives of the deceased who will be paying an additional fee in their funeral costs in order to pay for this new system. Logistical measures pertaining to the movement and storage of the deceased whilst waiting for review and for gathering and transportation of medical records have not been outlined.

3. Do you agree with the proposed creation of a system of Medical Reviewers?

In the proposed form, it is uncertain how effective a medical reviewer can be. The remit of the reviewer is limited as they will be employed by Health Improvement Scotland and have no remit in terms of individual Health Boards as this relies on Clinical Health Boards “co-operating” with the Medical Reviewer. There is also limited input into the Procurator Fiscal Service as the Medical Reviewer has no powers to instruct a post-mortem examination, only the ability to refer to the COPFS as any other interested party currently can. It falls then to a Procurator Fiscal to make a decision and instruct the Medical Reviewer. The SRC feels that this arrangement does not use the expertise of the Medical Reviewer appropriately and instruction by the PF service may be driven by cost rather than need of the individual case. It might serve better if the Medical Reviewer was formally tied into the COPFS.

4. Do you have any comments on the costs identified in the Financial Memorandum?

The costs outlined in the financial memorandum highlight how this proposed system is a drop in the ocean compared to the proposed system in England and Wales. The budget is tight even for a system of six reviewers.
The changes to Death Certification in England and Wales are different from those proposed in Scotland and any learning modules written by the Royal College of Pathologists may not be applicable to proposed Scottish system and Scottish Law.

There does not seem to be any flexibility in the financial memorandum for the SMR and their team to organise official training on Death Certification for medics and medical students in general. This should be factored in as it would seem the most important and possibly only potentially effective role of the MR system.

5. Are there any other comments you wish to make on the Bill?

View and Grant examinations are a limited procedure falling short of an adequate post mortem examination.

The medical reviewer role is unlikely in its current proposed form to induce a change in practice or improve the general attitude to death certification. If the numbers of cases reviewed were sufficient to generate statistically significant data, then there would be the potential to drive change.

The MR system has no impact on undergraduate or postgraduate medical curricula as it stands and is poorly placed to influence training pertaining to death certification. Links with the medical schools and NES would need to be mandated.

Much of the detail enabling success or otherwise of the Death Certification (Scotland) Bill will be in the regulations and detail regarding the death certificates, medical reviewers job descriptions and training. Also, at a 1% scrutiny level it will be many years before any measurable effect from this legislation may become evident. The idea of more directed audits of death certification has merit but the trigger for these is not clear from the Bill.

Bernie Croal
Chair
Royal College of Pathologists Scottish Council
17 November 2010
Certification of Death (Scotland) Bill
Royal College of Physicians and Surgeons of Glasgow

The Royal College of Physicians and Surgeons of Glasgow (RCPSG) is pleased to respond to the call for evidence on the Death Certification (Scotland) Bill.

Please find below comments which I trust will be of assistance when collating a response:

1. It is appropriate that medical reviewer (MR) and senior medical reviewer are appointed and employed by HIS as the recommended changes form part of a wider clinical governance process
2. We welcome the role that MR will have in providing telephone support and advice
3. We welcome the plans for extensive education and training around the new system
4. We are of the opinion that the changes suggested will result in improved quality of death certification and that better information will be extremely useful from a public health perspective
5. We are uncertain that random sampling of certificates for medical review will necessarily highlight trends/areas of concern and therefore doubt that this system would prevent criminal behaviour, eg Shipman, but agree that this is probably a deterrent
6. It is essential that timescales are in place for turning around cases sent for medical review. This is an upsetting and stressful time for carers, and we would not wish to add to this by having long delays before registration of death can take place – we are concerned that half a day per case is thought to be necessary
7. We strongly support the simplified and unified system of certification, abolishment of separate cremation certificate and feel this will simplify and facilitate process
8. We welcome the role of MR in facilitating management of death occurring abroad issues
9. Clause (5a) on interested persons requires further clarification
10. If the outcome of a medical review is unsatisfactory there should be some indication of timescale allowed for the senior medical reviewer to attempt to resolve the disagreement

Dr Jackie Taylor
Honorary Secretary
Royal College of Physicians and Surgeons of Glasgow
12 November 2010
Certification of Death (Scotland) Bill
Royal College of Physicians of Edinburgh

The Royal College of Physicians of Edinburgh (the College) is pleased to respond to the Scottish Parliament’s consultation on the Certification of Death (Scotland) Bill.

The College supports moves to streamline processes and reduce cremation costs. Answers to the consultation questions are set out below.

Consultation Questions

Do you agree or disagree with the general principles of the Bill?

The College agrees with the policy aims underpinning the Bill, namely to:

- introduce a single system of independent, effective scrutiny applicable to deaths that do not require an investigation by the Procurator Fiscal;
- improve the quality and accuracy of the medical certificate of cause of death form; and
- provide improved public health information and strengthened clinical governance in relation to deaths.

The College also supports moves to improve the efficiency and cost of death certification for the majority of families and the removal of inconsistencies between the processing and scrutiny of cremations and burials.

Do you agree with the proposed changes to the system of death certification in Scotland?

In general, the College supports the proposed changes to provide for a single signatory to certify death in Scotland.

However, the College has several concerns including:

- the need for a threshold test and shorter time limit in relation to interested person reviews; and
- the impact of delays caused by random reviews of death certificates upon families.

Interested person reviews

It is noted that the proposed system appears to require the Medical Reviewer to review a death certificate where requested by an interested person, unless the application is vexatious. It may be difficult for the Medical Reviewer to
determine whether an application is vexatious, meaning that the Reviewer may end up reviewing the majority of applications he or she receives. This could involve applications from persons who don't “like” the cause of death noted by the certifying doctor.

To ensure efficiency and fairness, the College considers that there a need for the introduction of a threshold test describing the circumstances within which an interested person can seek a review. For example, the person could be required to demonstrate that they are concerned that the cause of death listed may not represent a reasonable conclusion as to the likely cause of death and/or a belief that other information contained in the certificate may be incorrect. An appeal mechanism would also need to be built into such a system.

Consideration could be given to whether such a test should be incorporated in the legislation or introduced as guidance after the passage of the Bill.

There is also concern that the 3 year time limit within which an interested person may seek a review is too long a time period to allow a meaningful review to take place.

**Concern for families**

The College is concerned about the impact of intervention and delays where deaths are randomly selected for scrutiny pre-registration.

It is noted that the Government anticipates that scrutiny will have minimal impact on the scheduling of funerals, and that, in certain circumstances, families will be able to request that the registration of the death takes before the review is completed. Registration will only be allowed where the Medical Reviewer is satisfied that the circumstances of the case justify registration and there are no obvious indications that the medical certificate is not in order.

It may be extremely distressing for families to have someone intervening where the family perceives there is no issue and where they are not eligible for the expedited registration procedure.

Early consideration must be given to who will be responsible for explaining to families the possibility that the certificate may be selected for review or the subject of a review application from an interested person, and at what point this should occur. That person must be appropriately trained and readily accessible to the family. Once a certificate is selected for review, the process and timescales should be explained to affected families in person.

Delays during reviews must be kept to a minimum and timescales should be set out in guidance accompanying the legislation. It is imperative that the process is speedy, transparent and properly explained to avoid undue distress to bereaved families.
Do you agree with the proposed creation of a system of Medical Reviewers?

Yes.

Do you have any comments on the costs identified in the Financial Memorandum?

The College welcomes proposals to replace cremation fees with a modest certification fee for both cremations and burials to fund the running costs of the new certification system. This will reduce costs for the majority of families and offers a more equitable system.

Are there any other comments you wish to make on the Bill?

The College is supportive of moves to include more medical information on death certificates regarding surgical implants and public health risks, which should also improve statistical recording of such information. The College welcomes the General Register for Office’s proposed inclusion of the Community Health Initiative (CHI) number on the form.

In order to improve the accuracy of death certificates, the College recommends that a doctor of Specialist Registrar level or higher should always be involved in the issue of a certificate.

The College acknowledges that legislative amendment cannot prevent Shipman-style cases, and should be driven instead by broader patient safety initiatives.

Dr A D Dwarakanath FRCP Edin
Secretary
Royal College of Physicians of Edinburgh
17 November 2010
Certification of Death (Scotland) Bill

Scotland Patients Association

1. Do you agree or disagree with general principles of the Bill?

SPA agrees.

2. Do you agree with the proposed changes to the system of death certification in Scotland?

SPA agrees.

3. Do you agree with the proposed creation of a system of Medical Reviewers?

SPA agrees.

4. Do you have any comments on costs identified in the Financial Memorandum?

- SPA feel that “Scrutiny of Death Certification” should in the main be a financial burden shared by all taxpayers, since the statistical information gathered should benefit all. More accurate recording of causes of death and other illnesses present prior to, or in addition to, the main cause of death such as MRSA and C. Diff. Is beneficial to the NHS boards and to health professionals’ learning.
- The public are used to having to pay a fee for cremation certification rather than burial and full explanation would need to be given to the public for the change. It may seem fairer if this cost is to be equalised but some of the general public have grudgingly paid those fees in the past thinking that it is “easy money” to the medical profession without full understanding of what is involved in the time taken to cover death certification accurately, by viewing the remains and speaking to relevant others, including other doctors who knew and treated the deceased. Relatives do not see work done particularly at time of grieving. It is another added expense at a very expensive time when funeral costs have to be met.
- It was mentioned that if the number of deaths per year were fewer than expected that the cost of this scrutiny could go up per individual certificate and the burden would be met by the relatives paying more for certificates at time of death. (This seems a variable death tax when times are hard enough, financially.)

5. Are there any other comments you wish to make on the Bill?

- I think that the post of Medical Reviewer and Senior Medical Reviewer should require 10 years qualified experience, having worked as a
Consultant or General Medical Practitioner full time prior to applying for the post.

- In addition to the education programme intended for medical personnel, SPA believes that an appropriate education programme should be included for the public to reassure them why there is a need for extra scrutiny and how this will benefit them.
- Many relatives would wish that the death certificate had more information and are often disappointed to note that MRSA has not been included when they know it had been diagnosed.
- SPA believes if more internal post mortem examinations were carried out this would enhance medical teaching and provide more accurate death certification.
- Relatives may ask for more post mortems to be carried out because of worries about nursing care and this may also push up costs.
- More relatives may agree to post-mortem (PM) examination if it were offered. In retrospect many wish they had had that opportunity of a PM in the hope that it would give a more accurate cause of death and also provide more understanding and acceptance for the cause of death. This may even cancel some formal complaints or prevent a formal complaint being commenced.
- Nowadays, patients are passed between health boards for treatment and are moved within hospital and on discharge could be moved to another hospital, home or to a care home or hospice. As a result continuity of care is fragmented or nonexistent and when relatives cannot get answers to satisfy why a relative died they make a formal complaint and could request a post mortem.
- So many people have poor nutrition these days prior to hospitalisation, for many reasons, as well as having difficulty feeding and drinking while in hospital. Relatives worry that food and fluid balance recording is not so common until someone is really ill, compared with the past when it was more routine to record input and output. This is a great worry for relatives because they fear that poor nutrition could contribute to premature death.
- Bed sores are also a great worry to relatives for the same reason and are more common now than in the past in addition to worries about accuracy in administration of drugs in hospitals and care homes.
- With the reduction of hospital beds more frail elderly and vulnerable people with more complex conditions are nursed in care homes of varying standards as inspected by the Care Commission. Relatives worry about their loved ones general care and wellbeing and some are now worrying that their loved one may be prematurely put onto the “Liverpool Care Pathway” without full discussion with them. The Liverpool Care Pathway is being rolled out across the many Care Homes as well as in the few Hospices which are still surviving. Some relatives are unclear as to when palliative care has the Liverpool Care Pathway introduced.
- SPA is aware that there is confusion over what is requested as a post-mortem (PM) examination by the hospital or the Procurator Fiscal. A PM may be requested and agreed but we have one example of a
person we know of who did not have a full explanation and did not understand that it was a Procurator Fiscal PM which was sought. Since the Procurator Fiscal was satisfied as to the cause of death the PM was not done. This person thought her request for a PM was to be done at the hospital and so she was extremely disappointed when she was denied a more accurate answer on the cause of death of her husband.

- SPA is aware of one grieving relative who had to dispute the date and time of death with a hospital which only came to light at the point of registering the death.

The Importance of post mortem examination by a pathologist aids accuracy of cause of death and of certification but also may have further value to provide answers to grieving relatives which may assist understanding and give closure to a sudden or unexplained death. It is possible that these answers may reduce the need for further formal complaint.

SPA believe that the task of scrutiny may take more time than anticipated since patients are treated in many places for one illness and often in different hospitals and between different health board areas, so gathering information prior to death may take much more time than first anticipated and so cost more.

More information on death certificates will be reassuring to relatives and add safety to all personnel who have to deal with the remains of the dead such as Funeral Directors and embalmers. Notification of infectious diseases and all other relevant information should be given appropriately and with the understanding of the code of confidentiality.

Jean Turner
Chair
Scotland Patients Association
17 November 2010
Thank you for giving us the opportunity to provide written evidence for the consideration of the Certification of Death (Scotland) Bill (the Bill) at Stage 1.

The Scottish Public Services Ombudsman (SPSO) provides a 'one-stop-shop' for members of the public making complaints about organisations providing public services in Scotland. This includes complaints about the National Health Service (NHS). The SPSO’s experience of dealing with complaints from members of the public about the NHS provides us with a unique perspective on the delivery of health services in Scotland and the concerns of service users.

Although we have no comment to make on the specific questions listed in the call for evidence, the SPSO has upheld a number of complaints relating to certification of death in recent years. The major issue arising from these complaints relates to lack of clarity and inaccuracy in the cause of death recorded on death certificates. Some of these cases, which reflect the real life experiences of aggrieved citizens, are summarized below and may provide useful background and context to the Committee’s consideration of the Bill.

**Case 200802381**

Mr. C complained that the cause of his late wife’s death was inaccurately recorded as Alzheimer’s disease on her death certificate. The SPSO concluded that renal failure was a more accurate reflection of her cause of death. We recommended that the Health Board should review the death certificate and provide Mr. C with a definitive answer regarding his late wife’s cause of death.

**Case 200700814**

Mr. C complained that there was an inaccuracy on his late father’s death certificate in that one of the causes of death was listed as chronic lung disease. The SPSO concluded that chronic lung disease should not have been listed on the death certificate. However, because the death certificate also listed the correct causes of death and because the Health Board’s recording error had no impact on Mr. C’s late father’s care and treatment, the complaint was not upheld. The SPSO did, nonetheless, draw the Health Board’s attention to the importance of making accurate records on death certificates.

**Case 200601576**

Mr C complained that the cause of his late mother’s death was inaccurately recorded as Alzheimer’s disease on her death certificate. The SPSO concluded that the cause of death on the death certificate was inconsistent with the clinical records and that a more accurate reflection of the cause of Mr.
C’s late mother’s death was: ‘1a. Myocardial Infarction 1b. Ischemic Heart Disease 2. Vascular Dementia’. The SPSO upheld the complaint and recommended that the Health Board:

- Take steps to correct the death certificate or to explain why that cannot be done;
- Consider whether death certification should be included in the continuing education of medical staff; and
- Apologise to Mr. C for failing to respond appropriately to his concerns about death certification.

Case 200500775

Mrs. C complained that she had not been given a satisfactory explanation regarding her husband’s death and that a post-mortem was not performed and the death certificate was not correctly completed. The SPSO upheld Mrs. C’s complaint and recommended that the Health Board carry out a review of their procedures in respect of requesting post-mortem examinations and the completion of death certificates and consider training requirements to ensure staff are aware of their responsibilities in this area.

Copies of the full reports on these cases can be made available on request.

This submission forms part of our continuing aim to ensure that learning from complaints is used to improve public services and inform public policy. We hope you find it helpful and would be happy to provide any further information to assist the Committee’s consideration of the Bill.

Jim Martin
Ombudsman
Scottish Public Services Ombudsman
18 November 2010
Certification of Death (Scotland) Bill

South Lanarkshire Council

I write on behalf of South Lanarkshire Council and would begin by welcoming the opportunity to comment on the proposed Bill.

In general terms South Lanarkshire Council welcomes the introduction of such a robust process in order to address the requirements of death certification. Equally the promotion of the role of Medical Reviewers, as defined within the proposed Bill, is of value.

It is fair to say however that this legislation may have limited impact on the general role occupied by the Council’s Bereavement Services when managing the disposal of the dead. Of interest would be the impact associated with this Bill as it affects the ongoing Scottish Law review which is being directed towards a modern and contemporary bereavement service.

In summary I would confirm the Council’s approval of the provision of effective liaison between Medical Reviewers and those who are delegated with responsibility for the disposal of the dead as well as the amendment of the 1965 Act to address disposal of bodies as detailed in paragraph 24 of the proposed legislation.

Stephen Kelly
Head of Facilities, Fleet and Grounds Services
Community Resources, Support Services
South Lanarkshire Council
22 October 2010
Certification of Death (Scotland) Bill

William Stanley

As a Professional Bereavement Practitioner and a Fellow of the Institute of Cemetery and Crematorium Management I would offer the following comments:

Medical Reviewer System

I cannot agree with the proposed adoption of the Medical Reviewer model. I feel very strongly that the Scottish Government should opt for the Medical Examiner model [paragraphs 19 & 20 of the Policy Memorandum]. I also feel that it is important that every death registered in Scotland should be subject to a basic level of scrutiny. Informed by my experience with cremation medical certificates, I believe that only a scrutiny of every MCCD will ensure that these certificates are fully and correctly completed.

I also believe that the system proposed will be less robust than the system it is replacing and certainly less robust than the system in England & Wales [paragraph 107 of the Policy Memorandum]. I wish to express my concern that this latter point could lead to problems where a death is registered in Scotland with disposal to take place in England.

Within paragraph 16 of the Policy Memorandum, it states that the proposed system “should also act as a deterrent to criminal activity or malpractice”. I fail to see how a random sample of around 1 – 2% can have such an effect.

Deaths Occurring Outside Scotland

Under the proposed system, the onus of ensuring (a) that a medical certificate equivalent to the MCCD has been produced and (b) that the death has been properly registered will fall on the person having charge of the cemetery or crematorium. I personally feel that it is inappropriate and irresponsible that this is placed on a medically-qualified member of staff, bearing in mind the penalties to be introduced for disposing of a body without authorisation. This is particularly so in the case of a small cemetery which is rarely used and which will normally be administered by someone whose primary responsibilities may lie elsewhere.

Paragraph 16 of the Policy Memorandum states that one of the policy aims of the Bill is “to introduce a single system of independent, effective scrutiny”. I cannot see how leaving responsibility to a member of staff of the cemetery/crematorium can accord with this aim.
Body Parts

Within paragraph 9 of the Explanatory Notes, it states that it will be an offence to dispose of a body or body parts without authorisation. It is nowhere stated how or by whom such authorisation may be granted.

William Stanley FICCM
18 November 2010
Certification of Death (Scotland) Bill

Strathcarron Hospice

General comments

We agree that Scotland’s burial and cremation legislation requires updating and consider the proposed bill to have significant merit.

The approach taken in England and Wales, of requiring the actions of a certifying doctor to be double-checked, is not an efficient or desirable use of resources and may indeed be perfunctory.

The proposed Scottish Medical Reviewer system provides for more comprehensive scrutiny of deaths including a review of paperwork and medical records and discussions with the certifying doctor and family of the deceased, if necessary. In particular, the abolition of cremation fees is welcomed. The removal of charges for cremation forms demonstrates equality. However, a further refinement, in the form of electronic access by the Medical Reviewer to Scottish Care Information (SCI) Store reports of investigations, may be advantageous.

Medical Certificate of Cause of Death (MCCD)

There are several deficiencies in the current MCCD:

- The MCCD does not actually state *when* the certifying doctor saw the patient alive, only *if* the patient was seen.
- The format of the current MCCD differs from the section on cause of death in the rather archaic cremation form. This can create confusion.
- There is a puzzling mixture of tick boxes and circles.
- The guidance notes on the MCCD no longer reflect the categories of death to be reported to the Procurator Fiscal, following the publication of the updated Death and the Procurator Fiscal 2008.
- The information on the reverse of the MCCD limits where the death may be registered though registration may now take place in any registration office in Scotland.

It will be helpful to streamline the design of the MCCD. Presumably the Bill will also provide an opportunity to make administrative changes to the MCCD through primary or secondary legislation and permit better use of the available space in addition to the proposed Identification code (possibly GMC Number). It would seem logical to develop an electronic MCCD (e MCCD) in the near future.

Policy Memorandum

The aims of the Bill detailed in the helpful Policy Memorandum (page 4) are laudable. The introduction of effective scrutiny, improved accuracy of
certification and public health information appears to be balanced by sensitivity to the needs of bereaved families and a desire to ensure that the improvements do not cause unnecessary delays to funerals.

- On page 9 of the Policy Memorandum, while the flow chart is a useful résumé, we feel it is essential that a full explanation is provided for relatives regarding random scrutiny to ensure they do not feel victimised or incriminated in any way.
- On page 10 there seems to be a missing word/words in the box “PF carries out…”
- On page 11 emerging statistics may highlight hospices as having elevated mortality rates and will require interpretation.

**Educational Role of the Medical Reviewer**

The establishment of the medical reviewer posts provides a tremendous opportunity for education of medical staff on accurate completion of MCCDs which will in turn improve the quality of Public Health information.

There may be scope for joint educational initiatives with the COPFS through the regional Deaths Units.

Discussions on the completion of death certificates and communication with relatives are currently incorporated into undergraduate medical training by Hospice medical staff and a similar post graduate module may be effective.

Irene McKie  
Hospice Director  
Strathcarron Hospice  
5 November 2010
Dear Christine

Finance Committee – consideration of the Financial Memorandum of the Health (Certification of Death) Bill

As you are aware, the Finance Committee examines the financial implications of all legislation, through the scrutiny of Financial Memoranda. The Committee agreed to adopt level one scrutiny in relation to the Health (Certification of Death) Bill. Applying this level of scrutiny means that the Committee does not take oral evidence or produce a report, but it does seek written evidence from affected organisations.

The Committee received one submission, from the British Medical Association, which is attached to this letter. If you have any questions about the Committee’s scrutiny of the FM, please contact the clerks to the Committee via the contact details above.

Yours sincerely

Andrew Welsh MSP,
Convener
Submission from the British Medical Association

The British Medical Association is a registered trade union and professional association representing doctors from all branches of medicine. The BMA has a total membership of around 140,000 doctors representing 70% of all practising doctors in the UK. In Scotland, the BMA represents around 15,500 doctors.

BMA Scotland is grateful for the opportunity to provide comment on the Certification of Death (Scotland) Bill. BMA Scotland took part in the consultation exercise for the Bill. We also provided a written response to the Health and Sport Committee detailing the following concerns regarding financial assumptions made.

- Although the system detailed in the Bill may appear to be reasonably priced, we believe it does not provide the best value for money since it does not offer adequate or effective protection levels to society. We highlighted this in the Scottish Government’s initial consultation.

- We have concerns that the level of costs detailed in the Financial Memorandum is seriously underestimated. This could have severe implications as any lack of funding or staff shortages could cause delays to funerals causing distress to families at a particularly difficult time. Any pilots taking place should be examined carefully to provide more accurate costs and Scotland’s rural nature should also be taken into consideration when considering costs.

- With regard to cost, additional workload for doctors would need to be considered. We acknowledge that all reviews can be suspended during times of an epidemic, however doctors in primary and secondary care settings constantly work under very tight timescales juggling patients in both planned and emergency situations. If an unrealistic timescale is set, or an emergency arises, or due to pressures from staff absence, a doctor will be required to decide whether to let patient care suffer or to be imprisoned.

- Finally, with regard to providing the information to the medical reviewer, confidentiality is paramount in preserving trust between patients and doctors. Doctors must have guarantees that all documents provided to the medical reviewer are secure in transit, be that electronically or by other means, to avoid any distress to relatives and preserve the dignity of the dead. Resources for the cost of this would also need to be sufficient.

Conclusion
The BMA has real concerns regarding whether this Bill would provide improved public protection given the lack of real-time scrutiny, and the minimal level of that scrutiny, despite the fact that one aim of the Bill is to provide improved safeguards and increased public confidence in the system.

We have concerns about cost and believe the medical reviewer system is less robust and not as comprehensive as the current system or the scheme being introduced in England and Wales. Indeed, there will in fact be a two tier system in the UK, and it is
doubtful that this would reassure the Scottish public. We are by no means saying the current system is perfect, however we should take this chance to change the certification of death for the better and not implement inadequate and unsafe changes to save money.

Dr Charles Saunders  
Deputy Chairman of BMA Scotland
Subordinate Legislation Committee

Remit and membership

Remit:

1. The remit of the Subordinate Legislation Committee is to consider and report on-

   (a) any-

      (i) subordinate legislation laid before the Parliament;

      (ii) Scottish Statutory Instrument not laid before the Parliament but classified as general according to its subject matter;

      (iii) Pension or grants motion as described in Rule 8.11A.1;

and, in particular, to determine whether the attention of the Parliament should be drawn to any of the matters mentioned in Rule 10.3.1;

(b) proposed powers to make subordinate legislation in particular Bills or other proposed legislation;

(c) general questions relating to powers to make subordinate legislation; and

(d) whether any proposed delegated powers in particular Bills or other legislation should be expressed as a power to make subordinate legislation.

(Standing Orders of the Scottish Parliament, Rule 6.11)

Membership:

Bob Doris
Helen Eadie
Rhoda Grant
Alex Johnstone
Ian McKee (Deputy Convener)
Elaine Smith
Jamie Stone (Convener)
Committee Clerking Team:

Clerk to the Committee
Irene Fleming

Assistant Clerk
Jake Thomas

Support Manager
Lori Gray
Subordinate Legislation Committee

66th Report, 2010 (Session 3)

Certification of Death (Scotland) Bill

The Committee reports to the Parliament as follows—

INTRODUCTION

1. At its meetings on 23 November and 7 December 2010, the Subordinate Legislation Committee considered the delegated powers provisions in the Certification of Death (Scotland) Bill at Stage 1. The Committee submits this report to the Health and Sport Committee as the lead committee for the Bill under Rule 9.6.2 of Standing Orders.

OVERVIEW OF THE BILL

2. The Certification of Death (Scotland) Bill (“the Bill”) was introduced in the Parliament on 7 October 2010 by the Cabinet Secretary for Health and Wellbeing, Nicola Sturgeon MSP.

3. The Scottish Government provided the Parliament with a memorandum on the delegated powers provisions in the Bill (“the DPM”).

4. Correspondence between the Committee and the Scottish Government is reproduced in the Annexe.

5. The Committee determined that it did not need to draw the attention of the Parliament to the delegated powers in sections: 2 (Power of Scottish Ministers to give directions to the Registrar General), 4(5)(e), 4(8), 8(5), 17(4), 18(4), 22(3), 24, 25(1), 25(2), 27 and 31(3) and the power to be inserted in paragraph 7A of Schedule 5A to the National Health Service (Scotland) Act 1978 by paragraph 2 of schedule 1 to the Bill.
Delegated powers provisions

Section 2: Suspension of referral of certificates for review during emergencies

Power conferred on: Scottish Ministers
Power exercisable by: Order
Parliamentary procedure: Negative resolution

6. Section 2 inserts section 24A(7) into the 1965 Act. This allows the Scottish Ministers to suspend by order the referral to medical reviewers of medical certificates of cause of death during an epidemic, or when it is considered on reasonable grounds that it is necessary to do so to prevent (or to prevent the spread of) infectious diseases or contamination. Such orders can also make ancillary provisions, as necessary or expedient.

7. The DPM explains that it may be necessary to suspend the referral of the certificates to medical reviewers during an epidemic, or other situation where an infectious disease or contamination is spreading rapidly, if there are large numbers of deaths. This could place a significant burden on the registration system and doctors. In some circumstances funerals may need to take place straightaway to prevent the development of a danger to public health. This power is designed to allow these rare but extreme circumstances to be catered for.

8. On the choice of procedure, the DPM states that negative procedure has been chosen “as this power will be required in emergency situations where there is a serious risk to public health that has to be addressed urgently. Negative procedure will allow such an order to be brought into force almost immediately, whereas if the emergency took place at the beginning of a long parliamentary recess, it would be impossible for the order to be made quickly enough to deal with the situation using affirmative procedure.”

9. The Committee accepts that it may be necessary to suspend the operation of the proposed scheme for review of medical certificates for the reasons given in the DPM. It therefore accepts the need for this order-making power in principle. On the choice of procedure, the Committee notes that there is a specific form of affirmative procedure which is designed for emergencies. This would allow the instrument to be made and brought into force immediately, but for the order to remain in force beyond a specified period (whatever period the Parliament considers appropriate) it must be approved by resolution of the Parliament.

10. The choice of negative procedure here would mean that it would be likely that the “21 day rule” would be breached in every case, given the circumstances in which the power is to be used. The Committee does not consider it sensible to select a form of procedure which it is clear the Government would find it difficult to comply with in practice. It therefore suggested to the Government that emergency affirmative procedure would be more appropriate.

11. The Government’s reply indicates that it did not initially select emergency affirmative procedure since it thought that the intervention of a long period of recess would be problematic. However, the Committee notes
that periods of recess need not count for the purposes of calculating the specified period. The Government has indicated that it intends to amend the power to adopt emergency affirmative procedure discounting periods of recess. The Committee is content with this.

Section 4(7): Suspension of applications under section 4 during emergencies

Power conferred on: the Scottish Ministers
Power exercisable by: Order
Parliamentary procedure: Negative resolution

12. Section 4(7) contains a power to suspend applications under section 4, just as section 24A(7) of the 1965 Act (added by section 2) contains a power to suspend the referral of certificates under that section. That is, during an epidemic or when it is necessary to do so to prevent the spread of infectious diseases or contamination.

13. The DPM explains that this power, and the choice of procedure, are taken for the same reasons as for the power taken under section 24A(7) of the 1965 Act (inserted by section 2).

14. The Committee considered that the same arguments against adoption of negative procedure applied here as are described in relation to section 2. The Government has agreed to amend the procedure for this power to emergency affirmative and the Committee is content with this approach for the reasons given above.

Section 23(3): Fees

Power conferred on: the Scottish Ministers
Power exercisable by: Regulations made by statutory instrument
Parliamentary procedure: Affirmative resolution

15. Section 23(3) permits the Scottish Ministers to make regulations about the charging of a fee (a) in respect of the review functions of medical reviewers and (b) for an application to cremate a person who has died outwith Scotland. The regulations can set out the amount of fees, arrangements for fee collection, including who will collect them for the Scottish Ministers, and the circumstances where there may be no fee.

16. Section 23(2) provides that the cost of medical reviewers is to be shared universally by a new separate fee payable in respect of every death registered (whether the cause of death is reviewed or not). The personal representatives of the deceased are liable to pay the fee which is to be treated as an administrative expense of the deceased’s estate.

17. By section 23(5), in setting the amount of fees, Ministers must have regard to the reasonable costs of the exercise of the functions in respect of which the fee is charged. They must consult such persons as they consider appropriate.
18. The Committee is content that a power to specify different fee levels over time is appropriate in principle, and that subordinate legislation is also appropriate for the specification of more detail on the collection arrangements.

19. However, the Committee queried whether draft affirmative procedure was the appropriate level of scrutiny for the setting of application fees, and arrangements for collection. Such arrangements would more usually be subject to negative resolution procedure. The DPM does not expand on why draft affirmative procedure rather than negative was adopted. The Committee therefore asked for clarification of this, particularly since the power cannot modify the basis of liability for the fee.

20. The Scottish Government responded that it had originally considered that the subject matter of the manner of collection of the fee could be rather sensitive. However it proposes to amend the Bill to apply negative procedure in light of the Committee's comments. The Committee is content with this and notes that the principle that a new fee is to be payable in respect of the registration of every death, and liability for it, are both matters set out on the face of the Bill and therefore subject to full scrutiny by the Parliament.
Correspondence with the Scottish Government

Section 2: Suspension of referral of certificates for review during emergencies

The Committee asks:

- Q – Given that this power is designed for an emergency situation, why has it been considered appropriate to propose negative procedure in place of the “Class 3” emergency affirmative procedure?

The Scottish Government notes the Committee’s comment that the “Class 3” procedure could be used to bring an order into force immediately without breaching the 21 day rule, allowing it to remain in force for a sufficiently long period (including that of a long Parliamentary recess) before requiring approval.

Whilst the Scottish Government had considered the application of “Class 3” emergency procedure, it understood that it would be an unusual use of that procedure to allow an order to remain in force for longer than 28 to 40 days without being approved by the Scottish Parliament (indeed it is understood that orders using this procedure are often referred to as “28 day orders” because, in most cases, they stipulate a period of 28 days).

As the objective here was to ensure that an order could be made and come into force at any time without requiring Parliamentary approval, including during a long period of recess, the Scottish Government considered that Class 3 procedure might not be suitable as the order might have to be made at the beginning of the summer Parliamentary recess (it is noted, for example, that the most recent summer recess lasted 62 days).

However, it appears that the Committee would consider the use of Class 3 procedure appropriate in these circumstances and the Scottish Government therefore plans to amend subsection (9) of section 24A (as inserted by section 2 of the Bill) accordingly (discounting periods of recess from the period before approval).

Section 4(7): Suspension of applications under section 4 during emergencies

The Committee asks:

- Q – Given that this power is designed for an emergency situation, why has it been considered appropriate to propose negative procedure in place of the “Class 3” emergency affirmative procedure?

For the same reasons as set out above in relation to section 2, the Scottish Government intends to amend the procedure applicable to the exercise of the power in section 4(7) from negative to “Class 3” emergency procedure.
Section 23(3): Fees

The Committee asks:

- Q - Why has affirmative procedure been applied to the power to make regulations to set the amount of fees and prescribe arrangements for collection of those fees, rather than negative procedure?

The Scottish Government had considered that affirmative procedure might be appropriate here as there may be particular sensitivities for bereaved families regarding the manner in which the fee is to be collected (for example, one of the options is for registrars to collect the fee from the person seeking to register a death; but the Association of Registrars of Scotland has commented that the recently bereaved may find it difficult to take on board the necessary information relating to payment of the fee at the point of registration).

However, the Scottish Government notes the Committee’s comment that the prescription of fee levels and collection arrangements are more usually subject to negative procedure and in the light of this, it intends to amend section 28 of the Bill accordingly.
Supplementary written evidence to the Health and Sport Committee, in response to the announcement of proposed amendments made by the Minister for Public Health and Sport at the Committee’s meeting on 15 December 2010

Scottish Pathology Network
Professor Stewart Fleming
Scottish Council of Jewish Communities
Association of Registrars of Scotland
Federation of Burial and Cremation Authorities
Information Services Division, NHS National Services Scotland
Ishbel Gall, Association of Anatomical Pathology Technology
Scottish Pathology Network (SPAN)

Thank you for giving the opportunity to comment on the proposed revisions to the Death Certification (Scotland) Bill.

The Scottish Pathology Network (SPAN) has previously commented on earlier drafts of this legislation and its comments are a matter of record. I note the introduction of two levels of review:

Level 1 Reviews

I note the proposal to introduce these reviews for 25% of all certificates. Furthermore I am told that these reviews will entail enquiry by the Medical Reviewer of the certifying doctor seeking information about the circumstances of the death. I also understand that the Medical Reviewer will have the further option of undertaking scrutiny of the case records, further enquiry or even referral to the Procurator Fiscal. I believe that this will cover much of the ground currently covered by procedures for cremation and while the overall percentage of enquiry will be lower, applying the process to all deaths is a step forward. SPAN has always held the view however that the new Death Certificate should bear two signatories and this view is unchanged.

Level 2 Reviews

I note that these reviews will still be carried out at a rate of 1 – 2 % of all deaths. I am still of the opinion that this level is too low but at the present time I do not have the evidence base to advise as to what the correct percentage should be. You may note that my evidence to the Health & Sport Committee on Dec 1st referred to review procedures for diagnostic histopathology which may not be precisely comparable to death certification. I understand that the sample size proposed is likely to reveal the major and minor error rate in death certification and I would advise that once this is known it will be possible to arrive at the correct percentage of case sampling to detect errors at a significant level and that the whole process should be reviewed in the light of that knowledge.

As previously discussed with the Bill Team in St Andrew's House on November 4th I believe much of the success of the new legislation will depend on the effective performance management of the Medical Reviewer(s).

Dr Jeremy Thomas
Clinical Lead
Scottish Pathology Network

Consultant Pathologist
Pathology Department
Western General Hospital
Edinburgh
Following my written and verbal evidence to the Health and Sport Committee the Bill team have sent me a brief overview of the proposals introduced by the Minister during her dialogue with the Committee on December 15th 2010. Although there is no further consultation at this late stage I felt it may be worthwhile to make some comment on the new proposals. The new proposals would appear to consist of:

- an increase in the number of in depth (now designated level 2) reviews from 500-1,000, that is approximately 2% of deaths;
- the introduction of brief level 1 reviews on 25% of all deaths.

As you know my position has consistently been a call for a second confirmatory certificate for all deaths similar to the current position for cremation forms. The second signatory to be obliged to investigate the mode and circumstances of the patient's death in order to confirm the cause of death or otherwise prompt investigations. I welcome the new proposals as a step in the right direction but believe they still fall short of what I would consider safe and accurate death certification. The level 2 review is more detailed than the current cremation confirmatory procedure but the level 1 review of 25% of deaths is less detailed than currently required.

The Government have accepted the costs of the new proposals will be met centrally and there is obviously a need to balance cost against the achievement of safe and accurate death certification. As I have said previously in my written evidence there are parts of the Bill which I strongly support, but in this crucial, as I see it, aspect of confirmation of the cause of death the new proposals remain short of the standard I would wish to see.

Professor Stewart Fleming
Professor of Cellular and Molecular Pathology
University of Dundee
Ninewells Hospital
Certification of Death (Scotland) Bill Stage 1 Report:
Scottish Parliament Health and Sport Committee request for additional information
Response from the Scottish Council of Jewish Communities

Whilst The Scottish Council of Jewish Communities fully supports the principle of effective scrutiny, we are concerned that the introduction of widespread Level 1 reviews, and an increase in the number of Level 2 reviews are likely to increase delays before burial.

Parallel or Expedited Procedure

a) Review, Registration, and Disposal?

We welcome the Minister’s assurance in her supplementary evidence to the Committee that “Under the expedited procedure it will be possible to proceed to dispose of the body before the review is complete. ... Accordingly, families will be able to proceed directly to funeral, whilst the review is ongoing.” However, we remain concerned that this may be difficult to achieve in practice unless the legislation is sufficiently explicit to reassure not only registrars but also funeral directors, a representative of whom stated at a Scottish Government briefing shortly before the introduction of the Bill, that the “Proposals will cause a delay in all burials ... because no funeral director will be willing to begin to prepare for disposal until it has been confirmed that that disposal can go ahead.” (personal note).

We therefore recommend that section 7 of the Bill should be amended to state explicitly that when the parallel or expedited procedure has been approved, disposal and not merely registration may take place before the review has been completed.

b) Presumption v “a judgment made by the medical reviewer”

We remain very concerned at the Minister’s statement that parallel review and registration would “not happen automatically but would have to be at the say-so of the medical reviewer. In effect, it would be a judgment made by the medical reviewer.”

We attach a Freedom of Information release requested by Stewart Maxwell MSP, that lists the methods used for post-mortem examinations requested by the procurator fiscal service in cases of sudden unexplained deaths between 2006 and 2010. Since it is highly unlikely that there is any intrinsic difference in such deaths between Dundee and Glasgow, there can be no explanation for the very large difference in rates of non-invasive “view and grant” examinations (35% in Dundee and 1% in Glasgow) other than the personal preference of senior staff, and this has been confirmed by Prof Derrick Pounder (personal communication).

This has frequently proved problematic for the Scottish Jewish community, the vast majority of whom live in the Glasgow area, since there are very strong imperatives both to respect the integrity of the deceased and to expedite burial so that mourning can commence. In the context of the distress of bereavement, interference with the body of a person who has died, and the sometimes lengthy delays to burial which are inevitably occasioned by invasive

2 http://www.scottish.parliament.uk/s3/committees/hs/or-10/he10-3802.htm
surgical post-mortem examinations cause needless additional suffering, and interfere with the process of grieving.

In order to prevent a similar situation arising in respect of parallel review, registration, and burial, we would request the Committee to accept the Minister’s offer that “we can certainly explore it further.” (ibid., col 3875), and we urge that section 7 of the Bill should also be amended to require a presumption that registration and disposal may proceed in parallel with review, unless there are compelling counterarguments in any individual case.

“As soon as possible”

We remain concerned at the probability of delays due to unavailability of personnel outwith office hours. In her supplementary evidence, the Minister stated that “when a case is selected for review, an application may be made directly to the medical reviewer who will confirm to the registrar as soon as possible whether the expedited procedure can be used”, and, giving evidence to the Committee for the Scottish Government, Dr Mini Mishra commented that “a three-hour review should … tie into an expedited burial” (ibid. col 3874). “As soon as possible” would permit an unacceptable amount of leeway, and, since Jewish burials do not normally take place after dark, and several hours are required for the body to be prepared for burial, a three hour review beginning even late morning during the winter would preclude the possibility of a same-day burial.

Moreover, since medical reviewers will generally be involved in scrutinising several cases at any one time, will “hold educational sessions locally” (Shona Robison, ibid. col 3884), and “will be expected to contribute to training through seminars, making links with the deans and talking to boards” (Frauke Sinclair, ibid. col 3885), they will evidently not always be immediately available to receive an application for use of the expedited procedure. Indeed, if attending a seminar, a medical reviewer could conceivably be out of the office for a full day. This length of delay to applications would be entirely unacceptable.

Even with good will on the part of all concerned, the matter will be further complicated in cases when deaths occur outwith office hours. As we have already mentioned in our earlier evidence, the availability of an out-of-hours service varies widely from area to area, and in practice often depends on the family happening to have contacts who happen to have the personal contact details of the registrar. In a recent case in which we assisted a bereaved family, the duty registrar, although extremely sympathetic when contacted at 10am on a Sunday morning, was unable to register the death until 4pm because he was engaged to conduct marriage ceremonies at several different locations during the whole of the intervening period. As a result, despite the MCCD having been provided to the family within half an hour of the death which took place shortly after 9am, the burial could not take place until the following day. This caused the family considerable distress. “As soon as possible” is not a satisfactory premise on which to establish this service, and we urge the establishment of an effective out-of-hours service to prevent selection for review causing even longer delays, particularly over weekends and bank holidays.

**Alternative methods of non-invasive post-mortem examination**

We agree with the Minister’s supplementary evidence that “MRI scans are additional tools in a post mortem examination” but experience in England, where MRI and other scanning technology, as well as minimally invasive techniques such as needle biopsy, are now part of a range of post-mortem examination tools approved in the Coroners and Justice Act, demonstrates that she is incorrect in the blanket statement that they “cannot replace an autopsy.” We maintain that different tools are required in different situations, and it is certainly the case that surgical post-mortem examinations will continue to be required in some, though
by no means all, cases. We have been advised, for example, that in cases of pneumothorax a more accurate conclusion of the cause of death is obtainable by means of MRI than surgical post-mortem, since trapped air escapes from the chest cavity as soon as a scalpel is inserted. The Minister has stated that “Trained staff and appropriate equipment are not currently available” to permit the use of MRI for post-mortem examinations. This is correct as regards staff, and naturally, priority must always be given to treatment and diagnosis of living patients, but we are aware of reports that spare capacity for hospital MRI scanners is leased to the oil industry and non-medical research, since they would otherwise be unused overnight. In any event these are not reasons to exclude a potentially more cost-effective resource, and we suggest that this is simply a matter of appropriate training and procurement.

For a more detailed discussion of this subject, we would draw the Committee’s attention to our evidence in relation to the Criminal Justice and Licensing Bill.

**Recommendations**

1. Section 7 of the Bill should be amended to require a presumption that registration may proceed in parallel with review unless there are compelling counterarguments in any individual case.

2. Section 7 of the Bill should be amended to state explicitly that the expedited procedure permits disposal as well as registration before the review has been completed.

3. Regulations should state a maximum time after a death by which a medical reviewer must notify his or her intention to stay registration until after the review has been completed, after which burial may proceed.

4. An effective, equitable, and consistent Scotland-wide out-of-hours registration and medical reviewer service should be established.

5. The use of non-invasive post-mortem examination techniques, primarily view and grant, but not excluding other technologies, should be actively encouraged.

6. A Scotland-wide programme to train staff in the use of new non-invasive post-mortem examination techniques such as CT, MRI, and other scanning technology should be implemented without delay.

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Note: The Scottish Council of Jewish Communities (SCoJeC) is the representative body of all the Jewish communities in Scotland comprising Glasgow, Edinburgh, Aberdeen, and Dundee as well as the more loosely linked groups of the Jewish Network of Argyll and the Highlands, and of students studying in Scottish Universities and Colleges. SCoJeC is Scottish Charity SC029438, and its aims are to advance public understanding about the Jewish religion, culture and community. It works with others to promote good relations and understanding among community groups and to promote equality, and represents the Jewish community in Scotland to government and other statutory and official bodies on matters affecting the Jewish community.

In preparing this response we have consulted widely among members of the Scottish Jewish community.

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3 *How can we reduce the number of coroner autopsies? Lessons from Scotland and the Dundee initiative*, Prof Derrick Pounder, Journal of the Royal Society of Medicine, 2011: 104: 19–24  

Dear Mr Maxwell

Thank you for your letter of 12 July 2010 requesting information under the Freedom of Information (Scotland) Act 2002, in relation to forensic pathology contracts.

I can advise that Crown Office currently has forensic pathology contracts with the following institutions:

University of Aberdeen – contract ends 31 March 2013
University of Dundee – contract ends 31 March 2013
University of Glasgow – contract ends 31 March 2013
Lothian Health Board – contract ends 30 September 2013
NHS Ayrshire & Arran – contract ends 31 March 2012

There is an option to extend the contracts for a further two separate 12 month periods, at COPFS’ discretion.

Service providers are contracted to deliver pathology services in cases referred to them by relevant Procurators Fiscal, whether death has resulted from natural or non-natural causes. The contracts are based on a calculated annual workload of post mortem examinations to be carried out by each institution but there is no assumed number of view and grant examinations within the calculation.

Information in relation to the number of view and grant examinations and post mortem examinations carried out by each of the four lead institutions (Aberdeen, Dundee, Glasgow and Lothian) during the current contract period (2006-2010) is attached. Procurators Fiscal instruct forensic examinations in cases of sudden, suspicious and unexplained deaths. However reportable categories of death are not recorded within our database and therefore, in terms of section 17 of the Freedom of Information (Scotland) Act, the information requested is not held.
I hope this information is helpful to you. However, if you are dissatisfied with the way in which your request has been handled, you do have the right to ask us to review it. Your request should be made within 40 working days of receipt of this letter and we will reply within 20 working days of receipt. If you require a review of our decision to be carried out, please write to The Disclosure Section, Policy Division, 25 Chambers Street, Edinburgh, EH1 1LA or e-mail foi@copts.gsi.gov.uk. The review will be undertaken by staff not involved in the original decision making process. If our decision is unchanged following a review and you remain dissatisfied with this, you then have the right to make a formal complaint to the Scottish Information Commissioner.

Yours sincerely

[Signature]

Rosemary Lester
Policy Division
## Forensic Pathology Data 2006-2010

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**Key**

- **V&G** = View and Grant examination
- **PM** = Post mortem examination
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The Association of Registrars of Scotland (ARoS) is a professional body established in 1865 to represent Registration Staff in Scotland. When registration staff become qualified they are invited to become members of the Association. At the Annual General Meeting, members elect an Executive Council to represent them and work on their behalf. The Executive Council then proposes officer bearers. The Executive Council meets 3 times a year and reports back to the members via the ARoS website and at the AGM. In 2010 the membership was 175 which represented 30 different Local Authorities. ARoS is a member of the European Association of Registrars.

Certification of Death (Scotland) Bill Stage 1 Report

ARoS welcomes the opportunity to comment on the steps the Government intends to take regarding the increase in the number of cases which will be reviewed under the above act.

ARoS feels the increase in the number of reviews is excessive and will cause distress to more families than originally proposed. The comments made by the faith-based community witnesses, regarding the grieving process being more difficult if delays are introduced or, the bereaved becoming anxious of a system they do not see a reason for, is relevant in all cases regardless of faith.

Any delay to the registration causes distress to relatives who come to register a death. This already happens regularly when an MCCD is not properly completed and we are required to contact a doctor. An additional delay brought about by the review process was accepted by ARoS but considering the numbers were small and over the country a random review would happen so infrequently we did not see it as a major issue. However now that it has been proposed that around 13,500 be reviewed at level one and 500 – 1000 at level two, this becomes a larger problem to more members of the public. This is compounded by also having to pay to register a death.

We would like to know if, when the reasonableness test was applied, did it take into consideration the emotional state of bereaved relatives?

ARoS accepts that test sites are being proposed to assess whether the system is working in the reviews and other areas and hopes that the views of the public will be sought and considered during the test period.

Alison Quigley
Honorary Secretary
Association of Registrars of Scotland
THE FEDERATION OF BURIAL AND CREMATION AUTHORITIES

41 Salisbury Road, Carshalton, Surrey SM5 3HA
Telephone/Fax: 020 8669 4521
Email: fbcasec@btconnect.com
www.fbca.org.uk

Secretary: Richard J Powell

Date: 31st January 2011

Ref: RJP/44/COD/Scotland

Health and Sport Committee
Room T3.60
The Scottish Parliament
Edinburgh
EH99 1SP

Dear Sir

Certification of Death (Scotland) Bill Stage 1 Report – Request for Additional Information

The Federation of Burial and Cremation Authorities is pleased to have the opportunity to comment on the steps that the Minister for Public Health and Sport, Shona Robinson has outlined that the Scottish Government intends to take in response to concerns raised by witnesses in relation to the Bill.

I can say that although the Federation would have preferred to see the Scottish Government adopt a level of scrutiny in respect of Death Certification similar to that being proposed for England and Wales, it accepts that the current proposals will bring about a significant improvement in the level of scrutiny likely to be achieved. The Federation welcomes the addition of the 25% Level 1 reviews, and the 100% increase in the Level 2 reviews but would ask that every effort is made to minimise delays to funeral plans as a result of the scrutiny process.

The Federation is also pleased to see that the Committee considers that the responsibility for assessing the validity of documentation in cases of repatriation of the deceased for burial or cremation should be exercised centrally.

In conclusion I would confirm that the Federation agrees with the Committee’s concern that it might still be possible for a medical practitioner to sign an MCCD without examining the body of the deceased. The Federation would like to add weight to the Committee's point in drawing this matter to the Minister’s attention and requests that further consideration should be given to this point in order to resolve this anomaly.

Yours sincerely

Richard J Powell
Secretary
Thank you for this opportunity to comment on the proposals being made in relation to the Certification of Death Bill.

I welcome the increase in the number of level 2 reviews (comprehensive scrutinies) from 500 to 1,000 cases annually. I believe that this will allow a reliable assessment of the accuracy and quality of death certification at Scotland level and provide information about whether accuracy is improving or not. It should provide a starting point for a programme aimed at improving the quality of death certification in Scotland and provide information about the impact of training and other interventions.

I note the suggestion that the number of level 1 reviews be increased to 25% of deaths in Scotland. I understand that the purpose of these reviews is to provide some deterrence against criminal activity (by health care workers or the public) and to provide public reassurance. In my view a decision about the correct number of reviews required to provide this deterrence and reassurance is unavoidably arbitrary and cannot be made on purely statistical grounds.

Dr Colin M Fischbacher
Consultant in Public Health Medicine
Information Services Division (ISD)
NHS National Services Scotland
Thank you for this opportunity to comment further on the Certification of Death (Scotland) Bill at Stage 1.

Whilst welcoming the proposed increase in the number of reviews to be carried out I still have reservations regarding how the registration and review process will improve overall quality and public confidence in practice. The sample size does not approach the level of scrutiny currently carried out if 62% of deceased are cremated. There does appear to be some ambiguity as to what is meant by the terms registration and disposal which are two distinct processes. Currently it is possible for burial to take place prior to registration being completed but not cremation and I acknowledge that this will change under proposed legislation but it will be possible to request an expedited review to allow disposal to proceed in parallel. This is primarily seen as something which will be requested by certain faith groups although if people know that this option is available to them then more people will request this parallel review. This may occur when Level 1 reviews, where the MCCD is discussed with the certifying doctor, may be perceived to cause delay as doctors work different shift patterns and therefore may be unavailable during regular office hours to discuss the case with the reviewer. This is most likely when the death occurs overnight or at a weekend. In parts of Scotland there is a culture of burial as quickly as possible, certainly with three days of death, and as a population this might result in almost 100% requests for parallel review. Most discussion has been around disposal by burial whilst the parallel review is taking place but little has been said about disposal by cremation under these circumstances. Where disposal is by burial conducting a review after disposal might not be so problematic but where disposal is by cremation the body cannot be retrieved.

Currently the doctor completing the Form C, confirmatory certificate, to verify the statements made in Form B will often find omissions or errors in the Form B and question statements made by this doctor leading to deaths being reported to the Procurator fiscal or the cause of death being modified. Supplementary information, such as known respiratory issues or conditions like diabetes are often added as a result of the second doctor reviewing medical records. This verification will be lost and with the number of cremations carried out currently the number of reviews would have to be increased to equal the checks already in place. The proposals to remove the current scrutiny prior to cremation should not be about cost to the bereaved rather it should be about an improvement to what is current practice. Many doctors are not entirely happy taking money for completion of the cremation forms and often waive the fee or donate the money to a medical charity rather than taking the money themselves.

I am most concerned that there will be less scrutiny than there is presently where the deceased is to be cremated. The Bill also needs to address the issue of whether or not it is to be mandatory that the doctor issuing the MCCD should examine the deceased.
For disposal, especially by cremation, to proceed without any examination of the deceased would seem to be a backward step.

Mortuary provision still remains an issue and many funerals in rural areas will be subject to delay because funeral directors do not have storage facilities and will not be making arrangements until registration is confirmed, alternatively they will request parallel review in all cases. The biggest impact will be in areas where transport links are poor and relatives are unable to travel to collect death certificates. This will be most problematic where deaths occur on the mainland and the deceased was resident in the western or northern isles and also rural areas where the hospital may be some distance from the place of residence of the deceased.

It is unclear as to how the mechanism for disposal of body parts is to work under new legislation. The Cremation Laws were amended in 2003 to allow cremation of body parts and this involved an application for disposal, the AA Form, and confirmation, by a registered medical practitioner, of the source of the body part and that it can legally be disposed off, the DD Form. The medical referee then reviews the application and issues an FF Form to allow the body part(s) to be cremated. There has been little mention of how body part disposal will be possible under the Medical Reviewer model. Likewise the cremation of fetuses which is often carried out by hospitals on behalf of parents has not been discussed as part of the proposed Bill. Many fetuses, especially later gestation fetuses, are cremated every year and this does need to be included in legislation. Although having no legal status it is important for families to know that their “baby” is respectfully disposed off.

The proposed fee for every death cannot be collected by funeral directors as there is no legal requirement to use the services of a funeral director. It is a legal requirement for a death to be registered so that is the logical place for a fee to be collected. I know this is unpopular with registrars, as no doubt breaking the news that a death has been selected for random review will be too. It may be though that people are less willing to register a death where there is a “death tax”. Often hospital chaplains, police, carers and other healthcare professionals will register a death where there are reasons that the family cannot do this themselves and this may in future increasingly fall to the Local Authority or Ultimus Haeres (Crown Office).

I am unsure what is being referred to in the letter from the Minister for Public Health and Sport when she refers to fees. “A further point of clarification I would like to add is that the £9 applicable for the Full Extract of Death Certificate currently payable at registrars' offices is a separate fee to the fee proposed for Level 2 reviews and will remain a separate fee. We have explained this to COSLA, who have confirmed their understanding that these are two distinct fees for distinct purposes.”

Is there to be different fees for different levels of review or does this just refer to the one fee payable for registration of any death whether a review is being carried out or not?
Currently there is no provision in the bill for those deaths where a post mortem, authorised by the next of kin, or their representative, has been carried out. When the certifying doctor is aware of the post mortem results and these appear on the death certificate it would seem this should be taken as an adequate review of the cause of death and no further investigation required. Under current legislation only Cremation Form B requires to be completed when the doctor is aware of the post mortem findings and has at the very least discussed these with the pathologist who is at least five years post registration. To review these cases would appear to be unnecessary.

It is imperative that the issue of identifying and removing implanted devices such as cardiac pacemakers, ICDs, intrathecal pumps and Fixion nails is explored. All these devices must be removed prior to cremation and it is not always possible to palpate or see the implant. Many of these devices are discovered after the MCCD is issued by the second medical practitioner reading the medical records or examining the deceased.

If the aim of the Bill is to drive up the quality of death certification then it is imperative that training, much more stringent than that currently undertaken, is available not just to junior doctors but to more senior medical professionals, especially as the current Medical Certificate of Cause of Death will have to be changed considerably. To educate all 20,000 registered medical practitioners in Scotland who are qualified to write MCCDs is a big undertaking for the deaneries. There is also the issue of training recently retired medical practitioners who may be called upon in times of excess death. During these periods the review process may be suspended so it is imperative that those who may have to issue MCCDs are trained adequately in any new paperwork required.

There are a number of deaths in the UK each year where the deceased is returned to Scotland from areas where legislation is different. Has the number of deceased arriving from other parts of the UK been included in the “overseas deaths” or are there to be separate arrangements put in place? This may be an issue which is of particular importance in the Dumfries & Galloway and Borders areas of Scotland.

Ishbel Gall  
Association of Anatomical Pathology Technology
Certification of Death (Scotland) Bill: The Minister for Public Health and Sport (Shona Robison) moved S3M-7821—That the Parliament agrees to the general principles of the Certification of Death (Scotland) Bill.

After debate, the motion was agreed to (DT).

Certification of Death (Scotland) Bill: Financial Resolution: The Minister for Public Health and Sport (Shona Robison) moved S3M-7822—That the Parliament, for the purposes of any Act of the Scottish Parliament resulting from the Certification of Death (Scotland) Bill, agrees to any increase in expenditure payable out of the Scottish Consolidated Fund arising in consequence of the Act.

The motion was agreed to (DT).
The Deputy Presiding Officer (Alasdair Morgan): The next item of business is a debate on motion S3M-7821, in the name of Shona Robison, on the Certification of Death (Scotland) Bill.

14:56

The Minister for Public Health and Sport (Shona Robison): I am pleased to open the debate on the general principles of the Certification of Death (Scotland) Bill. Before I turn to the substance of my speech, I want to thank a number of people. First, I thank the organisations and individuals who helped to shape the legislative proposals and those who provided evidence to the Health and Sport Committee—our proposals have benefited from their expertise and experience. Secondly, I thank Christine Grahame and the Health and Sport Committee for their detailed scrutiny of our proposals and considered conclusions in the stage 1 report. I stress that I will continue to listen to and work with stakeholders when taking forward the proposals in order to ensure that we have a sound and workable system.

The bill will introduce a single system of independent scrutiny of medical death certificates that will apply to deaths that do not require a procurator fiscal investigation. It will replace the current crematoria medical referee system and associated forms and will, therefore, abolish the cremation fees that families pay to doctors. As well as removing historical differences between cremation and burial that were introduced when medicine was less advanced, the new system will provide us with a robust and modern approach to scrutiny of death.

As the committee acknowledged in its scrutiny, a death certification system cannot prevent criminal activity of the kind that was carried out by Harold Shipman, but our proposals have been designed to deter malpractice and to provide public reassurance. They have been developed with the people who will be most affected in mind. Foremost of those are bereaved families, to whom we owe a duty to ensure that the new system minimises distress, avoids undue delay to funerals, and is affordable. Consequently, the reforms will result in a financially sustainable and proportionate system.

At the heart of the new system will be an emphasis on improving the quality of death certification. Improved quality of information on cause of death will help us to understand the distribution and determinants of mortality and to
identify at-risk populations. It will inform quality improvements in national health service services and provide better information to help us to deal with outbreaks of infectious disease.

The provisions will create the posts of medical reviewer and senior medical reviewer, who will be independent medical practitioners. Their key function will be to review death certificates. The bill provides powers for the reviewers to scrutinise an agreed number of death certificates each year. Those arrangements have been discussed in detail with the committee. Medical reviewers will undertake 1,000 comprehensive, random, real-time level 2 reviews and they will carry out additional targeted reviews, when they believe that there may still be cause for concern, after discussion with the certifying doctor. Crucially, the bill will also for the first time empower individuals to request a review, where they have concerns. Taken together, the package of reviews will amount to around 2,000 cases a year. Furthermore, medical reviewers will randomly scrutinise 25 per cent of all deaths—around 13,500 in all—by way of shorter level 1 reviews.

Medical reviewers will also assist families and authorise funding for post mortems in certain circumstances if the death has occurred abroad, the cause of death is unknown and the funeral is to take place in Scotland.

I now turn to the key issues raised in the stage 1 report. The report highlights a number of matters on which I have been asked to report back to the Health and Sport Committee. It also contains some specific recommendations for amendments, which I have considered. I will, of course, consider those points carefully and sympathetically and report back in detail to the committee shortly.

I am grateful for the committee’s recommendation that the general principles of the bill be agreed. I am also grateful for its general welcome for our proposals to reform the death certification system and to align procedures between burial and cremation. I also welcome its response to the additional proposals that I outlined during stage 1.

The appropriate level of scrutiny has clearly been a key consideration for all of us. We have worked hard with the committee to try to reach a satisfactory conclusion. I will clarify what the proposals entail and reflect on the reasons for reviewing the current system.

Under the current system, in which up to 3 doctors countersign cremation forms and receive a substantial fee from families, there is no guarantee of detecting malpractice. We know from discussions with many stakeholders and from the conclusions of the independent review group—which examined the subject in recent years—that existing checks may, in some cases, be perfunctory. In addition, quality can be poor and there is no systematic approach to improving quality nationally.

We should not forget that the failings of the current system led the previous Administration to establish the independent review group and to the group’s recommendations for change. Our proposals, as they will be amended after stage 1, will deliver a deterrent effect, be proportionate and deliver on quality.

On deterrence, level 1 reviews will maintain the checks by a second and now fully independent doctor for 25 per cent of all death certificates, with an option for each of those reviews to be increased to a more detailed level 2 review if required. Level 2 reviews will provide detailed checks of 1,000 certificates. Importantly, those checks will be entirely random and doctors will not be in a position to predict when their certificates will be scrutinised.

Additional targeted scrutiny will also be carried out where medical reviewers have identified issues locally, based on analysis by the new posts of statisticians who will examine all death data. Further reviews will also be initiated by families or other interested persons.

In fact, our proposed reviews, combined with the number of cases that are reported to the procurator fiscal each year, will mean that around 50 per cent of deaths in Scotland will be subject to more robust scrutiny than under the current system.

The bill’s provisions on quality will establish a quality improvement programme to change behaviour and practice around death certification. The programme will place the medical reviewers’ reviews within an audit cycle of continuous improvement.

Informed by the evidence that has been gained from a number of sources—including NHS deaths data, General Register Office for Scotland statistics, national statistics and patterns of death produced by the national mortalities statistician, random reviews and interested party reviews—the reviewers will carry out interventions ranging from targeted reviews, to critical clinical governance links with NHS boards, to training. Those interventions are intended to follow up concerns and bring about changes in behaviour and practice—some immediate, others over longer periods of time—and will be monitored so that they can be adjusted over time.

The 1,000 random level 2 reviews will provide a Scotland-level benchmark and year-on-year monitoring information that will allow us to gauge progress in driving up quality standards for death certification. The number of reviews that will be
conducted remains flexible and can be changed upwards or, possibly, downwards in the light of the evidence that we gather from early implementation of the new system, including the proposed test sites.

Our proposals on proportionality will maintain an appropriate balance between cost and scrutiny. Let us not forget that any increase in scrutiny will have an impact on costs. The proposed system is affordable to the public and I have agreed with the committee that the Scottish Government will bear the cost of the additional reviews that we discussed at stage 1. That amounts to around £600,000 in addition to the set-up costs that we already intend to fund.

The anticipated fee charged to the public is £30. For those who currently pay cremation fees, which is around 60 per cent of the public, that represents a substantial saving of about £120. I appreciate the committee’s positive comments about the setting of the fee and the abolition of the higher cremation fee in favour of a lower universal fee for all deaths. We will continue to work constructively with stakeholders on developing an effective fee collection mechanism.

The proposed legislation has been designed to require an annual report to Parliament on the activities and performance of the medical reviewers. That will allow for a transparent examination of the operation and impact of the new system by all interested parties, including colleagues in the Parliament, and for adjustments to be made to the level of scrutiny, as required. I have also committed to report back to the Health and Sport Committee following the operation of the test sites before full roll-out. That will take account of stakeholder input and will feed into the monitoring and evaluation plans.

The committee considers that faith groups’ needs—particularly the needs of the Jewish and Muslim faith groups—for a quick funeral should be specifically reflected in the bill. I assure members that we have carefully considered the issue and have met faith groups’ representatives. We have considered the committee’s point thoroughly. The expedited procedure that is included in the bill is intended to benefit a range of individuals who need to arrange a funeral quickly. That includes faith groups, although it will cover other circumstances.

I welcome the committee’s attention to the impact of the proposals on certain remote and island communities. I confirm that it is absolutely not my intention to disadvantage remote communities. We will examine that aspect specifically during the test-site phase before implementation. We will also consult funeral industry representatives from remote areas regarding the specific issues that are raised.

The committee also raised the question of where responsibility for checking certificates that are associated with deaths overseas should lie. Having reflected on that matter and listened to stakeholder concerns about the proposals in the bill to give that function to superintendents at local burial grounds and crematoria, I will amend the bill at stage 2 to require the medical reviewers office to carry out that function instead. I hope that that will address the concerns of stakeholders and the committee.

I welcome the committee’s comments on training and education. The bill seeks to improve existing training requirements and we will be examining the issue of supervision and training in more detail.

On electronic certification, I recognise the potential benefits that it could bring and I will further explore the feasibility of introducing such a system. Legislation already exists to allow for the introduction of electronic medical certificates of the cause of death, should implementation be desired.

The committee expressed a concern that the number of medical reviewers might not be adequate. We believe that our figures are robust, and they have been revised to take account of the additional proposed reviews. However, the number of reviewers is not specified in the bill and can therefore be adjusted. Furthermore, in the year before implementation, we will run test sites, a key evaluation aim of which will be to provide more detailed information on the duration of reviews. That will let us know how many staff are required.

I move,

That the Parliament agrees to the general principles of the Certification of Death (Scotland) Bill.

15:08

Christine Grahame (South of Scotland) (SNP): I speak as convener of the Health and Sport Committee on yet another cheery topic for the committee. Going from patients’ rights and palliative care to certification of death with, for some, a detour through end of life assistance was a logical but grim direction of travel—that is the popular phrase, I think. The process was lightened by gallows humour off camera, none of which I can repeat on the record for reasons that members will understand. Suffice it to say that the deputy convener’s sonorous baritone voice seemed most appropriate to the business at hand.

Speaking of business, I turn to our stage 1 report. It is a bit difficult when speaking as convener if a minister has addressed in advance many of the things that the committee put in its stage 1 report. Perhaps we should turn round the procedure so that the committee gets to speak to
its report first and the minister then addresses our concerns. However, that is for another day.

The bill was introduced on 7 October 2010 and was referred to the Health and Sport Committee. We launched a six-week call for written evidence, during which we received 39 written submissions. We began taking oral evidence on 24 November, when we heard from the Scottish Government’s bill team officials. We went on to take evidence from witnesses representing the University of Dundee, the Information Services Division of NHS National Services Scotland, the Association of Anatomical Pathology Technology, the Scottish Pathology Network, the Federation of Burial and Cremation Authorities, the National Association of Funeral Directors, and from the chief registrar of the City of Edinburgh Council. We concluded our oral evidence taking on 15 December, when we heard from the Scottish Council of Jewish Communities, the Muslim Council of Scotland and, last but not least, the Minister for Public Health and Sport.

On behalf of the committee, I put on record our thanks to everyone who provided evidence, especially the people who braved the inclement weather and lengthy and testing journeys in December—through blizzards or black ice and sometimes both—to give oral evidence to the committee. I also thank the minister and her officials for the evidence that they provided.

As the minister said, the bill’s overall purpose is to introduce a new system for the scrutiny of death certificates in Scotland. The primary objective is to increase the quality of, and confidence in, the system of death certification.

The bill will introduce a new system in Scotland for scrutiny of medical certificates of cause of death, which will be useful in public health planning. It will create the posts of medical reviewer and senior medical reviewer, whose functions will be to review the accuracy of death certificates. It will provide for the form of MCCDs to be amended to show additional relevant medical information, for example to indicate whether it is safe to dispose of the body by cremation. It will make it an offence in Scotland to dispose of a body or body parts without authorisation.

The bill also provides that if a person has died outwith Scotland and the body is to be cremated in Scotland, medical reviewers will determine whether it is safe to cremate the body. In a case in which a person dies outside Scotland and the body is to be buried or cremated in Scotland but no cause of death is available, the bill provides that a medical reviewer may assist with arranging a post-mortem to establish the cause of death.

The committee published its stage 1 report on Friday 21 January. Although we supported the general principles of the bill, we sought more clarity from the Government on several areas. To some extent the minister has pre-empted what I will say in that regard.

The bill will introduce arrangements for a sample examination of death certificates by medical reviewers on a random basis. We welcomed the steps that the minister announced to increase the random sample size—indeed, we welcome much that she said today, which we will consider. We were concerned that there should be a rigorous statistical analysis of the sample, to create confidence in the system.

As a result of the evidence that we received, we were concerned that the proposed new system for scrutiny of death certificates could prove to be less rigorous than the system that is currently in place. In the light of recent controversial cases, the most notable of which is the Harold Shipman case, the committee thinks that it is essential that the public have confidence in any system for examining and scrutinising causes of death. That is vital, in the context of the identification of possible cases of medical negligence or criminal activity, and in the context of accurate recording of public health data.

The committee thought that the proposed new scrutiny system could be improved through the use of modern technology to collect, collate and analyse information on causes of death. We were surprised—that is the diplomatic word—to learn that the Government is not taking this opportunity to specify a modern electronic system for death certification in Scotland. Instead, the bill calls for the continuation of a paper-based system.

An electronic system would have obvious advantages. There could be prompts and guidance for completion of death certificates, and the need for repeated data entry would be reduced. There would also be benefits from having a readily accessible audit trail. The committee did not make this point, but the activities of a Shipman, who I understand regularly moved practice and area, thereby covering his tracks, would be more readily detectable, because the electronic database would surely uncover a suspicious pattern. In the light of the benefits of an electronic system, the committee strongly urged the Scottish Government to provide for the use of such a system for death certification before national roll-out. We accept that it would not be possible to use such a system in the pilot.

The committee was anxious to ensure that the new system for death certification would not give rise to undue delay for grieving families who must make funeral arrangements. Such delays could present issues for various faith communities and for remote communities, and would potentially
cause difficulties in relation to organ donation. The bill should be amended to clarify such matters. I think that the minister is addressing the issue.

Another area of concern that emerged from the committee’s scrutiny related to the role of inexperienced junior doctors in signing death certificates. To ensure the accurate recording of causes of death, the committee thought that a doctor should be required to attain a specified level of experience before he or she is considered eligible to perform that function. In the absence of any oversight of that process by an experienced consultant, junior doctors should not be allowed to sign a death certificate without having completed appropriate training. I am sure that the committee will consider what the minister has said on that today.

The committee welcomes the provision in the bill to strengthen the current procedures for dealing with circumstances in which a death occurs outside Scotland. However, under the current proposals in the bill, examination of the relevant paperwork and certificates provided by the authorities in the country where the death occurred would fall to staff of the crematorium or cemetery here in Scotland. As only a small number of such cases occur each year—the Government estimates the figure to be around 250—the committee felt that the assessment of the validity of such documentation should be carried out centrally by the Scottish Government. I note the minister’s comments in that regard, which we can consider.

On the financial aspects of the bill, the committee welcomes the abolition of the higher fee that relates to the disposal of a body by cremation, which currently applies in about 64 per cent of cases, in favour of a lower and universal fee that will cover all cremations and burials in Scotland. The committee also supports the Government’s original policy intention that any new system of death certification should be self-funding; I note that the minister reinforced that intention today.

We noted the rationale for giving the responsibility for collecting the fee to registrars, but we acknowledged the concerns that their representatives raised on that issue.

I welcome the opportunity to debate these important issues, and I look forward to hearing contributions from other committee members in developing the general concerns that I have highlighted.

**15:16**

**Dr Richard Simpson (Mid Scotland and Fife) (Lab):** The bill is important, as much of the legislation on burial and cremation is more than 100 years old. Although it was the Shipman inquiry that led to the substantial revision that the bill proposes and to the revision in England, it was increasingly evident that this area of Scots law was no longer fit for purpose.

Today, there are many fewer post mortems, which are the most accurate form of diagnosis, although stillbirth remains one of the areas in which that process is frequently recommended to ensure a clear understanding of cause. Moreover, we are in the early stages of a new era of non-invasive post mortems, which may make a major contribution to accurate diagnosis in the future.

We know that the accuracy of existing medical certificates of cause of death is not great, although the minister’s suggestion that old age was never acceptable as a diagnosis hugely irritated my colleague Dr McKee; I am glad that that slur on his—and indeed my—past certification was later corrected by officials.

Evidence on the current system pointed to significant levels of inaccuracy. Professor Fleming said in columns 3752 and 3754 of the Health and Sport Committee *Official Report* that in the 62 per cent of disposals that took place by cremation, the required reviews to be undertaken by two further independent doctors resulted in some 20 or 30 post mortems through the procurator fiscal, but more importantly resulted in 15 per cent of certificates being “fine-tuned”. That amounted to 4,500 cases.

Dr Colin Fischbacher from the Information Services Division indicated that he has to contact doctors about 2,000 MCCDs annually, which is around 4 per cent of total deaths. I found it disturbing to learn for the first time that those doctors were not obliged to respond to the request for further information, so that needs to be addressed. Despite all that, however, it is agreed that the current system—and indeed any system—could not have prevented Shipman from killing hundreds of patients over the past quarter of a century.

Regrettably, it has taken a long time to go through this process in Scotland. It began in 2005, with a group reporting three years later in 2008 and a consultation, which led to the bill, in 2010. When the committee began to consider the matter, it was quickly established that the priorities included the need to retain public confidence, about which we must be very clear. Another issue, which the Government has highlighted, is the need for quality and accuracy.

We need a modern system that has some chance of providing Scotland today with legislation that will stand the test of time—if not 100 years, then a reasonable time—but that was not contained in the original bill. I welcome the
interaction that is already occurring between the Government and the committee, which has resulted in some improvements. Nevertheless, the removal of the three-doctor review on cremation and its replacement with a two-level review system as originally proposed is wholly inadequate. Around 500 random reviews, and a further 500 reviews that were either targeted or resulted from interested person requests, would have resulted in only 1,000 level 2 reviews, which is 2 per cent of deaths. Some of those reviews could be retrospective, taking place up to three years after death, which is not exactly an immediate response.

The increase to 2,000 level 2 reviews, along with an increase to 25 per cent for level 1 reviews, is excellent. As the committee report says, that is a step in the right direction. We have no idea, however, where that figure comes from, and it contrasts with the English proposal to have reviews in 100 per cent of cases—which I acknowledge will be far more expensive. Our system has to be proportionate, but it must be driven by public confidence, and it cannot be driven solely by short-term cost considerations. It must be recognised that all the experts agreed, as I have mentioned previously, that no system could totally eliminate criminal activity.

The absence of a requirement to examine the body is still a matter of some concern, and we might need to make that a requirement for cremation if it is not already provided for.

If the Government's other main intention is to improve the quality of the MCCD, it is extraordinary that it has not considered moving to an electronic system from the very start of the process. That we are now going to rush into having paper test sites and will then probably have to consider using further test sites with an electronic system is frankly a sign of some timidity and lack of vision.

Let us consider some small elements that would improve our health care system, but that have not been mentioned—the minister can correct me on that. The inclusion in the MCCD of ethnicity was considered at the joint cross-party group meeting by the racial equality in Scotland and mental health groups last night, and that would help us in our understanding of some of the premature death outcomes among ethnic minority groups.

The automatic requirement to include the community health index number—the CHI number—would allow for data linkage in a way that is crucial for determining a number of epidemiological factors. At least in the hospital and care-home settings, the requirement to say whether there is a presence or absence of health care-acquired infection would improve the quality of outcome data substantially.

As the committee convener mentioned, there is an issue around the experience of the signing doctor. The current system means that 34,000 of the MCCDs that are signed in hospital are probably being signed by an FY2—a foundation year 2 doctor—or another inexperienced junior doctor. It is appropriate that that should be part of their training, but as things stand 22,000 of those cases would be reviewed by a doctor of at least five years' experience, because of the cremation process. In my view the MCCD must be signed only by a doctor who has completed a module of training specifically on death certification. If an FY2 signs it, it should be countersigned by a consultant.

Moreover, there should be a feedback system to ensure that, as part of their training, all specialists and general practitioners have some of their certificates reviewed automatically at level 1. That might require a greater focusing of level 1 prescribing. All of that will be much easier if the MCCD is electronic.

I do not have time in this opening speech to review a number of other important issues, including post mortems ordered by the family, the disposal of body parts and foetuses, the certification of the absence of devices that could cause dangerous explosions at cremation, expedited MCCDs for faith groups, the implementation of the eventual act for remote and rural communities, overseas deaths and the whole financial approach, but I know that other members will cover those areas.

Labour supports the bill at stage 1.

15:23

Mary Scanlon (Highlands and Islands) (Con):

I appreciate the timetable for dissolution in March, but in my view it is not good practice when committee members and those who are speaking in the debate do not get an opportunity to see or hear the Government's response to the committee's stage 1 report until the minister speaks at the start of the debate. That system might suit the Government, it might suit our timetable and it might suit officials, but it certainly does not enhance the democratic process or the debate.

When the Certification of Death (Scotland) Bill came to the Health and Sport Committee for scrutiny I thought that it would be uncontroversial, that it would probably be fairly technical and that it was likely to pass all stages without hitches or criticisms. I could not have been more wrong.

The policy memorandum cites the

"need to examine the processes governing death certification following the inquiry into the case of Dr Harold Shipman."
At the very least, I expected proposals for a more robust system of death certification than is currently in place. It is only right to put on record that it was funeral directors who raised concerns about the deaths of elderly people under Dr Shipman’s care.

Professor Stewart Fleming from Dundee stated with regard to the bill:

“I am not convinced that it will necessarily improve accuracy on the medical causes of death. I am even less convinced that unnatural deaths will be identified as a result of it.”—[Official Report, Health and Sport Committee, 1 December 2010; c 3750.]

He said that, under the proposals, a doctor would be checked on every five to 10 years.

Ishbel Gall expressed her concerns about a body not being examined by even one doctor before the medical certificate of cause of death was issued.

The National Association of Funeral Directors said that the bill, as introduced, would mean that the system would be not nearly as robust as the one that we have in place at present, and that it would be nowhere near as robust as the system in England and Wales.

Given that the certification of death sets out to confirm the fact of death, to confirm the cause of death for input into health care planning, and to detect and investigate unnatural death, the concerns that were raised in evidence are very worrying indeed. When I asked Professor Fleming whether there would be more accurate information on the death certificate as a result of the bill, his response was “I do not believe so”. There will be no improved input into health care planning. That is well outlined in the Health Committee’s stage 1 report.

The committee welcomed the increase in the sample size for review to 4 per cent, but that falls well short of the 10 per cent that is said to be necessary if there is to be a realistic chance of errors being identified. I acknowledge the points that the minister made today, but there is a lack of experience and training. That and other issues were well covered by Dr Simpson; I have no doubt that we will return to them.

As a Highlands and Islands MSP, I am concerned that there seems to be very little comprehension of the difficulties that are faced by remote and island communities, which could lead to potential delays in certification and review.

Other issues that were raised in the committee’s stage 1 report relate to organ donation and bodies that have been donated for medical research.

The minister addressed some of the concerns that were raised by the Association of Anatomical Pathology Technology, but the association still states its concern that there will be less scrutiny than there is at present when the deceased is to be cremated. With 62 per cent of deceased persons being cremated, that is a notable concern. Given the large number of cremations, there does not seem to be a system of identifying and removing implanted devices such as cardiac pacemakers, which must be removed prior to cremation. Currently many of those devices are discovered after the MCCD is issued by the second medical practitioner after reading the medical records or examining the deceased.

The Scottish Pathology Network still contends that the new death certificate should bear two signatures for level 1 reviews, and it notes that the level 2 reviews are still considered to be too low.

I will reflect on the minister’s statements today and I am sure that many of the witnesses will keep a watchful eye on the bill.

In this age of technology, it is quite ridiculous that the idea of using electronic death certificates was first raised by Richard Simpson. That is a reflection of the poor standard of the bill. I hope that the Government has heard all the significant criticisms and that it will respond to them with amendments at stage 2 and stage 3. We support the general principles of the bill, while acknowledging that the Government and the bill team still have much work to do.

15:28

Ross Finnie (West of Scotland) (LD): The prospect of being able to take part in the scrutiny of a bill such as the Certification of Death (Scotland) Bill will almost undoubtedly guarantee that the number of candidates who offer themselves for election to the Parliament in May will reach record levels.

As Richard Simpson said, this is a serious debate. The certification of death is an important matter. The legislation on it is extraordinarily old and, in many ways, not fit for purpose.

The changes were driven by both a recognition of that and an element of the Shipman inquiry. I am bound to say that we accept the Government’s proposition that no system will deal with the particular perfidy of Dr Simpson—sorry, Shipman. I repeat, Shipman. [Laughter.]

Ian McKee (Lothians) (SNP): He said it.

Ross Finnie: I hear Dr McKee trying to correct me again.

The important point is that, in all walks of life where there are attempts by some perverse purpose to subvert a system, there needs to be a system of checks and balances. Therefore, I hope that the Government is not reading into the
committee’s and parties’ criticism of the level of check and balance some view that we aspire to eliminating the chances of a Shipman-type situation. That is not what we are saying; we are saying that we should concentrate on the checks and balances.

The minister mentioned in her opening remarks her pleasure that there is a sense that we want to accept the harmonisation between the systems for burial and cremation. In accepting that, I direct her attention to much of the evidence in which many of the witnesses stated that, if the Government wants to harmonise the two systems, it should be moving towards the degree of certification, check and balance inherent in the cremation system, not the other way. If one supports the harmonisation, one does so not on the basis of moving towards the burial system but to be aware of the other.

The difficulty is that the Government proposes other fundamental changes in the training, preparation and standards that it expects the medical profession to reach. That is a question of assessing risk. I want to make an important point to the minister. The evidence led to the committee by Dr Thomas, which is quoted in paragraph 28 of the committee’s stage 1 report, was that there might be a requirement for 10 per cent of certificates to be checked. That is contrasted with the fact that, even on the basis of the Government’s revised plans, a rate of around 4 per cent would be reached.

I do not want the minister to believe that I am advocating that she has to go to a rate of 10 per cent, because the 10 per cent figure is based on an existing system with the existing level of training and everything else. I believe that the committee, the political parties and, more important, the public would like a better statistical analysis of the confidence that the Government wishes to claim to have in the system.

In other words, to put that in simple terms, Dr Thomas was of the view that on the existing system and with existing methodology the Government would have to get the rate of checks to 10 per cent. I am not saying that the Government has to get to 10 per cent; I am saying that, given the changes that it is recommending, including in training, and the different system, it ought to be able to indicate to Parliament the degree of comfort that it is deriving and the statistical basis for that. That would be enormously helpful in resolving the real difficulties and reservations that have been expressed by committee members and by every speaker in the debate from the political parties so far.

That is the major issue. Richard Simpson raised a number of other issues. It was good of Mary Scanlon to give Richard Simpson credit for proposing an electronic system, but I am bound to say that in its report in October 2007 the burial and cremation review group stated at paragraph 24:

“It was considered by all that change was indicated to the current death certification process in Scotland, not only as an outcome of the Shipman Inquiry, but to reflect modern society, facilitate electronic transfer and storage and use of data”.

Even the review group suggested that electronic storage of data was in its thinking. That point is a major concern.

I am pleased to hear the minister’s response on the change in who is responsible in relation to deaths overseas and the other changes that she has mentioned, which we can reflect upon. Those matters are all manageable and can be addressed. However, the one thing that the general public are looking for is something that they can point to as a level and degree of public confidence in the system. I regret to say that, as things stand, that question has not been satisfactorily answered. I believe that it can be answered, but it needs to be answered before we go much further.

The Liberal Democrats will, however, support the bill at stage 1.

15:35

Ian McKee (Lothians) (SNP): I welcome this long-overdue reform of the arrangements concerning the certification of death in Scotland. I comment on the bill not only as a member of the committee that has scrutinised it, but as a person who has signed scores, if not hundreds, of death certificates as well as cremation forms B and C.

The original driver for change in this field was the events surrounding the Harold Shipman case, but I share the Government’s belief that we cannot guarantee to prevent the criminal actions of an intelligent but psychopathic doctor, although electronic record keeping and careful surveillance could possibly detect such actions at an earlier stage. Several goals have subsequently become apparent. The Government sensibly wishes to initiate a system that is affordable and simple, that improves the quality and accuracy of medical certification and that provides improved public health information and clinical governance. Let us consider how those objectives have been met, and I will express some genuine but remediable concerns.

The proposed system is certainly much less costly for the 62 per cent of Scots who are cremated. In place of the cremation certificate combined fee of £158, the cost has been reduced to £30. Members will know that I have never been regarded as an apologist for the British Medical Association—indeed, that body has been the only organisation to threaten to sue me in my time in
Parliament. However, having been on the receiving end of lawyers’ fees of £220 an hour plus VAT, I believe that the sum of £73.50 for an experienced professional to take evidence from the doctor who is signing the medical certificate, interrogate those who have been looking after the deceased in his or her final days and travel to a chapel of rest or mortuary to view the body is a relative bargain. The fee of £30 must be even more acceptable. That sum is less acceptable, of course, if the deceased is to be buried, as there is no charge for that at present; however, it fades to almost nothing in comparison with the total cost of a funeral these days.

Let us consider the quality and accuracy of a medical certificate. Here, two issues are at stake. The first issue arises if a non-recognised term such as asthenia is used by the certifying doctor. Such a term cannot be codified and is useless for the purpose of another objective—to improve public health information—although the proposed medical reviewers can follow up such indiscretions and have them corrected. The second issue is much more complex. All the wording on a certificate may be totally correct for coding purposes but still get the cause of death completely wrong. That may be unavoidable, especially when the number of post-mortems that can be carried out is falling year by year. When an elderly, frail person gets weaker and dies, an accurate diagnosis of cause of death is often impossible, yet something has to be put on the certificate. Alternatively, the error may be due to clinical incompetence or inattention to the deceased’s history on the part of the certifying doctor.

Some of that can be picked up by another doctor. The committee heard evidence from Professor Fleming of Dundee University that, every year, about 30 cases of unnatural deaths in Scotland are detected only at the stage when the second part of the cremation certificate is completed. He cited the case of an elderly lady whose cause of death was initially stated to be bronchial pneumonia, only for the second doctor to unearth the fact that she was slowly dying in hospital as the result of a road accident—a difference of some public health significance. So, having at least a second doctor to complete a certificate has value.

We should contrast what happens now with what is proposed. Today, the 62 per cent of us who are cremated do not go to the furnace until three doctors have signed the necessary certification and the process always involves an impartial doctor who quizzes usually those who were present at around the time of death. Only one doctor signs for a burial, but with a burial exhumation is a possibility if there are subsequent doubts as to the cause of death.

What is proposed in future is that up to 4 per cent of deaths will be intensively investigated, 25 per cent will have the certifying doctor quizzed over the telephone by a medical reviewer and, by the minister’s estimate, 50 per cent of all deaths will be certified only by a single doctor—perhaps even one who is relatively junior and who might not even have seen the body after death. However, there is the safeguard that a doctor or doctors suspected of failing may have all his or her deaths subjected to selective scrutiny. We must decide whether that system, while undoubtedly less expensive overall, is more likely to achieve the stated objective of more accurate medical certificates of higher quality.

Of course, an important function of medical reviewers will be to provide training and guidance to those completing medical certificates. A problem to be overcome here is that there are about 20,000 doctors in Scotland with this potential responsibility. Paragraph 3 of schedule 1 states that any function of a medical reviewer may not be delegated by healthcare improvement Scotland, yet it is obvious that most of this function must be delegated to the postgraduate deaneries. Will even they have the time and resources to complete satisfactorily this huge task?

Those are some of the issues that come to mind when considering the bill, which I strongly support in principle. I will listen to the minister’s response with interest.

15:41

Rhoda Grant (Highlands and Islands) (Lab): This was not the most gripping of bills, but it is safe to say that it is one that will affect us all eventually.

The bill seeks to change the process under which death certification is carried out. As the minister said, the work towards the bill was instigated as a result of the Shipman inquiry and the need to try to provide more robust checks. However, witnesses told us that, if anything, the bill will give less protection.

Evidence also stated that the sample to be reviewed was not of any statistical use and would act only as a deterrent rather than provide adequate scrutiny—even though the Government has stated that it will raise the sample size to 4 per cent. In evidence we were told that a sample of 10 per cent would be required to pick up any anomalies.

The policy memorandum stated that the average time to organise a funeral is around seven days and that, therefore, there is ample time to carry out the review without delaying the burial process. However, that does not take account of social customs or religious beliefs that
dictate a much quicker burial. The Jewish and Muslim communities require burial to be on the day of death if at all possible. Their formal grieving process cannot start until the burial has taken place. Therefore, any delay will lead to further distress.

The Government responded to those points by saying that medical reviewers would have the flexibility to fast-track the process to deal with those issues. In response to that, we have had further written evidence from the Scottish Council of Jewish Communities, which suggests some fairly straightforward remedies that would speed up the process. It has asked that the bill be amended to require a presumption that registration take place in parallel with a review. It would be for the medical reviewer to state if that was not the case.

The council also asked that it be clear in the bill that the expedited procedure permits disposal as well as registration. That way, funeral directors would begin their work immediately. Otherwise, they would wait until the body was released for disposal before making arrangements, which would build in a further delay.

The council states that there should be an out-of-hours service and that adequate cover should be available when the reviewer is attending to their training duties. It went on to quote a case where there was a delay in burial due to a registrar being unable to register a death timeously because they were taken up with other duties—I think that they were conducting weddings on that day—which meant that the funeral was delayed, which caused the family further distress. Our laws need to be sensitive to those needs.

In our rural and island communities, there are customs that require rapid burial on a timescale of two to three days after death. The deceased's body is normally brought home, where it remains until the funeral. In some communities, family and friends are able to view the body at this time, which is essential to them in their grieving process. If there was a delay in burial, the body would need to be stored in refrigerated conditions. That poses two issues. First, it would mean that the bereaved could not take the remains home, which would give rise to distress. Secondly, as Ishbel Gall from the Association of Anatomical Pathology Technology—that is hard to get my tongue round at this time of night—pointed out, there are very few mortuaries in remote and rural communities, and where they exist they are not likely to be refrigerated. If storage is not available locally, bodies need to be kept some distance away. With regards to island communities, that could culminate in delays to funerals, if weather conditions delay the movement of the body, and it would add to funeral costs and arrangements.

Delay can also be caused by access to a medical reviewer. Their numbers are limited and it is unclear where they will be situated. If every island group were to have its own reviewer, few would be based in the centres of population. If they are not based on islands and in rural communities, what happens when a body is randomly selected for review? In normal circumstances, the reviewer would have to make travel arrangements to get to islands, which can be challenging for a range of reasons, but would probably take longer than two to three days, which is the normal timescale for burial in those communities. We should also remember that flights and ferries can often be full in the summer, because of holidaymakers, or cancelled or delayed in the winter, because of adverse weather conditions.

A process must be put in place that deals with all those issues but which is still able to deliver the same level of protection to the communities that are affected. I welcome the minister's commitment to considering the matter and working with those communities to find solutions to those issues.

There was some debate about who would collect fees for the process. The general consensus was that registrars should collect the fees, because that is the one duty that is carried out in relation to death. However, registrars were not keen on that. They felt that that could delay registration of death, because deaths are not always registered by family members or people with an interest in the estate. Quite often, a neighbour, a funeral director or a police officer registers a death, and they are not in a position to pay the fee. The Government needs to consider what can be done in such a situation to ensure that people do not put off registering deaths.

On the whole, this is a technical bill, which means that the community is dependent on experts who give evidence. There are tensions in the bill between keeping down costs and providing a robust service. It is clear that the bill will impact on people when they are especially vulnerable, so we need to ensure that what is in place is sensitive to community traditions as well as to religious beliefs. I believe that there is a will to get it right, and I hope that the Government will take those suggestions on board.

15:47

Stewart Stevenson (Banff and Buchan) (SNP): I find myself at both an advantage and a disadvantage in this debate, as I am a doctor's son and therefore have much of the language of the medical profession but almost none of the understanding. As my father once said, that is a perfect fit for politics, because one is a plausible ignoramus.
The registration system that we have today came into operation in 1855. For many years after, it was not uncommon, in situations in which a doctor was not reasonably to hand, for the cause of death to be shown on the certificate as “Doctor not present” or something similar. As a person who has pursued genealogical studies for 50 years, I have come across many instances of that, almost invariably on the islands. It is interesting that, 150 years on, we are still confronting the issues that are associated with population sparsity and remoteness.

We have come a long way from the situation in 1855. In particular, cremation is now a significant option that is chosen by families. Even when my father became a GP in the 1940s, it was pretty much the exception. Of course, there were practical reasons for that. For example, where my father practised, in Cupar, there was no crematorium to hand. In my constituency, where the crematoria are some distance away, it is a less significant part of funeral arrangements than it might be elsewhere.

I hope to be cremated about a year after my death because, like others in my family, I have recorded my wish to be sent for medical research, and the arrangements are that the various bits come together a year later and are cremated. If I get my wish—it is increasingly difficult for the wish to be delivered, I have to say—I will be most thoroughly examined post mortem. Of course, for me, as for one or two others here who are perhaps, arguably, in the last quarter of our lives, this is not a matter of philosophical debate but a matter of practical concern.

The proposed measures will make more systematic and robust the system of checks and balances that oversees our system of registration. Of course, the bill is not simply about implementing a new process. It is about what that process has to deliver, and about detecting statistically significant variations from the norm and, crucially, the factors of personnel or treatment with which they are associated. In that sense, like others, I believe that we will have to move sooner rather than later to a process that, however it is achieved, allows the analysis of robustly captured data on computer systems. As a genealogist, however, I hope that we will continue to see the signature of the person who registers the death in the electronic record, because it is fascinating to see one’s ancestors’ signatures. Indeed, in one case, the signature showed me, to my surprise, that my father registered the death of someone I had not previously realised he was in contact with at that stage in his life, and that was before he was a doctor.

In one of its variants—I recognise that there are many—the Hippocratic oath includes the phrase: “I will neither prescribe nor administer a lethal dose of medicine to any patient even if asked nor counsel any such thing”.

Not all doctors take the Hippocratic oath, which is perhaps diminishing in importance, but, after a period of 2000-plus years, it does still capture something important about the relationship between doctors and their patients. Above all, the ignoramus that is the general public in relation to medical matters places an immense trust in doctors and, if the bill can further build confidence in doctors and other health professionals, it will serve a good purpose indeed. What we do in the bill must address that issue.

When I was a trainee nurse some 47 years ago now—it is quite alarming how long ago it was—ours was essentially the ward that people came to if they were expected to die. When someone died, we did not necessarily wait for a doctor before laying out and moving the remains to the mortuary. I believe that practices such as that have been much refined and there is now clear involvement of doctors or other qualified health professionals. The fact that they are masters of the fact of death is important.

Let me talk about statistics and inspection. The issue of cover, be it 25 per cent, 50 per cent, 4 per cent or 100 per cent, is not a trivial one. Superficially, the higher the figure, the better it sounds, but a higher figure does not necessarily deliver better outcomes. What is equally important is what is examined and the depth of the examination. In many areas and different professions, if a large number of examinations are conducted for little return and there is little resulting intervention, the psychological phenomenon of ennui comes in, and when a case comes along that requires attention, people are more likely to miss it because there is less time to devote to each individual activity that is undertaken. I do not come up with any answer to that. I merely say that we have to be careful.

Returning to electronic recording, I point out that there is a system that is operated by the registrars of births, marriages and deaths, and that is the system into which the data go. I wonder—without having any answers myself—whether it would be an idea to roll the system out more widely with mild adaptations to allow conditional registration by health practitioners and to capture data relatively early. However, I know that it can often be quite difficult to adapt computer systems.

It is remarkably easy to make errors. When, in 1984, I registered my mother’s death, I forgot her father’s name and put her grandfather’s name on the death certificate by accident. I had not known those grandparents; they were not familiar to me. There is plenty of scope at all levels for getting things wrong.
Ian McKee said that we will all die. Arguably, we will all die from heart attacks. It is not at all clear that there is no room for judgment and debate about what should go on a death certificate. Indeed, in these days of mechanical apparatus that keep the body functioning, if not alive, it is not always entirely clear when death might happen.

I hope that we respect the rites and practices of a wide range of religions—in fact, I am sure that we will—and I very much support the bill.

15:56

Helen Eadie (Dunfermline East) (Lab): I identify with many of the opening remarks of the committee convenor, Christine Grahame, on the various legislative proposals and bills that the committee has been dealing with. As I was walking to the chamber this afternoon, Ross Finnie crept up on me, humming a funereal dirge and saying that we should really walk very slowly to this debate. I smiled as the penny dropped about what he meant. Indeed, I also smiled at Stewart Stevenson’s research proposals. I have to confess that I have never thought about that before, but it seems to be very worth while and something that people should at least consider and explore.

I am very glad to hear that the minister will continue to listen very carefully as the bill proceeds and I am willing to support my colleagues’ view that the Parliament should approve its general principles. I also welcome the minister’s response to the faith communities, in particular the Jewish community, with regard to expediting burials. We received submissions to that effect not only during the consultation process but afterwards and, in her evidence, Leah Granat very much underlined the importance of addressing those concerns. I also welcome the minister’s response on the issue of electronic certification processes, which was raised by Richard Simpson and other colleagues.

Since we concluded our report, we have continued to receive a variety of views about the bill. Indeed, Mary Scanlon, Richard Simpson and Rhoda Grant have mentioned the submission that was made only this week by the Association of Anatomical Pathology Technology. I will not repeat the points that have been made in that respect—suffice it to say that I endorse my colleagues’ views—but I think that the issue of clarifying the position of burials abroad, which has also been raised in these papers, merits more careful thought.

Although nearly all the submissions that were received supported, for the reasons that others have mentioned, attempts to improve the death certification process and to reassure the public, many respondents did not believe that either of those aims would be achieved under the current proposals. Indeed, a report that we received details changes to the current situation, costs and problems with the timing of reviews and the training of doctors. As Christine Grahame pointed out, the proposals are not as robust as the current system or the new system in England and Wales. For example, 75 per cent of burials and cremations will take place after only one doctor has seen the deceased or the death certificate.

We should use this opportunity to change the certification of death for the better and not implement inadequate and unreliable changes just to save money. We need reassurances regarding the training requirements for doctors and reviews involving part-time doctors to ensure that there are no delays to funerals and, indeed, the bill’s proposals must be adequately resourced to avoid any such delays.

Currently, at least two doctors are required to examine a death certificate in cremation cases. Therefore, at least two doctors are involved in approximately 67 per cent of deaths. In the remaining cases, the body is buried, which leaves scope for further examination in the future if that is required. The Government has stated that the two-doctor check is perfunctory, but the BMA refuted that in giving evidence to the Health and Sport Committee. It said that those second checks resulted in a “15 per cent improvement in accuracy and picking up on dozens of unnatural deaths”.—[Official Report, Health and Sport Committee, 1 December 2010; c 3754.]

The bill, as amended by the minister, will mean that approximately 75 per cent of funerals for burial or cremation will go ahead with only one doctor having seen the death certificate or body. The committee and others do not question the ability or professionalism of doctors, but we recognise that the proposed system is significantly less robust than the current system and does not provide any reassurance to the public. Training a doctor to fill out a form adequately will not provide any additional reassurance to the public.

Shona Robison stated that “affordability is an issue” and that

“The bill establishes the best system for doing all the things that we want to do.”—[Official Report, Health and Sport Committee, 15 December 2010; c 3878.]

We believe that we should use the opportunity to change the certification of death for the better and not implement inadequate and unreliable changes to save money.

The Government recently examined the numbers and decided that the number of reviews needs to increase. There will now be 25 per cent level 1 reviews and approximately 4 per cent level 2 reviews, but I believe that that is still not enough,
and I highlight the need for more medical reviewers to undertake that additional number of reviews. In England and Wales, 100 per cent of death certificates will be seen by more than one doctor. That is an improvement on the current system, in which all cremation cases—or 67 per cent of those who are dead—are seen by more than one doctor. However, Scotland is moving to a system in which only 25 per cent of certificates will be seen by more than one doctor, and only 4 per cent will be examined in any depth.

The Government has defended that by arguing that the bill seeks to drive up completion of death certificate standards rather than using the assumption that checks on certificates are needed. The different approach will work only if the education and training element of the bill is adequately resourced and implemented. Indeed, there is a danger that, should the number of checks be increased—the bill contains the ability for a medical reviewer to scrutinise up to 100 per cent of cases in any geographical area or practice where they believe that that is appropriate—financial constraints could limit such a move or result in the important education and training side suffering, despite a medical reviewer’s belief that more reviews are necessary.

There are concerns about the additional workload for doctors and the short timescale for each review. We appreciate that that is required to avoid delays to funerals and that all reviews can be suspended during epidemics but, outwith such circumstances, doctors in primary and secondary care settings constantly work to very tight timescales and juggle patients in planned and emergency situations. A doctor will be required to decide whether to let a patient suffer or cause a delay to a funeral if, for example, an unrealistic timescale is set, an emergency arises or there are pressures due to staff absence. The result of choosing a patient over the review is a fine or imprisonment.

There is particular concern about part-time or shift-working doctors and how they will take part in reviews. Either a part-time doctor would be expected to be, in effect, on call when they are not working to respond to a review, or they could cause a delay to a review and, ultimately, to a funeral. We look forward to hearing further details on how the system would work with part-time doctors, given the large and ever-increasing number of such doctors in the profession.

I support the bill but, as members have heard, that support is qualified.

16:04

Michael Matheson (Falkirk West) (SNP): I am one of four members of the Health and Sport Committee whose direction of travel in the past six or seven months has gone from membership of the End of Life Assistance (Scotland) Bill Committee to consideration of the Palliative Care (Scotland) Bill to consideration of the Certification of Death (Scotland) Bill. There was a synergy between those three bills to a large extent, which made it an interesting time for those of us who went through the issues.

People often say that two things in life are certain—taxes and death. What becomes of us after our death? Who knows? The only certainty is that our passing away will have to be certified. The bill will improve on the existing legislation, which goes back to the 19th century.

I had considered the bill before it arrived at the Health and Sport Committee, but I do not think that many other members had given it much consideration before then. The bill was introduced after a considerable number of years in which representations had been made to the Government on the need to reform the law. One person who has advocated reform for some time is Graeme Easton, a funeral director in Bonnybridge in my constituency, who is the president of the British Institute of Funeral Directors. He has highlighted to me for a time the need to reform the death certification process. I welcome the bill as a step in the right direction, despite some concerns that have been expressed, to which I will return.

I welcome in particular the removal of the historical difference between the costs of a burial and the costs of a cremation. It is important to recognise that step. It is not entirely clear to me why such a marked distinction was made. I can presume only that it was based on issues with medical science when cremations began to take place and on the fact that a buried body can at least be exhumed, which cannot happen after a cremation, as Ian McKee said. However, things have moved on and we need legislation that reflects that. The bill seeks to achieve that.

The cost to a family for a cremation is significant. It is almost a straight £150, whereas a burial incurs no charge. Moving to a universal charge of about £30 for cremations and burials is reasonable, although it means that burials, for which people previously did not pay, will incur a £30 charge.

As Richard Simpson said, part of the genesis for the bill was the investigation into the Harold Shipman case. As the committee fully accepts and as even the witnesses who gave evidence to the committee accepted, there can be no fail-safe system. No piece of legislation could be brought before the Parliament to ensure that such a case never happened again. The aim is to put in place a reasonable and proportionate system to deal with the issue.
I will not rehearse many of the concerns that members have already raised, particularly on training and education for certifying doctors, which are extremely important. A legitimate concern is whether the new system will be as robust as the existing system is. We will have to keep an active eye on that.

I repeat that we are trying to find a reasonable and appropriate system. Comparisons have been drawn with the new system that has been introduced in England and Wales. The cost to families of that new system is significantly higher than that of either the system in Scotland now and the one that the bill proposes.

We must be mindful that, if we wanted to ramp up the potential checks in any new system, that could increase the costs of certification that families must deal with. Before we jump into saying, “Let’s just do a bit more,” we must recognise that we are shifting the financial burden on to families, because—as the committee agreed with the Government—the process should be largely self-financing.

I listened closely to Ian McKee’s contribution. He is a good friend and always someone who is prepared to challenge the vested interests in the medical world, his former profession. I very much respect him for that.

I have long been puzzled by why doctors are paid £73 for two certificates of cremation. The rate may be reasonable when compared to fees of around £200 an hour for a lawyer, but I do not think that doctors should have been paid that sort of money in the first place—never mind people making comparisons between them and lawyers. Some in the medical profession may not agree with that, but I suspect that the debate on the matter has more to do with the GP contract than anything else. At some point, I would like to see doctors not being paid for any of this type of thing. Unfortunately, GPs and others in the medical profession are paid for things that we should get as a matter of right from people who are in well-paid public sector jobs.

I was taken by the concerns that were expressed by people from the Muslim and Jewish communities, in particular Leah Granat, about the need to ensure that the bill recognises the religious observances of faith groups that wish to see the disposal of a body within a 24-hour period after death. I note that the bill provides for an expedited procedure, but there remain concerns that delays may be caused if a case is elevated to a level 2 review. From the minister’s comments so far, I recognise that she is prepared to improve the bill further. I hope that we can provide that assurance to those in faith groups who remain concerned.

Overall, like other members who have contributed to the debate, I am happy to support the bill at stage 1.

16:12

Ross Finnie: One of the unanimous committee conclusions is to be found at paragraph 121 of our report:

“The Committee also notes the need for expedited procedures where bodies were being donated for medical research and notes the Minister’s response that this would be dealt with in guidance.”

Now that Mr Stevenson has addressed us, we have to reconsider that unanimous conclusion. Apparently, there is no need for an expedited process for medical research, as Mr Stevenson is to be cremated a year after his death. I am sure that that has come as a great sadness to us all.

I do not have a lot to add to what I said in my opening speech. I simply leave the minister with my concern that, at the end of the day, it will be for the public to consider whether they have confidence in the system.

I turn to a confusion that arose at committee. In her opening remarks, the minister said that the review group had found the present system to be “perfunctory”. The difficulty for the committee was that that evidence was not sustained by anybody who gave evidence to us. That neither makes the committee right nor the review group wrong; it simply means that those who ventilated their views on these matters in public did not agree. People were more inclined to support the view that Ian McKee expressed in his excellent speech that the procedures for certification of cremation are a process in which funeral directors, medical professionals and families repose a degree of confidence. That may not be well based in evidence, but it is a matter of fact in terms of how people see things.

As I said in my opening remarks, before we get to stage 3, the Government needs to make clear the statistical basis on which checks will be made. Ministers need to respond in some detail on that. As Dr Simpson said, there is no prerequisite level of experience for any doctor who is to sign the medical certificate of cause of death. That has a bearing on confidence in the system. That is equally true of the fact that, as Richard Simpson made clear in his opening remarks, currently there appears to be no need for an examination of the body. I am not saying that such an examination is needed or that anyone who signs a certificate needs to have 10 years’ experience. However, if those conditions are not in place, that has a bearing on the level of confidence that is required and the level of checking that needs to be carried out. I accept wholly that a balance must be struck.
However, at the moment it is not clear from ministers’ statements in support of the bill that that balance has been adequately achieved or that the explanations that have been given in support of the bill’s proposals meet the required test. In my opening speech, I said that such a balance can be achieved but that there is a lot of work to do before that happens.

I regret to say that the minister may be left with half an afternoon for her concluding remarks. All of us will look forward to them with considerable interest.

16:16

Nanette Milne (North East Scotland) (Con): It has been interesting to hear the comments about and criticisms of the bill as introduced. I agree with most of them. I note that nearly all those who have spoken are members of the Health and Sport Committee, which puts me in a small minority alongside Stewart Stevenson, who entertained us with his personal experiences.

When one is not a member of the committee that is scrutinising a bill, it is difficult enough to assimilate the detail of what is proposed and the reaction of the witnesses called by the committee, without having to absorb the Government’s response during a stage 1 debate to issues that the committee raised in its detailed report. Like Mary Scanlon, I would have welcomed some prior knowledge of what the minister was going to say, because the debate has not been enhanced by what has happened today.

Like most members, I agree that there is a need for new legislation, given that much of Scotland’s burial and cremation legislation is more than a century old and does not reflect life in the 21st century. The Harold Shipman affair was a wake-up call that highlighted the need for a review of the processes governing death certification, burial and cremation, even though—as everyone has agreed—no new system could deal with a future Dr Shipman.

An improvement in the accuracy of death certification is needed in the interests of health care planning and, not least, to provide reassurance to the public. However, when I read the Government’s proposals, they seemed to me to be less robust than the current system. My initial reaction has been backed up by the expert witnesses who gave evidence to the committee and by the BMA in its briefing for the debate.

As we know, currently at least two doctors are required to examine a death certificate before cremation can be sanctioned. Consequently, in around two thirds of deaths, three doctors are involved, with the remaining one third of deaths, following which the deceased is buried, requiring just one medical signature to certify death. Although the Government has stated that the two-doctor check may be perfunctory, the second medical check has resulted in a 15 per cent improvement in the accuracy of certification, as Richard Simpson pointed out, and has picked up a significant number of unnatural deaths that would otherwise have gone undetected.

Clearly, the Government disagrees with that approach and considers that its proposals to introduce a systemic quality improvement system, via intelligence-led medical review, would be more effective than the current system. It also does not approve of the non-targeted system that is being introduced in England and Wales, which would be more expensive.

As I understand it, under the minister’s amended proposals, which were presented in evidence to the committee on 15 December, 25 per cent of deaths will be randomly selected for level 1 review, with around 4 per cent being subject to level 2 review. That will mean that 75 per cent of deceased people will be buried or cremated on certification by only one doctor. The intended increase to 4 per cent in the number of deaths that are selected for level 2 review will still fall well short of the 10 per cent that witnesses recommended as the minimum percentage sample that is required to give a realistic chance of picking up errors.

The concern about the lack of confirmatory checks under the proposed system was summed up by Gerard Boyle of the National Association of Funeral Directors, who said:

“We welcome any improvement to the medical certification for statistical analysis, but we feel that, for cremation, going from a two-doctor system plus a medical referee at the crematorium down to one doctor is ... a bit of a backward step ... the proposed system is definitely not as robust as the current one.”—[Official Report, Health and Sport Committee, 1 December 2010; c 3764.]

Professor Fleming acknowledged that, without post-mortem examination, we will not get anywhere near 100 per cent accuracy. Nevertheless, he thinks that we can improve the current accuracy rate, although he believes that the bill’s proposals will make that less likely.

The committee’s concerns about the changes to certification for cremation have not yet been fully addressed. Although I accept that the procedures for burial and cremation should be aligned, I agree with the committee’s conclusion that, given the finality of cremation, any alignment should have as its benchmark the rigor of the current cremation procedures. Ross Finnie emphasised that point well.

The proposed universal fee in relation to burial and cremation is welcome. It will ensure that a lower fee is payable by everyone rather than a
higher one being payable by only a proportion of bereaved relatives.

There is also a concern that no level of experience is specified before a doctor can sign a medical certificate on cause of death. That means that a junior doctor could authorise cremation without any supervision. The BMA makes a good point that, if the second doctor—who must have five years’ post-registration experience before they can sign a cremation certificate—is to be removed from the process, all junior doctors must be supported by high-quality training programmes before they become eligible to sign such certificates. That is a huge training commitment, as Ian McKee pointed out.

Concerns have also been expressed about the adequacy of the proposed medical reviewer workforce, given its remit to advise, train and carry out the level 1 scrutiny of 25 per cent of deaths and given the likely resultant increase in the number of level 2 reviews. I was pleased to hear the minister say that the number of reviewers is not set in stone.

The short timescale for reviews will impact on doctors’ workloads, and there are worries about how part-time or shift-working doctors will take part in reviews. It is clearly important to avoid delays to funerals in the interests of the bereaved and of faith groups for whom early funerals are the norm.

Members have flagged up several other issues in the debate, most notably the lack of proposals for an electronic registration system.

It is obvious that a great deal of work remains to be done during the next stages of the bill’s passage through Parliament if the result is to be improved and more robust legislation.

We will support the general principles of the bill at this stage but we expect amendments at stages 2 and 3 in response to the concerns and criticisms that many people expressed during the stage 1 scrutiny.

The Presiding Officer (Alex Fergusson): I call Dr Richard Simpson. Dr Simpson, you have quite a long time.

Christine Grahame: Aw!

Ross Finnie: Oh!

16:22

Dr Simpson: My colleagues on the Health and Sport Committee are probably booing because they remember the rather long speech I made during one committee meeting.

This has been a thoughtful and useful debate. It reflects the Parliament’s scrutiny at its best. The expert group came up with a view on which the Government consulted. We have all been through a fairly lengthy process, but we start from an agreed point.

As Stewart Stevenson thoughtfully pointed out, the current procedures began to come into place in 1855 and certainly are no longer sufficiently robust. That is the starting point. They no longer have full public confidence, but the Shipman inquiry was only part of a process that indicated that they were no longer fit for purpose.

The accuracy of the data is important to us in epidemiological research, in holding the Government to account on progress on reducing premature deaths and in ensuring that there is equality of treatment in ethnic communities. Those are all dependent on the quality of the data that are obtained.

At the same time, we want to prevent the possibility of any criminal activity, although we have all agreed that it is not possible to guarantee that such activity will be prevented. Nonetheless, as all speakers have made clear, the central issue in the debate is that whatever system we come up with at the end of stage 3 must retain public confidence. The easiest way to do that is to have level 2 scrutiny in 100 per cent of cases. That is what has been done through the English legislation and how the English intend to proceed. However, as Michael Matheson and others pointed out, the cost of that per individual will be high—perhaps around £150 or £170—if the system is to be self-financing. The proportionate measure that is proposed in Scotland would cost around £30 or, if it were totally self-financing, perhaps £50.

The core issue of public confidence remains vital. Proportionality is all very well, but if we do not retain public confidence, the system will require revision.

Already as a result of the debate and the evidence that was received in committee, the Government has moved to increase the level 1 scrutiny to 25 per cent of certificates and the level 2 scrutiny to 4 per cent. The minister mentioned in her opening speech a figure of 50 per cent. I would be grateful if she could explain that a little further, because I do not see how we get to 50 per cent from the 25 per cent level 1 reviews and the 2,000 level 2s, particularly as the level 2s will mostly follow on from level 1s and might not be separate.

Shona Robison: The 50 per cent includes referrals to the procurator fiscal.

Dr Simpson: I cannot believe that we move from 25 per cent to 50 per cent by including procurator fiscal referrals. There cannot possibly be 25 per cent procurator fiscal referrals. I see that
the minister is nodding—I put that on the record. I would be very surprised if 25 per cent of cases are referred to the procurator fiscal, but the minister says that that is the case, so we should accept that.

Ross Finnie analysed the situation most clearly. He said that a figure of 4 per cent is better than the previous proposal, and the committee has said that that would be a step in the right direction. However, evidence to the committee suggested that 10 per cent might provide us with a proper statistical basis. If we get somewhere between 4 and 10 per cent, we might have something that we can work with. The minister has given an undertaking that the figure could be adjusted further as we go along and after the test sites have been looked at. That might be practical, but I ask her to produce a little more detail at stage 2 on how the 4 per cent figure was arrived at. What risk assessment was carried out in arriving at that figure rather than 10 per cent?

I return to the fundamental problem, which is that, in the current system, more than 62 per cent of certificates are scrutinised by three doctors. The new system will not distinguish between burial and cremation, but that distinction did not arise purely by chance; it arose because the public and Parliament felt that, when someone is cremated and the body is no longer there to be reviewed, a greater degree of scrutiny is required.

Many members have referred to the need for improvement in the accuracy and quality of the data. If that is achievable, we might not need to scrutinise 100 per cent of cases, as in England, or even the 10 per cent that it is suggested that we should have here. As Ian McKee and Helen Eadie said, to achieve that improvement, we need to ensure that there is an adequate training process. The training will not necessarily be provided by a medical reviewer—it might need to be devolved to the post-graduate deans, which the bill will need to allow for. As Helen Eadie said, the resources for training must be adequate and ring fenced in some way. I suggest that no one should be allowed to sign a form unless they have gone through a certificated training module to show that they understand what the process is about.

Ian McKee said that quality and accuracy are not the same thing. We might end up with what appears to be better quality but, at the end of the day, it might not be more accurate. That is a conundrum that I do not propose to unravel, despite the encouragement of the Presiding Officer to speak for a greater length of time.

The most important issue is that of electronic forms, because an electronic system could underpin the whole system. I remain surprised that consideration of electronic forms has not been undertaken—I was even more surprised after Ross Finnie pointed out to us that that suggestion was in the expert group’s report. That is a grave mistake. I would go further and suggest that we should not actually have test sites without having an electronic system. That might involve delay, but I would rather have a delay and get a system that is correct than go to test sites, amend the whole system and then have to come back and retest with electronic forms.

Christine Grahame: I remind the member that the committee agreed unanimously in our stage 1 report that we would not seek to have an electronic system brought in before the test sites commence.

Dr Simpson: I accepted the approach in the report, but on reflection and after hearing what members have said in the debate I think that we probably have to think again. I will be interested to hear what other members say.

We have not addressed some issues, such as the ordering of a post mortem by the family. The disposal of body parts and foetuses, which Stewart Stevenson mentioned, needs to be considered in more detail. The question of ensuring the certification of the absence of devices is important. It was pointed out that devices are sometimes not picked up until the second level of certification, which can be dangerous. If devices get as far as cremation we have—literally—an explosive situation on our hands.

The minister said that the certificates that are issued for the 250 deaths that occur overseas should be reviewed centrally. I welcome that. Helen Eadie mentioned the issue.

Rhoda Grant and other members talked about the needs of faith groups. I think that we have secured better consideration of the issue, but further issues to do with parallel or retrospective review need to be considered. There is also an important issue to do with deaths in remote and rural areas, as Mary Scanlon and Rhoda Grant, who both represent the Highlands and Islands, said. In the test sites, we must ensure that such issues are taken into account and followed through. Perhaps one of the sites should be in Glasgow, where there is a greater number of faith-based communities.

I will conclude—if that is acceptable to the Presiding Officer—by talking about finance. I was originally of the view that funeral directors should collect the fee, but as the arguments have been made I have begun to think that the registrars might well have to do that. Perhaps we can combine the proposed fee and the charge that is currently made for people who want a copy of the certificate, which registrars already administer—I think that they charge £9. However, as many members said, if the death is registered by
someone other than a family member, such as a police officer or a minister, there could be a problem. That is an administrative matter, with which I am sure the minister will be able to help us, perhaps through guidance.

A fee of £30 sounds reasonable—particularly given that people have been paying more than £150—but it might not be enough to enable the system to be self-funding. In an age of austerity, we must ask whether the Government should be putting a further £1 million or £1.5 million into the system. The approach would be welcomed by individuals but might need to be looked at again.

The central issues of public confidence and the proportionate nature of the bill will need to be considered at stage 2 when amendments are lodged. We support the bill at stage 1.

16:33

Shona Robison: I thank everyone who spoke in the debate, which has been—as the stage 1 report is—constructive and has brought to the fore important issues in relation to all the subjects that the bill covers.

Before I talk about those issues, I will take a moment to reinforce the importance of the measures that are set out in the bill, which are firmly embedded in the Scottish Government’s aim “to deliver the highest quality healthcare services”, as we set out in “The Healthcare Quality Strategy for NHSScotland”.

As I made clear in my opening speech, the bill will deliver a single system of independent scrutiny of all deaths that do not require a procurator fiscal investigation. There is no doubt that the current arrangements for death certification require reform, as many members said. The provisions in the bill will introduce a new and modern approach to scrutiny of death.

The current approach is based on double or triple-checking the certification for cremation, at a cost to families of £147 and with no link to quality improvement, and there is currently no scrutiny of deaths when burials are conducted.

The approach to which we propose to move is intelligence led, targeted and based on quality improvement. It does not discriminate between methods of disposal of the body. It is based on random checking of certificates, which is followed up in an audit cycle, and supported by improvements in training and education.

I confirm for Richard Simpson that 25 per cent of deaths are currently reported to the procurator fiscal: that covers unexpected or sudden deaths and deaths that occur under suspicious circumstances. That will not change; indeed, our proposals will result in around 50 per cent of all deaths being subjected to detailed scrutiny. I hope that that will provide some reassurance to the public—I will come to Ross Finnie’s point in a moment, because it is important—and act as a deterrent against malpractice.

I have listened with great interest to the many and varied points that members have made about the proposals, and I will now address as many of those as I can cover—which, given the time, will probably be all of them.

Christine Grahame and a number of others talked about an electronic system. I accept that that was mentioned in the review group’s report, but it did not go into any detail. There was a passing reference, but there was no detailed evidence or scrutiny in terms of a cost benefit analysis. As I have said, we should consider what can be done in that regard, but I caution against Richard Simpson’s suggestion that we wait for an electronic system before we use the test sites, because that would lead to huge delays and to an immediate increase in cost to develop that technology.

We should work on the technological requirements to get something up and running before roll-out, but people talk about electronic systems as if they can be taken off the shelf and plugged in. We all know that introducing electronic systems in the NHS and in public services generally is difficult and expensive, and takes time. We need to be aware of that before we put down preconditions, but I have made a commitment to look at the matter, certainly while the test sites are on-going.

Dr Simpson: I accept that we need to have a clear understanding of what that would involve, and that we should not delay the whole process unnecessarily with an electronic system. However, I understand that at present ISD, in linking to the registrars, already has an electronic system in place. The 2,000 cases that Dr Fischbacher told us had to be looked at again were brought up because of the electronic system. We may already be part of the way there.

Richard Simpson also talked about training. Junior doctors already receive training in death certification, and their competencies are tested and they are supervised in completing certificates in their first year. However, I have listened carefully to what has been said about training and education and I will reflect on that.
**Helen Eadie:** One of the papers that the committee received raised the issue of training for retired doctors in the event that there is a major outbreak in Scotland. How do you propose to address that? Their services might be called upon, as I think Richard Simpson or Ian McKee mentioned in committee.

**Shona Robison:** I would prefer to go away and reflect on Helen Eadie’s point rather than try to give a response just now, but I will certainly look into that matter in more detail.

Richard Simpson also raised the matter of viewing the body, which has been an issue throughout the debate. It comes down to a decision about proportionality. A trained professional will always examine the body to verify that life is extinct, and I think that everyone accepts that that is the case. As I said earlier, 25 per cent of deaths are referred to the procurator fiscal if they are unexpected, sudden or suspicious. The doctors who took part in the review process advised us that viewing a body is generally of no greater assistance than the medical records, and I and my officials have said that during the committee process. There is a judgment to be made about how important viewing the body is in the process.

Mary Scanlon and Rhoda Grant both raised issues concerning remote and island communities, and it will be important to pick up those issues during the test site period. As I said at committee, one of the test sites will cover a remote and rural area. In the meantime, officials are contacting the relevant funeral industry and local authority representatives to discuss the issues in preparation for the next phase. We are very much sighted on some of the concerns that have been raised by Mary Scanlon and Rhoda Grant.

I do not think that there should be concerns about implants, which Mary Scanlon also spoke about. In the future, details will be captured on amended MCCD forms across the UK by certifying doctors who have access to medical records. The current practice will continue: funeral directors will check whether implants such as pacemakers have been removed, and they will make any arrangements for any internal devices to be removed before disposal takes place. Funeral directors’ technicians are trained to remove such devices. Alternatively, they will get a medical practitioner to remove them.

I turn now to a point that Ross Finnie made, because it was one of the critical points of the debate. He talked about the 10 per cent rate of sampling, and about whether or not the proposed compromise on the increase in the proportion of sampling is adequate. There is, of course, a debate to be had on the matter. At stage 1, the committee heard from the statisticians with whom we have been working. To give some reassurance on the issue, we are happy to write to the committee with more detail regarding the consideration that has been made, in order to help the committee to understand how the statisticians came to some of their judgments. I think that was one of the main points that Ross Finnie was driving at.

Reference has been made to Dr Jeremy Thomas’s evidence, which was quoted by the committee in its stage 1 report with regard to the 10 per cent sample size, which Dr Thomas said was necessary to have “a realistic chance” of identifying errors. Dr Thomas has confirmed that that refers to review procedures for diagnostic histopathology. For members who, like me, do not know what histopathology is, it is “the microscopic examination of tissue in order to study the manifestations of disease.”

The issue is whether or not the 10 per cent sample that has been referred to in that context is really comparable with the sample sizes for death certification. I am not saying that the point is wrong, or that it is like comparing apples with pears, but we need to be cautious about the 10 per cent figure and about what was meant by it.

**Ross Finnie:** I thank the minister for that, but I reiterate what I said—and the minister might care to refer back to the *Official Report*. I was clear in making the point that 10 per cent was the figure that was put to the committee. I was not seeking a 10 per cent result. I am absolutely clear about the matter, but if the minister’s statisticians or directorates can come back to me—I cannot speak for everyone on the Health and Sport Committee—and lay out the statistical basis on which they believe the current sample meets certain tests, that will be satisfactory. I accept that the 10 per cent sample is on a particular basis, but we need some greater underpinning for the figure that the minister has now arrived at.

**Shona Robison:** I am happy to give that reassurance and to come back to the member on that important point.

Ian McKee raised the issue of delegating the functions of medical reviewers for training and education. I confirm that that does not mean that third parties cannot exercise that role. The purpose of the bill’s provisions on that is to ensure that functions are carried out only by a dedicated group of persons. The reviewer’s role is one of leadership; it is not to take over functions that are already carried out by others, for example the royal colleges.

Rhoda Grant made an important point about whether people might be put off from registering deaths because of fees. It is currently a statutory duty to register a death, and that will not change.
Equally, although the intention is to collect the new statutory fee at the point of registration, it will proceed regardless of whether payment is made at that point. Under the current system, most people who register a death pay a fee to obtain a full extract of the entry in the register of deaths. Collection and reimbursement of the new statutory fee will follow the same approach. For those reasons, we do not consider that the requirement to pay a fee will deter people from registering a death. However, we will monitor the situation.

**Rhoda Grant:** The issue was about when the police or a neighbour or someone who might not want a copy of the death certificate registers the death to help the bereaved family, or because the family is not around, for example. The registrars felt that those people might not be so willing to go along because they would be faced with having to pay a fee when it is not their role to do so; it is more appropriate for the family or estate to make that payment.

**Shona Robison:** Part of the solution to that will be communication about the new procedures. We will have to look at how we can send out a reassuring message. The important point is that registration will proceed regardless of whether payment is made at that point. Perhaps we need to pick up on the issue of communication to the public about the process so that we can give reassurance.

I take great comfort from the fact that there is a desire across the chamber to look at the issues and to come to some conclusions. We have made a lot of progress along that road already. There might be a few issues to be resolved, but I am sure that we can resolve them.

I believe that the proposals that are before the Parliament will provide robust deterrence and reassurance to the public, although I accept that we need to come back to the committee on some points. It will also harness the benefits of a targeted quality improvement approach that is proportionate and keeps the financial burden on the Government, as well as on bereaved families, at a reasonable level. Michael Matheson reminded us all that, for every increase, whether it be in the level of scrutiny or an immediate roll-out of an information technology system, there will be a cost. In these difficult financial times, there is a limit on what the Government can contribute to that, although I have already put in some additional resources. If further increases are to be cost-neutral, there will be a direct cost to families, and I would like to avoid that—as would everyone else in the chamber, I am sure.

We have to get a system that can reassure and comfort the public while costs are kept proportionate. I think that we can get there. There are still some issues to be resolved, but I am heartened by the tone of today’s debate. I look forward to working with the committee as we continue to progress with the bill.
Certification of Death (Scotland) Bill: Financial Resolution

16:48

The Presiding Officer (Alex Fergusson): The next item of business is consideration of motion S3M-7822, in the name of John Swinney, on the financial resolution for the Certification of Death (Scotland) Bill.

Motion moved,

That the Parliament, for the purposes of any Act of the Scottish Parliament resulting from the Certification of Death (Scotland) Bill, agrees to any increase in expenditure payable out of the Scottish Consolidated Fund arising in consequence of the Act—[Shona Robison.]

The Presiding Officer: The question on the motion will be put at decision time, which will be at 5 o’clock.

16:48

Meeting suspended.
Dear Christine

CERTIFICATION OF DEATH (SCOTLAND) BILL

RESPONSE TO HEALTH AND SPORT COMMITTEE STAGE 1 REPORT

I am grateful to the Committee for its detailed scrutiny of our proposals and considered conclusions in the stage 1 report.

Due to the tight timescales it has been impractical to provide a written response in advance of the debate. During the stage 1 debate on 3 February 2011 I gave an undertaking to respond to the detailed points raised in the report as well as those raised during the debate. Our position is set out in the Annex.

I trust that you will find this information helpful.

SHONA ROBISON
CERTIFICATION OF DEATH (SCOTLAND) BILL: RESPONSE TO STAGE 1 REPORT

Detection and investigation of unnatural death

159. The Committee has concerns about the Bill as introduced. Whilst the Committee accepts that no system can eliminate the possibility of criminal activity by, for example, a serial killer, the initial proposals were for a level of scrutiny and review of MCCDs that was much less rigorous than the existing arrangements. In particular, the Committee notes that a sample size of 10 per cent was said to be necessary to have a “realistic chance” of identifying errors.

160. The Committee welcomes the increasing of the random sample size and the planned addition of an extra tier of review, as announced by the Minister. However, the Committee notes that the sample size would be increased only to 4 per cent and remains concerned as to why this figure has been selected.

Response: I will first clarify queries about the 10% sample size referred to in the report and the 15% sample size raised during the debate before explaining the rationale for our proposals.

The 10% raised in the stage 1 report refers to evidence submitted by Dr Jeremy Thomas and relates to procedures for diagnostic histopathology. Dr Thomas has in fact agreed with the views of our own Senior Medical Officer that this figure may not be comparable to death certification. Furthermore, the 10% figure was raised by Dr Thomas before I announced the new level 1 reviews; in response to the new proposals, Dr Thomas said that “he believes the new level 1 reviews will cover much of the ground currently covered by procedures for cremation and while the overall percentage of enquiry will be lower, applying the process to all deaths is a step forward”.

The 15% figure was mentioned in a different context during the debate. It was cited in the BMA briefing which ‘refutes that the current second doctor check is perfunctory’ and quotes evidence submitted to the Committee which states these checks result in a “15% improvement in accuracy and picking up of dozens of unnatural deaths.” Yet it was the independent Review Group, of which the BMA were key members, who concluded that these checks are often perfunctory, not independent and that the current system needs replacing. The reference to a 15% improvement in accuracy relates to evidence provided by Professor Stewart Fleming, a pathologist, who based on his experience - not research - said that there is fine tuning or even an alteration of the diagnosis by the confirmatory medical certificate for “somewhere in the ballpark of 15%”. Professor Fleming was also a member of the original Review Group who concluded that second doctor checks could be perfunctory.

Turning to our proposals, I first want to repeat that the random sample sizes are flexible and the number is not fixed in the Bill.

The 1,000 level 2 random sample has a specific purpose: to provide a benchmark of the quality of death certificates (to estimate the true proportion of all MCCDs that are inaccurately coded) and for the first time an evidence-based error rate, which currently we do not have. ISD confirm that 1,000 cases a year will provide this error rate at a 97% confidence level (500 cases would have given a lower 95% confidence interval). Once the system is in operation, the first sample will provide a Scotland-level benchmark and then year-on-year monitoring information which will allow us to gauge progress in driving up
quality standards for death certification. The sample will also provide the intelligence on which the medical reviewers will base decisions on where to target reviews (they will also use the reports from the national statisticians who will analyse all death data at regular intervals).

The other level 2 reviews, targeted reviews initiated by medical reviewers and interested person reviews, are estimated to amount to a **further** 1,000 cases annually. The number of targeted reviews (500) was estimated by ISD to enable us to cost the model. The number of interested person reviews is demand led and the size (1% of deaths or c. 500) was estimated by the original Review Group.

I have added 25% level 1 reviews which will also involve a 'second doctor check' as they will be countersigned by the independent medical reviewer. The medical reviewer will review the MCCD form and discuss it with the certifying doctor. The quality and cause of death of 13,500 forms, randomly selected, will therefore be checked and any unusual factors or discrepancies queried. In addition, a level 1 review will act as a trigger for a comprehensive level 2 review if considered necessary or where there is any disagreement.

In proposing level 1 checks of 25%, I have previously indicated that a 'reasonableness test' has been applied, with the recognition that as the number of random reviews will be under Ministerial direction to the registrar, it can be changed upwards or downwards in light of the evidence that we gather from the practice of the new system, including the test sites.

However, it is very important to be clear that level 1 reviews are primarily being added for the purposes of deterrence and public reassurance in line with the concerns of the committee. Checks at that rate will mean that, overall, taking into account both our proposals and cases reported to the procurator fiscal, **around 50%** of deaths in Scotland would in future be subject to scrutiny. That means that a doctor in Scotland has potentially a 1 in 2 chance of their certificate being further scrutinised. It is therefore not correct to say, as the BMA have done, that under our proposals 75% of burials and cremations will take place after only one doctor has seen the deceased or the death certificate. In fact, a 1 in 2 chance of detection should operate as an effective deterrent.

I believe it is worth emphasising again that our focus will be on quality improvement, which will be implemented though changing behaviour and practice around death certification. The effects of these changes will be monitored and if necessary, adjustments to interventions can be made. This is a step very far in advance of current practice and, coupled with the changes described above to reassure the Committee on the issue of deterrence, I believe that this is a strong and workable package that provides public reassurance but is also a fair and proportionate response.

The Scottish Government has not chosen a different path from England and Wales (where every certificate will be double-checked) simply because it will be more affordable - though it will be considerably so, both to the taxpayer and bereaved families. I make no apology for considering the costs as any future system must be financially sustainable. However, our scrutiny system should build on the existing structures and established processes of the NHS, as well as on the professionalism and high standards of health professionals in Scotland. Our proposed approach provides a balanced and proportionate reform of death certification arrangements.

Turning to the issue of public confidence: the independent Review Group felt that ‘it was for the determination by the public through wide consultation whether the proposals would satisfy public confidence’. We did of course have a public consultation last year and whilst it
did not attract responses from ordinary members of the public, we do have responses from organisations representing patients and the bereaved: the Scottish Consumer Council, CRUSE Scotland and the Scottish Patients Association. All of these organisations are supportive of our proposals. Furthermore, I can also assure the Committee that we will continue to seek the views of the public and representative bodies during the test sites and take their views into account when I report back to Parliament before full implementation.

161. The Committee notes the intention to report to the Parliament on the outcome of the pilot in the test sites. In the meantime, the Committee will seek views on the Minister’s new proposals from witnesses who were critical of the Bill.

Response: I have already committed to report back to the Committee following the operation of the test sites, before full roll-out. This will take account of stakeholder input and will feed into the monitoring and evaluation plans. The proposed legislation has been designed to require an annual report to Parliament on the activities and performance of the medical reviewers. This will allow for a transparent examination of the operation and impact of the new system by all interested parties, including colleagues in this Chamber, and for adjustments to be made to the level of scrutiny as required.

163. The Committee notes the further explanation regarding proposals relating to stillbirths, given by the Minister in correspondence following her oral evidence.

Response: The Scottish Government notes the Committee’s view.

**Accurate recording of the cause of death**

164. The Committee considers that the new proposals increasing the level of scrutiny, announced by the Minister during oral evidence to the Committee, take a step towards addressing the main concerns about quality and confidence in the system.

Response: The Scottish Government notes the Committee’s view.

165. The Committee remains concerned that no level of experience is specified as a pre-requisite for eligibility to sign MCCDs in a professional culture where supervision can be very variable – with, for example, junior doctors sometimes being left responsible for death certification at weekends without consultants being present. The Committee believes that, if the aim is genuinely to drive up quality, there must either be an experience qualification or junior doctors should not be allowed to sign a death certificate unless they have been signed off by the deanery as having undertaken a module.

Response: During the debate I said that the Bill will be looking to improve existing training requirements and we will be examining the issue of supervision and training in more detail.

First of all I want to clarify that the content of competencies required of trainee medical practitioners, at both undergraduate and postgraduate levels, is a matter for the General Medical Council, as the regulatory body for all medical practitioners.

Junior doctors already receive training in death certification; their competencies are tested, and they have to be supervised in completing certificates in their first year (this does not mean supervision necessarily stops after that first year). Junior doctors are “fully registered” by the GMC on completion of their first foundation year. Restricting the function to grades
above junior doctor would lead to delays in issuing certificates and I agree with the Committee that this would be undesirable.

The functions given to medical reviewers in the Bill with regard to training, guidance and support do not replace the existing training which medical students and junior doctors will continue to receive in this area as part of their general training. Our new proposals will bring training and education benefits in various ways:

- As a result of the random and targeted checks by medical reviewers, quality issues will be picked up which can be fed back directly to certifying doctors.

- The senior medical reviewer will use his/her leadership role and establish links with Medical Directors of NHS Boards and Postgraduate Deans and contribute through talks at seminars / training events aimed at Responsible Officers / Medical Directors and others.

- In addition, an e-Learning module will be developed for the medical reviewers which will also be made available for others, including for doctors’ CPD.

- Medical reviewers will also provide direct support to certifying doctors, by phone. In addition, existing checks of MCCDs by registrars and coders will continue and district registrars too will receive support from medical reviewers who will directly support and guide them where information provided on MCCDs is inaccurate, incomplete or requires further inquiry.

- Links to clinical governance will be key: data from the statistical analyses of all deaths and reviews which identify training and performance issues / gaps will be discussed with those responsible for training doctors i.e. the Responsible Officers / Medical Directors in each health board.

- These will apply to all certifying doctors, not just junior ones.

All of the activities listed above have been taken into account in the assumptions for the cost model as evident in the Financial Memorandum.

Retired doctors

Another issue was raised during the debate, about the need to ensure that retired doctors who return to provide services including death certification during times of excess deaths are fully up-to-date in terms of training.

Response: This issue has been discussed as a result of Pandemic Flu and will continue to be a part of resilience and emergency planning in Scotland. It does not require legislation.

Confirming the fact of death

162. The Committee remains concerned, however, about the removal of the requirement for approval from a second and a third doctor from cremation cases. The Committee notes the argument that the procedures for burials and cremations should be aligned but believes that, owing to the finality of cremation, any alignment should have taken as its benchmark the rigour of the current cremation procedures.
Response: As Dr Jeremy Thomas commented to Committee, the new level 1 reviews will cover much of the ground currently covered by procedures for cremation, and it will be up to the medical reviewer to assess any additional evidence and speak to other people, where deemed necessary.

The logic of the more rigorous checks for cremation dates back to the early 20th century when such checks were introduced as safeguards, as it was considered that the exhumation of a buried body would allow further investigations which would not be available after cremation. However, current experts are now of the view that exhumation of buried bodies yields very little forensic information, particularly if the body is exhumed after a significant length of time.

The independent Review Group (whose members included the BMA, pathologists, Crown Office, GROS, faith group and funeral industry representatives) which considered these issues in detail, noted concerns about the quality of MCCD forms, specifically about the additional cremation checks: ‘many doctors completing the second Form C performing only a cursory check’ and ‘the completion of Forms B and C should in theory constitute two separate checks which are totally independent of each other, however, this is often not the case in practice’. These concerns have been confirmed during our recent public consultation and stakeholder meetings in relation to the proposals for the Bill: ‘the confirmatory certificate is not treated seriously by the signatories and medical referees are appointed by cremation authorities on word of mouth recommendation; they are nominally independent, but are paid by their authority; they are not subject to regular review of their practice’ (consultation respondent, former President of Association of Medical Referees).

167. The Committee is concerned that it might still be possible for a medical practitioner to sign an MCCD without examining the deceased. The Committee draws this point to the Minister’s attention and requests that she respond to it in the Scottish Government’s formal response to this report.

Response: Practice varies now according to whether someone is cremated or buried. No examination is carried out for the latter. I should make it clear that at the moment and in the future a trained professional will in all cases examine the body of the deceased to verify life is extinct. This will be a doctor or in some circumstances - where the death is expected, a nurse, or in cases of an accident, a paramedic.

Where a death is unexpected, sudden or occurs under suspicious circumstances, the deaths will be referred to the procurator fiscal. If a professional viewing the body to verify fact of death has any concerns, the case will also be referred to the procurator fiscal where the body will be examined by a doctor. The Committee will wish to note, that as referenced above, 25% of deaths are currently reported to the procurator fiscal. The circumstances for such referrals being made are not being changed.

When a doctor certifies the cause of death i.e. as part of his / her duty to complete the MCCD, he or she may decide to view or examine the body if they feel this is necessary to ascertain the cause of death.

The Committee may wish to note specifically that the doctors’ group of the original independent Review Group recommended that ‘viewing the body is generally of no greater assistance to a general practitioner than the medical records and that there was no need for the body to be routinely examined for signs of violence or mistreatment beyond the reporting of incidental findings by funeral directors or mortuary technicians to the Procurator Fiscal’.
Implants

During the debate it was commented that the removal of the second signature would be problematic for cremations because many devices like pacemakers or fixation nails which must be removed before cremation are currently only discovered after the MCCD is issued i.e. by the second practitioner reading the medical records or examining the deceased.

Response - I want to reiterate what I said during the debate: in future doctors, who provide the MCCDs and who have access to medical records, will be required to state the details of any implants on the ‘new’ MCCD forms.

Medical reviewers’ workload

168. The Committee notes the explanation that MRs' training and education role would be primarily supervisory whereas the responsibility for providing training and education would fall on doctors' educational supervisors. The Committee has reservations that, with a remit to advise, to train and, now, to carry out 25 per cent level 1 scrutiny, which is likely to lead to an increase also in level 2 reviews, the proposed workforce may still be inadequate.

Response: I believe that our figures are robust and they have been revised to take account of the additional proposed reviews. The number of medical reviewers is not specified in the Bill and can therefore be adjusted. Furthermore, in the year before implementation we will run test sites and a key evaluation aim of these will be to provide more detailed information on the duration of reviews which will confirm how many staff are required.

169. The Committee also draws the Parliament's attention to paragraph 3 of Schedule 1, which states that any function conferred on MRs may not be delegated by Healthcare Improvement Scotland, and requests that the Scottish Government clarify whether it will be possible, in the context of this provision, for the educational and training role of MRs to be exercised by third parties as was suggested in oral evidence to the Committee.

Response: This is based on a misunderstanding. The purpose of the prohibition in the Bill is to ensure that medical reviewer functions are only carried out by a dedicated group of persons with requisite qualifications. Their role in education and training is one of leadership and advice. They are not expected to take over functions currently undertaken by third parties i.e. training.

Use of technology

166. The Committee also believes that accuracy in the completion of MCCDs could be improved with appropriate use of technology. This is discussed later in the report under the heading ‘Use of technology’.

170. The Committee notes the Minister’s comments that the Bill would not confine practice to a paper-based system. The Committee is surprised, however, that an electronic system was not specified from the outset, given the evident advantages: an electronic system could provide prompts and help to those completing MCCDs, as well as ensuring that non-compliant MCCDs were impossible to submit. The need for repeated data entry, which is another source of possible error, would also be removed from the process. Using an electronic system would also establish a chain of evidence and would do much to clarify matters. The Committee notes that it would
now be difficult to devise and implement such a system in time for the beginning of
the test sites but, if this proves impossible to achieve, strongly urges the Scottish
Government to do so as soon as possible and, in any case, before the eventual roll-
out of the new system nationwide.

Response: As I indicated during the stage 1 debate I will further explore the feasibility of
introducing such a system.

A number of years ago GROS explored the possibility of obtaining cause of death data from,
for example, patient record databases, and has already paved the way for such an electronic
MCCD system in primary legislation (Local Electoral Administration and Registration
Services (Scotland) Act 2006).

However, I wish to express a degree of caution. Any new electronic MCCD system would
be a significant IT project that is unlikely to be available quickly enough to derive any
additional advantage to what is being proposed. What is envisaged in the Bill already takes
advantage of the existing electronic registration system in a cost-effective way.

In addition, until this has been considered further, we should not assume that the case in
favour of electronic MCCDs has been made. For example, electronic MCCDs cannot
address the issue of inaccurate MCCDs. Just because a form is submitted without a blank
space or the cause of death chosen is from a pull-down list, does not mean the diagnosis is
accurate (this is no different than for a paper system). An electronic system is said to offer
an audit trail, but it is not clear what additional audit information it would provide beyond that
already provided by the current paper based system. An electronic system is said to provide
information on doctors who move practices. That information is already available in Scotland
from workforce data, but it does not help to detect suspicious activity. Another important
point is that an individual doctor's mortality figures are always hidden in practice totals, as
patients are registered with the practice, not an individual doctor. With regards to avoiding
repeated data entry, at present the doctor fills in the MCCD manually and the registrar enters
it into an electronic system for transmission to GROS. The suggested system would have
the doctor completing the certificate electronically for transmission to the registrar and then
to GROS. In each case, data is only entered into a computer system once, though
admittedly only lot of manual recording (by the doctor) is avoided. However, this assumes
that electronic systems exist in each of the locations and that they can communicate with
each other - which is not the case.

Putting an electronic system in place is likely to be very costly. To give a flavour of what is
involved, the certifying doctor could either be a GP or could be working in a secondary care
setting and the doctors' expectations would be that this process would be appropriately
integrated into whatever systems they were using and where they were using them. There
would need to be controls in place to authenticate the certifying doctor and measures to
maintain the integrity of the electronic message through transmission to storage. There are
a number of activities that can stem from the completion of the MCCD, with other parties
involved. These include local registrars, registrars and GROS coders. The whole process
would benefit from process re-design back to the point of data entry where the information
that is recorded could be improved / standardised with the potential to save time and effort
downstream.

Under our current proposals, over 98% of deaths would continue to be registered
electronically, including the information recorded on the MCCD, on a central GROS
database. The remaining small number of manually registered deaths are added to the
database a week later. So deaths data will be available to the national statistician very quickly.

In addition, at present, there is no repeated data entry in the existing process (and the provisions in the Bill do not change that) and there is already a chain of evidence in the existing system - MCCDs are retained for 3 years, and the registration information is retained in perpetuity.

I will write again to the Committee on this issue once we have further investigated the feasibility issues.

**MCCD additional information**

Dr Simpson also raised the issue of inclusion of ethnicity information and the community health index number (the CHI number) on the MCCD form during the debate as examples of 'small elements that would improve health care systems'.

Response: GROS is proposing to consult on the issue of recording on the registration system information about a deceased person’s ethnicity when registering that person's death. It is envisaged that this could be done without the need to record ethnicity on the MCCD itself. Furthermore, GROS proposes to record the CHI number on the MCCD and has recently consulted on that proposal.

**Timescales**

171. The Committee believes it is important to respect the position of different faith groups in relation to the Bill’s provisions, particularly the Jewish and Muslim faiths. The Committee considers that the system should not unduly delay disposal of the body and this should be clear in the Bill. In the light of the Scottish Government’s evidence on this point, the Committee is not confident the Bill is entirely clear on this point and believes the expedited process should reflect the faith needs of certain groups in society. The Committee welcomes, therefore, the clarity brought by the Minister’s explanation given in correspondence but believes the Bill should be amended in order that the position be similarly clear in the legislation itself.

172. Concerns were also raised with respect to particular difficulties for remote and island communities, relating to potential delays in both initial certification and review.

Response: First of all I want to reiterate that once a death has been registered (registration is complete), a funeral can proceed. This is the current legal position and there is no need for the Bill to be amended in that respect.

In designing the proposals, we have listened to representations from faith groups and others to ensure that the new system allows for effective scrutiny and fairly balances the interests of bereaved families. The proposals have been designed so that reviews are carried out without imposing undue delays on bereaved families. It is anticipated that, as a norm, level 2 reviews will be completed within a day or two of the death and will have no perceptible impact for bereaved families on the scheduling of funerals. Level 1 reviews are anticipated to be completed more quickly. Actual timescales will be tested during the test sites.

We recognise that there may be circumstances where reviews impact on the scheduling of funerals because the scrutiny of an individual’s records takes longer than normal (for example, where records may need to be retrieved from rural and remote locations or where
public holidays constrain the swift retrieval of records). In addition, we recognise that there may be circumstances in which the delays inherent in a review system, even when they are fairly short, might create difficulties for particular bereaved families. Accordingly, in cases randomly selected for review, families will be able to request that registration takes place in parallel with the review process to allow the funeral to proceed as soon as possible after the registration requirements have been met.

The expedited procedure in section 6 is intended to apply to persons of all faiths and none, as long as they can show that the circumstances of the case justify its use. Indeed, one of our major considerations for introducing the expedited procedure was to accommodate the needs of faith groups. However, we do not want to limit that procedure to cases where faith is an issue and have therefore made it available to all persons. It is not our intention here to single out any particular group to suggest that they can obtain special treatment, although we fully accept the real concerns of faith groups on this issue. It is still our intention, following public consultation, to lay out in guidance, examples of the circumstances in which use of the procedure will be appropriate. This will ensure that the public understand how the process will work and who will be eligible to apply, and religious/faith requirements will be included in that context. For those reasons we do not intend to amend the Bill so as to specify that the procedure may be used where faith issues arise; this would be at odds with our general approach to section 6 and would give the appearance of discriminating in favour of persons who hold particular religious beliefs over those who do not.

I note suggestions to impose specific time limits for the conduct of reviews. We feel that it would not be helpful or conducive to discovering errors if medical reviewers are placed under stringent time constraints. Medical reviewers will be under the direction and leadership of a senior medical reviewer. This will ensure consistency in practice across the team of medical reviewers and their staff, including in the application of reasonable timescales. Reviewers will also receive training and guidelines on conducting reviews. Medical reviewers’ performance will be reviewed and their activities will be reported on, annually, to Parliament.

It is absolutely not my intention to disadvantage remote or island communities and we will examine aspects raised in relation to these communities specifically during the test site phase before implementation. In addition, officials have already started discussions about these issues with relevant stakeholders in remote and island communities in preparation for the next phase of activity.

With regard to the issues raised around mortuary provision, it might be helpful to draw to the Committee’s attention that there is already a statutory duty placed on NHS and local authorities under the Public Health etc. Scotland Act 2008 to co-operate to provide mortuary facilities. This includes premises and facilities for temporary storage of bodies and post mortem examinations.

173. The Committee notes the important concerns raised in relation to organ donation, which appear to conflict with the Scottish Government’s position on the matter. The Committee looks to the Government’s response for further clarity on this issue.

Response: I previously wrote to you on this matter to say that reviews would not affect organ and tissue donation because by the point at which scrutiny is flagged up - i.e. when the MCCD is presented to the registrar - tissues or organs would already have been removed. Equally it would be of no concern for the purposes of scrutiny that some parts of the body had been removed. We have been in discussion with the relevant officials and
professionals in arriving at this position and we will continue to involve them in implementation.

174. The Committee also notes the need for expedited procedures where bodies were being donated for medical research and notes the Minister’s response that this would be dealt with in guidance.

Response: The Scottish Government notes the Committee’s view.

Deaths abroad

175. The Committee considers that the responsibility for assessing the validity of documentation in cases of repatriation of the deceased for burial or cremation should be exercised centrally.

Response: As I indicated during the stage 1 debate, having reflected on the matter, and having listened to stakeholder concerns about the proposals in the Bill to give that function to superintendents at local burial grounds and crematoria, I will amend the Bill at stage 2 to require the medical reviewers’ office to carry out that function instead. I hope this will address the concerns of stakeholders and the Committee.

Collection of the new fee

176. The Committee welcomes the Minister’s comments relating to the setting of the fee and the comparison with the expected fee in England.

177. The Committee also welcomes the abolishing of the higher fee relating to cremation only, until now paid in 62 per cent of cases, in favour of a lower and universal fee. The Committee supports the original intention for the new system to be self-funding. The Committee notes the rationale for giving the responsibility for collecting the fee to registrars but acknowledges the concerns raised by representatives of registrars.

Response: I appreciate the Committee’s positive comments about the setting of the fee and the abolition of the higher cremation fee in favour of a lower universal fee for all deaths. We will continue to work constructively with stakeholders on developing an effective fee collection mechanism.

I also want to take the opportunity to address the points raised about whether someone may be deterred from registering a death due to payment of a fee and what happens when a police officer or someone else with no interest in the estate registers the death.

It is currently a statutory duty to register a death. This will not change. Equally, while the intention is to collect the new statutory fee at the point of registration, registration will proceed regardless of whether payment is made at that point. Under the current system, most people registering a death pay a fee to obtain a full extract of the entry in the register of deaths (and they can recover that fee from the estate). Collection (and reimbursement of the new statutory fee) will follow the same approach. For these reasons, we do not consider that the requirement to pay the fee will deter people from registering a death.

Under section 23 of the Bill, the persons liable for payment of the fee are the personal representatives of the deceased and that fee is then recoverable from the estate of the deceased. We are continuing to work out the operational details relating to the collection of
the fee and we appreciate that different approaches may be needed depending on the circumstances in which the death is registered. However, we do not feel that these issues cannot be resolved through good communication and the development of best practice.

**Delegated powers**

178. The Committee notes the Subordinate Legislation Committee’s report.

Response: The necessary amendments have already been drafted and a separate response will be submitted to the SLC.

**Other issues raised during the debate**

**Document provision to conduct reviews**

Concern was expressed during the debate about the additional workloads on doctors and the short timescale arising from reviews which might lead to doctors having to decide what is more important - responding to a medical reviewer’s request to produce documents for review or letting a patient suffer (noting that offence provisions apply for failure to produce documents for a review). Related to that, is the issue of how part-time or shift-working doctors will be able to respond to the new system.

Response: This issue is one the BMA has raised previously and I responded to it then. Let me clarify again that it is necessary to have an offence provision in place because without access to the relevant documents, the review system could not operate, or it might operate at a far, far slower rate than anticipated which would lead to lengthy delays for families. There is a need for a power to require documents which carries the threat of imprisonment in order to compel persons to comply with a request by the medical reviewer.

Medical reviewers must specify in the notice requiring the documents the date by which the person is required to produce them and the specified deadline must not be unreasonable. In practice, an administrative member of staff could deal with the location and transfer of the documents to the medical reviewer, rather than the certifying doctor.

In addition, it is a defence to a charge of refusing or failing to produce a document following a request under section 14 to prove that there was a reasonable excuse for the refusal or failure. So, if there was some form of emergency in a hospital context, for example, and documents could not be produced within the deadline set by the reviewer, it would be possible to avoid prosecution if the circumstances justified the failure to produce the documents within the timescale.

The same applies to doctors who work part-time and shifts.

**Disposal and body parts and fetal remains**

During the debate Dr Simpson said that the disposal of body parts and fetal remains needs to be considered in more detail.

Response: I want to take the opportunity to clarify the arrangements under the provisions of the Bill. Under the new arrangements, Scottish Ministers will specify in regulations the documents required for the disposal of a body (or parts of a body) and the person in charge of a place of interment or cremation (i.e. the responsible person at the burial ground or
crematoria) will be required to check whether these documents have been produced. Provision in the Bill under section 24 2(b) allows for the introduction of a new statutory certificates which will be required for disposal, the contents and form of which will be prescribed in regulations. These certificates will authorise the disposal of body parts.

With regards to fetal remains, there are no provisions contained in the legislation that relate to fetal disposal. The Scottish Government has set up a Working Group to review the existing guidance with a view to updating it to ensure that in future there is a consistent approach across Scotland. A consultative process is being used to put the guidance together and the Working Group anticipates the completion of their work in spring 2011.

9 February 2011
Certification of Death (Scotland) Bill – Response from the Bill Team

Background

1. The Subordinate Legislation Committee reported on the delegated powers in the Certification of Death (Scotland) Bill on 8 December 2010 in its 66th Report of 2010.

Government response

2. The Committee made three recommendations in its stage 1 report.

3. In its response, the Scottish Government has confirmed that it will lodge amendments in line with the recommendations made by the Committee.

4. The Subordinate Legislation Committee will give further consideration to the delegated powers contained in the Bill after Stage 2.

Recommendation

5. Members are invited to note the Government's response on this matter and to reconsider the powers in the Bill after it has completed Stage 2.

Irene Fleming
Clerk to the Committee
Correspondence from the Scottish Government dated 9 February 2011

Certification of Death (Scotland) Bill - Stage 1

Thank you for the letter from Jake Thomas, Assistant Clerk to the Subordinate Legislation Committee dated 7 December 2010 enclosing a copy of the Stage 1 Report of the Subordinate Legislation Committee.

The Committee drew attention to 3 sections in particular. In relation to the delegated powers in sections 2 and 4(7), the Scottish Government confirms that it will seek to amend the Bill at Stage 2 to adopt the emergency affirmative procedure for these powers, discounting periods of recess. In relation to the delegated power in section 23(3) to set fees, the Scottish Government confirms that it will seek to amend the Bill at stage 2 to provide for negative procedure in this case.

The Committee will wish to note that the Minister for Public Health & Sport confirmed in her response to the Health & Sport Committee Stage 1 report that the necessary amendments have already been drafted in relation to the above.

The Scottish Government is grateful to the Committee for its scrutiny of and comments on the Bill.

ANNETTE STUART
Bill Team
Certification of Death (Scotland) Bill

Marshalled List of Amendments for Stage 2

The Bill will be considered in the following order—

- Section 1
- Sections 2 to 29
- Sections 30 and 31
- Schedule 1
- Schedule 2
- Long Title

Amendments marked * are new (including manuscript amendments) or have been altered.

Schedule 1

Shona Robison
1 In schedule 1, page 17, line 23, leave out from <the> to end of line 24 and insert <any function of a medical reviewer other than those under section (Verification of foreign death certificates).>

Shona Robison
2 In schedule 1, page 17, line 30, after <functions)> insert—
   <( ) in sub-paragraph (1), for “and” where it first occurs substitute “to”>.

Shona Robison
3 In schedule 1, page 17, line 30, at end insert—
   <“(2ZA) HIS may authorise an employee to carry out the functions of a medical reviewer under section (Verification of foreign death certificates).>.

Shona Robison
4 In schedule 1, page 17, line 31, after <Any> insert <other>

Section 2

Helen Eadie
15 In section 2, page 1, line 16, leave out <randomly selected> and insert <all>

Mary Scanlon
16 In section 2, page 1, line 16, leave out <randomly selected> and insert <a selection of>

Helen Eadie
17 In section 2, page 1, line 25, leave out subsection (4)
Helen Eadie
18 In section 2, page 2, line 16, leave out subsection (6)

Mary Scanlon
19* In section 2, page 2, line 18, at end insert—

<( ) the minimum number of certificates of cause of death relating to deceased persons who are to be cremated which are to be selected for referral under subsection (1) in any year, and>

Shona Robison
5 In section 2, page 2, leave out lines 33 and 34 and insert—

<(9) An order under made subsection (7)—
(a) must be laid before the Scottish Parliament, and
(b) ceases to have effect at the expiry of a period of 28 days beginning with the date on which it was made unless, before the expiry of that period, the order has been approved by resolution of the Parliament.

(10) In reckoning for the purposes of subsection (9)(b) any period of 28 days, no account is to be taken of any period during which the Scottish Parliament is—
(a) dissolved, or
(b) in recess for more than 4 days.

(11) Subsection (9)(b) is without prejudice to anything previously done by reference to an order under subsection (7) or to the making of a new order under that subsection.”.>

Section 4

Helen Eadie
20 In section 4, page 3, leave out lines 25 and 26

Section 14

Shona Robison
6 In section 14, page 9, line 7, after <11(2),> insert <, or

(b) determining whether it is safe to cremate the body of a person who died outwith Scotland under section 17(2),>
Before section 17

Shona Robison

7 Before section 17, insert—

<Verification of foreign death certificates>

(1) This section applies where—
   (a) a person (“A”) died outwith the United Kingdom, and
   (b) the body of A is to be disposed of in Scotland.

(2) A medical reviewer must, on the request of a relevant person, determine whether the documentation relating to A’s death is in order.

(3) Documentation is in order if it appears to the medical reviewer to be—
   (a) authentic, and
   (b) equivalent to the certificates or other documentation required under section 27A of the 1965 Act (offence of disposal of body without authorisation) for the interment, cremation or disposal by other means of the body of a person who died in Scotland.

(4) If the medical reviewer determines that the documentation is in order, the medical reviewer must give the relevant person a certificate specified for the purposes of this section under section 27A(2) of the 1965 Act.

(5) In making a determination under subsection (2), a medical reviewer may make such enquiries as the medical reviewer considers appropriate.

(6) For the purposes of subsection (2), a relevant person is—
   (a) a person who wishes to arrange the interment, cremation or disposal by other means of A’s body, or
   (b) the person having charge of the place where A’s body is to be interred, cremated or disposed of by other means.>

Section 17

Shona Robison

8 In section 17, page 10, line 12, leave out <an individual> and insert <a person>

Section 23

Shona Robison

9 In section 23, page 12, line 24, leave out <have regard to> and insert <not set a fee in excess of>

Shona Robison

10 In section 23, page 12, line 30, after <sections> insert <(Verification of foreign death certificates),>
After section 24

Mary Scanlon

21*  After section 24, insert—

<Conditions under which cremation may take place

After section 27 of the 1965 Act insert—

“27B  Conditions under which cremation may take place

(1) Cremations of deceased persons must not take place except in a crematorium, the opening of which notice has been given to the Scottish Ministers.

(2) Where the body of a deceased person is to be cremated in such a crematorium, cremation must not take place unless—

(a) a medical certificate of cause of death has been provided by a registered medical practitioner who has attended to the deceased person during his last illness (or, if no medical practitioner attended the deceased during his last illness, by a registered medical practitioner who is the ordinary medical attendant of the deceased person provided that they can definitely certify the cause of death), and

(b) certification of a medical cause of death certificate under paragraph (a), has been given to that crematorium by a medical practitioner of not less than five years’ standing who is not a relative of the deceased person or a partner of the practitioner who has provided the certificate under subsection (a).>

After section 26

Ian McKee

22  After section 26, insert—

<Certificate of cause of death

Certificate of cause of death

(1) In section 24 of the 1965 Act (certificate of cause of death), after subsection (2), insert—

“(3) For the purposes of this section, the Scottish Ministers may by order incorporate registered nurses within the definition of registered medical practitioner.

(4) No order is to be made under subsection (3) unless a draft of the statutory instrument containing the order has been laid before, and approved by resolution of, the Parliament.”.>
Section 28

Shona Robison

11 In section 28, page 14, line 19, at end insert—

(1A) An order made under section 4(7)—

(a) must be laid before the Parliament, and

(b) ceases to have effect at the expiry of a period of 28 days beginning with the date on which it was made unless, before the expiry of that period, the order has been approved by resolution of the Parliament.

(1B) In reckoning for the purposes of subsection (1A)(b) any period of 28 days, no account is to be taken of any period during which the Parliament is—

(a) dissolved, or

(b) in recess for more than 4 days.

(1C) Subsection (1A)(b) is without prejudice to anything previously done by reference to an order under section 4(7) or to the making of a new order under that provision.

Schedule 2

Shona Robison

12 In section 28, page 14, leave out line 21

Shona Robison

13 In schedule 2, page 18, line 5, at beginning insert—

(1) The Cremation Act 1902 is amended as follows.

(2) In section 7 (regulations as to burning)—

(a) the words from “and” where it fifth occurs to “place” where it second occurs are repealed,

(b) the words from “Each” to “prescribe” are repealed.

(3) After section 7 insert—

“7A Forms of documentation for burning

The Scottish Ministers may make regulations prescribing the forms of notices, certificates and applications to be given or made before the burning of any human remains is permitted to take place.

7B Procedure for regulations

A statutory instrument containing regulations under section 7 or 7A is subject to annulment in pursuance of a resolution of the Scottish Parliament.”.

(4)
In schedule 2, page 18, line 7, at end insert—

<\textit{Cremation Act 1952 (c. 31)}

\textquotedblleft In section 2(2) of the Cremation Act 1952 (procedure for regulations made under section 7 of the Cremation Act 1902) the words from “Any” to “and” are repealed.\textquotedblright>
Certification of Death (Scotland) Bill

Groupings of Amendments for Stage 2

This document provides procedural information which will assist in preparing for and following proceedings on the above Bill. The information provided is as follows:

- the list of groupings (that is, the order in which amendments will be debated). Any procedural points relevant to each group are noted;
- the text of amendments to be debated at Stage 2, set out in the order in which they will be debated. **THIS LIST DOES NOT REPLACE THE MARSHALLED LIST, WHICH SETS OUT THE AMENDMENTS IN THE ORDER IN WHICH THEY WILL BE DISPOSED OF.**

Groupings of amendments

**Verification of foreign death certificates**
1, 2, 3, 4, 6, 7, 8, 10

**Referral of all medical certificates of cause of death for review**
15, 17, 18, 20

Notes on amendments in this group
Amendment 15 and amendment 16 in the next group are direct alternatives
Amendment 18 pre-empts amendment 19 in the next group

**Consideration of referral of medical certificates of cause of death for review where person is to be cremated**
16, 19

**Scottish Ministers’ order-making powers**
5, 11

**Fees in respect of medical reviewer functions**
9, 12

**Conditions under which cremation may take place**
21, 13, 14

**Power to extend registered medical practitioners’ role in relation to providing and signing certificates of cause of death to registered nurses**
22
HEALTH AND SPORT COMMITTEE

EXTRACT FROM THE MINUTES

4th Meeting, 2011 (Session 3)

Wednesday 2 March 2011

Present:

Helen Eadie
Christine Grahame (Convener)
Michael Matheson
Mary Scanlon
Ross Finnie (Deputy Convener)
Rhoda Grant
Ian McKee
Dr Richard Simpson

Also present: Minister for Public Health and Sport, Shona Robison MSP.

Certification of Death (Scotland) Bill: The Committee considered the Bill at Stage 2 (Day 1).

The following amendments were agreed to (without division): 1, 2, 3, 4, 5, 6, 7, 8, 9,10, 11, 12, 13 and 14.

The following amendments were moved and, with the agreement of the Committee, withdrawn: 15, 16, 21 and 22.

The following amendments were not moved: 17, 18, 19 and 20.

Sections 1, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 15, 16, 18, 19, 20, 21, 22, 24, 25, 26, 27, 29, 30 and 31 and the long title were agreed to without amendment.

Schedule 1, sections 2, 14, 17, 23 and 28 and schedule 2 were agreed to as amended.

The Committee completed Stage 2 consideration of the Bill.
On resuming—

Certification of Death (Scotland) Bill: Stage 2

The Convener: We move to stage 2 consideration of the Certification of Death (Scotland) Bill. Members should have a copy of the bill, the marshalled list of amendments and the list of groupings for debate. I welcome the Minister for Public Health and Sport, who is so fond of us that she will remain with us for the rest of the day.

Section 1 agreed to.

Schedule 1—Status and appointment of medical reviewers

The Convener: Amendment 1, in the name of the minister, is grouped with amendments 2, 3, 4, 6, 7, 8 and 10.

Shona Robison: The committee raised the issue of where responsibility for checking, prior to disposal, certificates that are associated with deaths abroad should lie. I reflected on the matter and listened to stakeholder concerns about the proposals in the bill to give that function to superintendents at local burial grounds and crematoria. As a result of that reflection, I lodged amendments 1 to 4 and 7, to require the medical reviewers office to carry out the function instead. I hope that the amendments will address the concerns of stakeholders and the committee.

The task of ensuring safe disposal for cremations is currently performed by medical referees. In future, the revised medical certificate of cause of death form will have the relevant information about implants and other devices, and that information will be transposed to the registration of death form. For deaths abroad, an application will have to be made to the medical reviewers, who will ascertain the presence of such devices.

Amendment 6 will ensure that the medical reviewers have powers to make any additional inquiries that may be necessary. Amendment 8 is simply technical, to provide consistent language in the bill. Amendment 10 confirms that we will not charge a fee for the change of responsibility for verifying foreign death certificates to the medical reviewers office.

I urge members to support the amendments in the group.

I move amendment 1.

Dr Simpson: I would like a little more explanation of how the medical reviewer will ascertain the presence of implants in people who
died abroad. Will he simply ask about that? The issue is tricky.

**Shona Robison:** I presume that investigations would be made and that some information on the death would be gathered in situ, wherever that might be. Paperwork might or might not reveal the presence of implants. If necessary, and if doubts remained about whether devices were present, medical reviewers could seek advice and expertise. In many cases, medical reviewers will be able to ascertain through paperwork that a person has a device—because of their medical history, for example. However, as a fallback position, further investigations could be made if required.

It is worth adding that most people who die abroad are on holiday and are registered with a GP in Scotland, so much of the paperwork about medical devices that have been fitted is available. However, the fallback is that external advice can be sought.

**Dr Simpson:** That is helpful. I support the amendments, but problems exist. I suggest that the minister seeks advice before stage 3. About 250 deaths a year occur abroad and the number of those people who have implants is of course small. However, any cremated implant would be explosive—the situation is really dangerous. Funeral directors abroad might check for implants—systems will be in place—but will the minister tell us at stage 3 how the issue will be dealt with? Would it be better to have a register of individuals in Scotland who have such devices, which the reviewer could access automatically? That suggestion might be impractical, but it has been raised with me for consideration.

**Helen Eadie:** Richard Simpson reminds me of a case that I dealt with that involved a young man who went to work in Thailand, where he stayed for several years. His parents were my constituents and came to seek my help when he died as the result of an accident in Thailand, because the costs of bringing his body home were enormous. In the end, they had him cremated, which reduced the costs significantly. I had to work closely with the embassy in Thailand, which made no comment on any of the checks that the minister talked about. As Richard Simpson said, perhaps the minister might consider the point further before stage 3. In my experience, it has been an issue.

**Shona Robison:** I am happy to undertake to give more information on the process. Guidance will be issued on such matters.

**Amendment 1 agreed to.**

**Amendments 2 to 4 moved—[Shona Robison]—and agreed to.**

**Schedule 1, as amended, agreed to.**
Although we heard in evidence from Professor Fleming that a figure of 10 per cent might be appropriate, I made it clear that I did not necessarily think that it was. He based that estimate on past experience, but I thought that it would be helpful to the committee to have a more mathematical assertion of how our degree of confidence in the system could be described in statistical terms.

I understand where the BMA and Helen Eadie are coming from with amendment 15 but, on the other hand, I wish to have some assurance about the statistical basis for the numbers that we would use under the minister's proposed amendment.

Michael Matheson (Falkirk West) (SNP): I am conscious that death certification is to be largely self-financing. It would be interesting to know from the minister what the cost implications would be for the issuing of death certificates if Helen Eadie's amendment 15 were agreed to.

Ian McKee: I have a great deal of sympathy with the sentiments that Helen Eadie and Ross Finnie expressed, but I cannot support amendment 15 because moving to a system in which all cases were referred would involve a great deal of expense.

I hesitate to use the word overkill in this context—

Michael Matheson: You just have.

Dr Simpson: It was not a great hesitation.

The Convener: Can that be the first and the last of the grim reaper remarks, please?

Ian McKee: I could not resist it. I beg your pardon.

Referring all cases is more than is needed to ensure the system's integrity and would be expensive. As my colleague Michael Matheson said, if the system is meant to be largely self-financing, 100 per cent referral would impose a large financial burden on patients.

I am reassured by the fact that the proposed legislation would allow ministers to direct that more death certificates be reviewed. I hope that that will be the case, because I have concerns about the low level that has been proposed so far.

11:15

Dr Simpson: The bill as introduced would have given us considerable difficulties, but the Government has moved a considerable way and 25 per cent of certificates will have level 1 reviews, with a further 25 per cent being reviewed because the death is reported to the procurator fiscal. I feel strongly that even the 100 per cent review system in England and Wales will not necessarily prevent another Shipman. We need to bear that in mind. In trying to create certainty, we may mislead the public in that respect. I believe that the Government's proposed measures are proportionate and cost effective.

I also hope that reviewers or the procurator fiscal can involve not just GPs but relatives of the deceased. My colleague Dr McKee may return to that point at a later stage.

Reviewers can focus on areas of concern, but I regret that an electronic approach will not be taken, although the bill does not exclude that approach and the Government has made positive noises about it. I believe that an electronic approach is necessary to underpin the whole system. Well-written software will lend itself to analysis that might demonstrate outliers much more effectively than any random review system, which is unlikely to pick those up. I hope that whoever is in Government after May will consider carefully whether we pilot a flawed paper system or delay the pilots until there is an electronic system; otherwise, a piloted paper system might have to be followed by an electronic system pilot.

Shona Robison: I understand the motivation behind the amendments in this group, but I regard them as disproportionate and unnecessary. They also have major cost implications. To answer Michael Matheson's question directly, based on the BMA's proposed model the costs to the public purse would be £15.3 million annually or, if the public was charged, that would result in a fee of £285 per case, a not insignificant cost. In contrast, our proposals in the bill cost £30 per case, plus an additional £640,000 a year for the increased reviews, which, as I said, will be paid for by the Scottish Government, bringing total annual costs to £1.84 million.

The Scottish Government has always preferred the medical reviewer model, which is a much strengthened version of one of the options proposed by the independent expert review group. I stand firm on my reasons for this. I am confident that the number of reviews currently proposed will allow a reliable assessment of the accuracy and quality of death certification and will introduce a proportionate and robust level of deterrence while introducing a number of changes that will make the new death certification system fit for the 21st century rather than the 19th century. However, Richard Simpson is right to say that no system, no matter how good it is, can be failsafe. We should acknowledge that.

We have worked closely with expert statisticians and I am happy, to address Ross Finnie's point, to get a bit more from them at stage 3 about their calculations, but we are content that the 1,000 random reviews that are proposed will give us a Scotland-wide benchmark for the quality of death
certificates in the first year of operation, and we will monitor improvements after that.

The system must be seen as a whole package. As well as the 1,000 comprehensive, random, real-time level 2 reviews, the medical reviewers will carry out additional targeted reviews where they believe that there may still be cause for concern. Crucially, the bill will, for the first time, empower individuals to request a review where they have concerns. All those levels of review will be part of a systematic quality improvement approach.

We agreed with the committee that there would be additional level 1 reviews for 25 per cent of all deaths. That will provide additional deterrence, public reassurance and independent scrutiny. Together with the deaths being reported to the procurator fiscal, which amount to around a further 25 per cent a year, this means that around 50 per cent of deaths will be subject to scrutiny under the new proposals. That means that every doctor has a one in two chance of their actions being scrutinised, which I hope reassures the committee on deterrence and public reassurance.

Our approach, coupled with the safeguards provided by random and targeted scrutiny and national statistical analysis of deaths data, will achieve more effective outcomes than a second signature on all certificates, which can lead to a focus on checking, rather than driving up quality at source.

Our proposals will also maintain an appropriate balance between cost and scrutiny. The need for such balance was acknowledged by more than one speaker in the stage 1 debate. There is sufficient flexibility in the system to allow the number of reviews to be adjusted up or down in future in response to the test site information and the early operation of the system. However, that would be firmly based on evidence.

If the amendments to require scrutiny of 100 per cent of certificates were agreed to, it would lead to a huge increase in costs, either to the taxpayer or to bereaved families, through a massive increase in the fee, which is not justified by the benefits. I hope that I have managed to illustrate why I believe that our proposals make that unnecessary and unnecessarily expensive. For the reasons that I have outlined, I believe that our approach is correct. I do not support amendment 15 or the other amendments in the group and I ask Helen Eadie to withdraw amendment 15 and not to move the others.

Helen Eadie: I am grateful to colleagues and to the minister for taking my concerns so seriously. I am also grateful to Ross Finnie for reminding us that the committee requested the statistical analysis and it is good to hear that the minister will bring the expert statistician’s report to the Parliament for stage 3.

On that basis and because of what I have heard about the degree of sympathy or otherwise around the committee table for the points that I have made this morning, I seek leave to withdraw amendment 15.

Amendment 15, by agreement, withdrawn

The Convener: Amendment 16, in the name of Mary Scanlon, is grouped with amendment 19.

Mary Scanlon: I appreciate that amendment 16 is similar to Helen Eadie’s amendments, although it focuses on cremation. There is no doubt that the main concern at stage 1 was that there would be what witnesses described as a much less rigorous system than exists at the moment. It was unusual and unfortunate that the Government’s response to the stage 1 committee report on the bill was not available until after the debate. However, although the bill will introduce a single system of independent scrutiny of medical death certificates that do not require procurator fiscal investigation, I am not yet convinced that it will succeed, as the minister states, in providing us with a robust and modern approach to the scrutiny of death. I feel that we need further information and reassurances as well as clarity before we agree to this part of the bill.

I welcome the plan that, for the first time, will allow individuals to request a review of the death certificate. That proposal is very welcome, but in comparison with the current system the new proposals just do not stack up. Moving from a system that requires three doctors to countersign cremation forms, which are required for 62 per cent of deaths in Scotland, to a system in which only 1,000 random level 2 reviews will be carried out each year, and in which 25 per cent of all death certificates will have a level 1 review, is a significant change. On that basis, I still find it difficult to be convinced that that level of scrutiny will deliver the deterrent that we are seeking or that it will be proportionate. The quality remains questionable.

As others have said, the proposed system contrasts with the English proposal, which is, I understand, to review 100 per cent of cases. The proposed system might be more cost effective, and I appreciate that that is a huge consideration, but I need to know that we are doing the right thing.

As I am not an expert on death certificates, I will quote from the responses of two of our stage 1 witnesses and the Government’s response to our stage 1 report. Professor Stewart Fleming, who is professor of cellular and molecular pathology at Ninewells hospital in Dundee, said:
“I welcome the new proposals as a step in the right direction but believe they still fall short of what I would consider safe and accurate death certification. The level 2 review is more detailed than the current cremation confirmatory procedure but the level 1 review of 25% of deaths is less detailed than currently required.”

Ishbel Gall, from the Association of Anatomical Pathology Technology, said:

“The proposals to remove the current scrutiny prior to cremation should not be about cost to the bereaved rather it should be about an improvement to what is current practice.”

She went on to say:

“I am most concerned that there will be less scrutiny than there is presently where the deceased is to be cremated. The Bill also needs to address the issue of whether or not it is to be mandatory that the doctor issuing the MCCD should examine the deceased. For disposal, especially by cremation, to proceed without any examination of the deceased would seem to be a backward step.”

I ask the minister to address the issues that I raised and, in particular, the responses from experts in the field.

I move amendment 16.

Ian McKee: I have a great deal of sympathy with the sentiments behind the amendments in Mary Scanlon’s name, because I, too, am concerned about the proposed low number of deaths that will be subject to level 1 and level 2 scrutiny. I am a little worried about evidence from test sites, because if we are missing things we do not have the evidence—because we have missed it. However, I am consoled by the bill’s provision for the ability to increase quite swiftly the number of deaths that are scrutinised, and I hope that the provision will be used.

I am concerned about amendment 16, because I strongly believe in random selection, which is the best way of finding out imperfect practices. If we are to go to a system whereby we have high standards for cremations while also scrutinising deaths when there is to be a burial, we will get back to the situation that we discussed in the context of Helen Eadie’s amendment 15, in which the system would be very expensive. Therefore, I think that we can have a trade-off, whereby not every cremation gets the full inspection but we start to include in the selection people who are being buried. I prefer the mechanism whereby the Scottish ministers can direct that there should be an increase in the number of MCCDs that are scrutinised to the requirement that Mary Scanlon proposes including in the bill.

Rhoda Grant (Highlands and Islands) (Lab): I wonder whether there is merit in having different levels of scrutiny for cremations and burials. I think that that is what amendment 19 seeks to achieve. I am not keen on amendment 18, but amendment 19 might be helpful. Under the current system there is much greater scrutiny in cremations, given that when a body has been cremated evidence is lost. I suppose that there is a fear that if someone were trying to cover up a crime, cremation would be the preferred option. It might be helpful to raise the level of scrutiny of cremations—I am just thinking around the issues.

Ross Finnie: May I make a quick request to the minister, convener? Minister, you said that before stage 3 you would make available information on the statistical basis for the proposed amount of scrutiny. I take it that you will do that before the final date for lodging amendments, because I think that the possession of such information will be material in deciding whether amendments are needed on the issues that Helen Eadie, Ian McKee and Rhoda Grant raised. An assurance in that regard would be most helpful.

The Convener: That was a timeous request.

11:30

Shona Robison: Starting with that last point—yes, we will get that information to you as quickly as possible.

Regarding the two amendments before us, for the reasons that I outlined earlier in response to Helen Eadie’s amendments, the Scottish Government has always preferred the medical reviewer model and I stand firm on my reasons for that.

Referring to the points that Mary Scanlon made, the proposed measures very much involve an improvement in current practice. It is not a matter of having less scrutiny; it is about more proportionate scrutiny. There is already flexibility in the system, so that the number of reviews can be adjusted. I explained earlier why that is important, and I outlined the rationale for our proposals.

I will explain why the bill specifies a random system of sampling—and this comes back to Rhoda Grant’s point. A random selection of certificates through the General Register Office for Scotland’s computer system is important for deterrence, as it will ensure that there is no selection bias or undue interference. Random selection will roughly reflect the proportion of cremations, so that we expect about two thirds of cases to be deaths for which the chosen method of disposal is cremation. At the time of issuing the MCCD and registering the death, such information is not always available. It is therefore not clear how the proposal in amendment 19 to select a minimum number of cremation cases for independent review can be implemented in practice. It would be extremely difficult.

On a more general point on the signing of the MCCD without examining the deceased, although
there is currently no express requirement on doctors completing the MCCD to view or examine the body, they would have to do so if they considered it necessary to ascertain the cause of death. We are not making any changes to that. In instances where the cause of death is unclear, the case would be referred to the procurator fiscal.

As I said earlier, 25 per cent of deaths are reported to the PF. Every person's death is already confirmed by a trained professional—a doctor, nurse or paramedic, who will examine the body to verify that life is extinct.

It is important that there is no evidence that a new requirement on certifying doctors to externally examine bodies will prevent or detect anything except the most apparent criminal activity or malpractice—and such a requirement certainly would not have detected what Harold Shipman did.

Bearing all that in mind, and for the reasons that I outlined earlier, I do not support amendment 16. I ask Mary Scanlon to withdraw it and not to move amendment 19.

Mary Scanlon: I do not know whether I made myself clear about this. The minister has spoken about a more robust and accurate system. Professor Fleming acknowledged that the level 2 procedures were more detailed than the current procedure. He also stated that the level 1 procedures are much less detailed than what is currently required.

I thank all my colleagues for their responses. Rhoda Grant spoke about increasing the number of cremations to be reviewed, and I hope that we can consider that again at stage 3. The main factor concerns statistics, as was discussed by Ross Finnie. I would certainly find it helpful to have further information, and in plenty time, so as to lodge amendments prior to stage 3.

On the basis that we will get another opportunity to address the matter, and noting that committee members are uncomfortable with many of the proposed changes, I am happy to withdraw amendment 16 and not to move amendment 19.

Amendment 16, by agreement, withdrawn.

Amendments 17 to 19 not moved.

The Convener: Amendment 5, in the name of the minister, is grouped with amendment 11.

Shona Robison: I have carefully considered the delegated powers in relation to the bill. The rationale for using the negative procedure to make orders suspending the review system during an epidemic was to ensure that, if necessary, the referral of certificates to medical reviewers can be suspended almost immediately during an epidemic or a situation in which an infectious disease or contamination is spreading rapidly, particularly if there are large numbers of deaths.

In such circumstances, funerals may need to take place straight away to prevent the development of a danger to public health if there is risk of infection or contamination. In addition, certifying doctors and medical reviewers may need to be redeployed to provide front-line assistance. However, in response to the suggestion that was made by the Subordinate Legislation Committee, I have considered the matter further and I am content to amend the bill so that emergency affirmative procedure can be used, discounting periods of recess from the period before approval. I am reassured that that is appropriate and will allow an order to come into force immediately and remain in force despite a long parliamentary recess.

I move amendment 5.

Helen Eadie: The minister is making Ian McKee, Rhoda Grant and I feel very good about the work that we do on the Subordinate Legislation Committee.

The Convener: The Health and Sport Committee always gives plaudits to the Subordinate Legislation Committee. With three of our members on that committee, what else can we do?

Amendment 5 agreed to.

Section 2, as amended, agreed to.

Section 3 agreed to.

Section 4—Application for review of certificate by interested person

Amendment 20 not moved.

Section 4 agreed to.

Sections 5 to 13 agreed to.

Section 14—Power to require documents

Amendment 6 moved—[Shona Robison]—and agreed to.

Section 14, as amended, agreed to.

Sections 15 and 16 agreed to.

Before section 17

Amendment 7 moved—[Shona Robison]—and agreed to.

Section 17, as amended, agreed to.

Section 17—Medical reviewers to authorise cremation

Amendment 8 moved—[Shona Robison]—and agreed to.

Section 17, as amended, agreed to.
Sections 18 to 22 agreed to.

Section 23—Fees in respect of medical reviewer functions

The Convener: Amendment 9, in the name of the minister, is grouped with amendment 12.

Shona Robison: When I outlined the additional reviews—first, the doubling of the random level 2 reviews and then the new level 1 reviews—I made a commitment that the costs associated with those will be borne by the Scottish Government. The fee that is expected to be charged to the public therefore remains £30. For those who currently pay cremation fees—which is around 60 per cent of the public—that represents a substantial saving of about £120. I appreciate the committee’s positive comments about the setting of the fee and the abolition of the higher cremation fee in favour of a lower universal fee for all deaths.

Section 23(5) provides currently that Scottish ministers must have regard to the reasonable costs of the revised functions when setting a fee. We have decided to amend that to make it clear that the fee can be set below cost recovery levels. Likewise, I am content to accept the Subordinate Legislation Committee’s recommendation to change the affirmative resolution procedure, which we originally proposed be used for the power to set the amount of fees and prescribe arrangements for the collection of those fees, to the negative resolution procedure because, as the Subordinate Legislation Committee notes, the arrangements

“would more usually be subject to negative resolution procedure.”

I move amendment 9.

Amendment 9 agreed to.

Amendment 10 moved—[Shona Robison]—and agreed to.

Section 23, as amended, agreed to.

Section 24 agreed to.

After section 24

The Convener: Amendment 21, in the name of Mary Scanlon, is grouped with amendments 13 and 14. I call Mary Scanlon to move amendment 21 and to speak to all the amendments in the group.

Mary Scanlon: Sorry—I have so many papers and I am not prepared. Can I just say, “Not moved”?

The Convener: You have to move the amendment.

Mary Scanlon: All right—I will just move it. It relates to my previous comments.

I move amendment 21.

The Convener: Mary, I take it that you wish to withdraw the amendment. I know that it is a technicality, but we have gone through the necessary hoops. Is it agreed that amendment 21 be withdrawn?

Douglas Wands (Clerk): The minister must be given the opportunity to speak first.

The Convener: Sorry—I beg your pardon, minister. I am so desperate to whizz on. I call the minister to speak to amendment 13 and the other amendments in the group.

Shona Robison: Given that it is proposed to withdraw amendment 21, I will not refer to it.

Amendments 13 and 14 are technical amendments that update the regulation-making power in the Cremation Act 1902 and the related provision in the Cremation Act 1952, as a result of the new arrangements that will be brought in under the new certification of death system in Scotland.

Amendment 13 adjusts the existing power of Scottish ministers to make regulations on the burning of human remains so as to remove aspects of the power that will become redundant as a result of the bill. It also adjusts the power to prescribe the notices, certificates and applications that are specific to cremation cases to make that discretionary rather than mandatory.

The amendment confirms that regulations made under the 1902 act are subject to negative procedure. That is a restatement of the current position, which is dealt with in the Cremation Act 1952. Consequential on amendment 13, amendment 14 repeals the relevant part of the Cremation Act 1952.

I ask members to support amendments 13 and 14.

Helen Eadie: This morning I met representatives of the National Association of Funeral Directors, who expressed concerns about a situation in which they find themselves. They have in their offices virtually a mountain of ashes, going back many years, which they cannot dispose of. They mentioned the issue in evidence to the committee but they feel that we have overlooked it. I put my hand up as one of those who are culpable in that regard. The NAFD is seeking to be allowed to dispose of the ashes that no one has claimed after a reasonable time has passed. It may not be possible for the minister to address the issue at this stage, but perhaps it could be addressed at stage 3.

Shona Robison: I thank Helen Eadie for raising that important and sensitive issue. I would like to reflect on the issue and perhaps I can get back to
the member on it. I do not know whether we can do anything in the short period before stage 3, but I will certainly consider the issue.

Ian McKee: Under the proposed section entitled “Forms of documentation for burning", is it the minister’s intention to define in the regulations what human remains are? After all, if a leg is amputated it is often just chucked into the incinerator. Is that a human remain, or does a human remain have to be a certain proportion of the body? It would be useful to know, although I do not expect the minister to provide an answer at the moment.

Shona Robison: I will have to get back to you on that. I was just asking whether the definition would be the same as in previous legislation.

The Convener: I was ahead of myself earlier. It is now time for Mary Scanlon to withdraw the amendment. We are both doing things twice this morning—it comes with my age, Mary, not yours. Do you wish to wind up?

Mary Scanlon: No. All the points were made earlier.

Amendment 21, by agreement, withdrawn.

The Convener: We are back on script now.

Sections 25 and 26 agreed to.

After section 26

The Convener: Amendment 22, in the name of Ian McKee, is a group on its own.

Ian McKee: Amendment 22 is a probing amendment. No one can doubt that the tasks undertaken by nurses have increased in complexity and responsibility over the years. When I was a junior doctor working in Edinburgh’s royal infirmary, nearly all the nurses were university graduates, yet I had to be called out of my bed in the middle of the night to authorise the prescription of a couple of paracetamol tablets for minor pain relief.

Today, specialist nurses run cardiovascular risk clinics, supervise drug misusers, have responsibility for much maternity work and play a leading role in palliative care, to name but a few tasks that they undertake. The most recent prescription that I got from my GP was signed by the nurse. As we move forward into the remainder of the 21st century, it is obvious that those roles will increase in number and complexity. When that happens, it is possible to envisage a situation in which signing a death certificate will be a logical extension of a specialist nurse’s duties, thus allowing more sympathetic handling of a relative’s grief, greater accuracy in what is recorded and greater efficiency in the running of the health service.

I had hoped with amendment 22 to allow the opportunity to add to the duties of a minuscule number of nurses the ability to sign death certificates. It was not my intention that that should happen now, nor that all nurses should routinely have that function, but merely that it should be given to specialist nurses who are in a position such that it would be beneficial to society and the running of the health service.

I appreciate that the suggestion will not always meet with mass approval in the health professions as a whole and it has not been put out to consultation. I would therefore be happy to withdraw the amendment later, but our discussion should be on the record because I feel that we will need such a development to take place in the future.

I move amendment 22.

Dr Simpson: I welcome amendment 22 and Ian McKee’s current intention to withdraw it, although we may need to reconsider the matter at stage 3. Despite the amendment being withdrawn, might we seek to take some evidence on it? I appreciate that time is extremely short.

I will add two points to Ian McKee’s remarks. First, there may well be an increasing reliance in remote and rural areas on nurse practitioners who, as Ian McKee said, are able to prescribe. Secondly, some practices in England are nurse led. Such practices are already in existence so, as Ian McKee said, we are moving into a new situation. When we discuss the primary legislation, we should give future sessions of Parliament and future ministers the scope to allow the extension that is proposed, if that seems to be appropriate and proportionate.

The Convener: On your question about taking evidence, we can look at the remainder of our programme and discuss whether we have space between now and going into purdah to deal with the issue. That is not a matter for this debate, but we can certainly look at it.

Rhoda Grant: I, too, have sympathy with amendment 22. Richard Simpson mentioned rural areas. When someone is terminally ill, it is usually a community nurse or the like who spends time with that person and with their family and builds a close relationship with them. In that situation, having to wait until a doctor arrives to certify a death is perhaps not appropriate and does not help the family.

I would like to consider widening the provision as suggested in amendment 22, but I am well aware that we may need to take more evidence. If we do not have time to take evidence, would it be possible to lodge an amendment to allow that
happen, perhaps through a super-affirmative procedure, so that the Parliament could scrutinise any such decision? We could perhaps consider at stage 3 whether such an approach would give us the appropriate safeguards.

Obviously, we do not want to change things dramatically without having taken evidence and scrutinised the issue properly, because there are always unintended consequences. However, the amendment makes a fair and reasonable suggestion that we should have the opportunity to work through. The stage that we are at in the parliamentary timetable might not allow for that to happen, but if the proposal could be scrutinised and legislation brought forward in the new session that may be worth while.

**Shona Robison:** The Scottish Government has considered Ian McKee’s amendment 22, which would incorporate nurses within the definition of “registered medical practitioner” to give them the power to certify cause of death.

I agree with Ian McKee’s comments on the role and contribution of nurses, which have changed considerably over time. We very much acknowledge the importance of that, both to the NHS and to nurses themselves in having fulfilling and rewarding careers. However, that aim also has to be aligned with the current requirements of the service and the needs of the public. Weighing up the pros and cons of the proposal, I do not think that we are yet in a position to know whether there is a demand for such a fundamental change. I understand that the Royal College of Nursing had a very limited consultation on the matter and got a very limited response.

In addition, putting the proposal in place would have a significant impact on the operation of the review system in the bill, because it is designed to deal with the review of medical certificates of cause of death completed by doctors.

A benefit of the new system lies in its links between the review system and the systems of clinical governance, annual appraisal and revalidation that are applicable to doctors. Full consideration must be given, in the light of discussions that we have had on other amendments, to how those aspects will work together to ensure that completed certificates are effectively scrutinised and standards improved.

Some of those links, such as revalidation, do not apply to nursing staff and further thought would have to be given to how those aspects could be accommodated in the new review system. That could prove to be very complex and there may be additional costs. For example, separate random checks of death certificates provided by nurses and doctors would need to be done as the numbers that would be required to give confidence

in the system would be quite different. As that illustrates, the proposal represents a significant departure from current policy and is therefore not simply a technical issue, nor is it about future proofing the bill.

Although I do not disagree that there may be valid reasons to consider the issue further, I believe that it would not be correct to create a statutory power to give nurses the power to certify cause of death without further detailed public consultation on the issue and further consideration of the policy implications, some of which I have briefly outlined. I therefore ask Ian McKee to withdraw amendment 22.

**Ian McKee:** I will add to what the minister said. I am not very concerned about the low number of respondents to the RCN’s poll of its members. A vast number of nurses would not be affected at all by the proposal, so it is not surprising that they did not respond. I am talking about a very small number of nurses and we should judge the proposal on an intellectual and practical basis rather than on a poll of nurses, most of whom would not be involved.

However, I accept that the proposal is fairly radical and that it would be unfair to introduce it by means of a stage 2 amendment. I therefore seek leave to withdraw amendment 22.

Amendment 22, by agreement, withdrawn. Section 27 agreed to.

**Section 28—Orders and regulations**

Amendments 11 and 12 moved—[Shona Robison]—and agreed to. Section 28, as amended, agreed to. Section 29 agreed to.

**Schedule 2—Minor and consequential modifications**

Amendments 13 and 14 moved—[Shona Robison]—and agreed to. Schedule 2, as amended, agreed to. Sections 30 and 31 agreed to. Long title agreed to.

**The Convener:** That ends stage 2 consideration of the bill. I thank the minister for her attendance.
Certification of Death (Scotland) Bill
[AS AMENDED AT STAGE 2]

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Certification of Death (Scotland) Bill
[AS AMENDED AT STAGE 2]

An Act of the Scottish Parliament to make provision about the certification of death and still-birth certificates; to make provision for medical reviewers, the senior medical reviewer and their functions; and for connected purposes.

Medical reviewers

1 Medical reviewers

(1) Medical reviewers are to exercise the functions conferred on them by this Act or any other enactment on behalf of Healthcare Improvement Scotland.

(2) The senior medical reviewer is to exercise the functions conferred on that person by this Act or any other enactment on behalf of Healthcare Improvement Scotland.

(3) Schedule 1 (which makes further provision about the appointment and status of medical reviewers) has effect.

Referral of medical certificates of cause of death for review

2 Referral of certain medical certificates of cause of death for review

After section 24 of the 1965 Act insert—

“24A Duty to refer certain certificates of cause of death for review

(1) The Registrar General must ensure that randomly selected certificates of cause of death are referred for review under section 8(1) of the 2010 Act prior to registration of the death to which each certificate relates.

(2) The Registrar General must ensure that certificates of cause of death of such descriptions as may be specified in a request by medical reviewers under section 3 of the 2010 Act are referred for review under section 8(1) of that Act.

(3) A district registrar for a registration district may refer for review under section 8(1) of that Act a certificate of cause of death where the district registrar considers it appropriate to do so.

(4) The following certificates may not be referred under subsections (1) to (3)—

(a) a certificate of cause of death relating to a body in respect of which a direction has been given by a Health Board under section 90(2) of the Public Health etc. (Scotland) Act 2008 (asp 5) (restrictions on release of infected etc. bodies from hospital),

(b) a certificate of cause of death which has already been referred under this section,
(c) a certificate of cause of death which has been (or is being) reviewed under section 8(1) of the 2010 Act following an application made under section 4(1) of that Act,

(d) a certificate of cause of death which is a replacement certificate attested and transmitted in response to an invitation to do so under section 10 or 11 of the 2010 Act,

(e) a certificate of cause of death where the cause of death of the deceased person has been (or is being) investigated by a procurator fiscal,

(f) a certificate of cause of death attested prior to the coming into force of this section.

(5) The Scottish Ministers may give directions to the Registrar General about the referral of certificates under this section; and the Registrar General must comply with any such direction.

(6) A direction under subsection (5) may in particular specify—

(a) the minimum number of certificates of cause of death which are to be selected for referral under subsection (1) in any year, and

(b) the method of determining which certificates are to be selected for referral under subsection (1).

(7) The Scottish Ministers may by order made by statutory instrument suspend the referral of certificates under this section—

(a) during an epidemic, or

(b) where the Scottish Ministers consider, on reasonable grounds, that it is necessary to do so to prevent, or to prevent the spread of, infectious diseases or contamination.

(8) An order made under subsection (7)—

(a) may include such supplementary, incidental, consequential, transitional, transitory or saving provision as the Scottish Ministers think necessary or expedient,

(b) may be exercised so as to make different provision for different purposes.

(9) An order under made subsection (7)—

(a) must be laid before the Scottish Parliament, and

(b) ceases to have effect at the expiry of a period of 28 days beginning with the date on which it was made unless, before the expiry of that period, the order has been approved by resolution of the Parliament.

(10) In reckoning for the purposes of subsection (9)(b) any period of 28 days, no account is to be taken of any period during which the Scottish Parliament is—

(a) dissolved, or

(b) in recess for more than 4 days.

(11) Subsection (9)(b) is without prejudice to anything previously done by reference to an order under subsection (7) or to the making of a new order under that subsection.”.
3 Medical reviewer requests

(1) A medical reviewer may request that the Registrar General ensure that medical certificates of cause of death of such description as the medical reviewer may specify are referred for review under section 8(1).

(2) A request under subsection (1) may relate to a certificate in respect of which the death has been registered.

4 Application for review of certificate by interested person

(1) An interested person may apply to a medical reviewer for a review under section 8(1) of an eligible medical certificate of cause of death.

(2) An application under subsection (1)—

(a) may relate to a certificate in respect of which the death has been registered,

(b) must be made within three years of the date of death of the deceased person to whom the certificate relates.

(3) Where the medical reviewer considers an application under subsection (1) to be vexatious, the medical reviewer may reject it.

(4) A medical reviewer must notify the Registrar General of an application received under subsection (1) (other than one which is rejected under subsection (3)).

(5) For the purposes of subsection (1), an interested person is—

(a) a person who, under the 1965 Act, is required or stated to be qualified to give information concerning the deceased’s death,

(b) a health care professional (or other carer) who was involved with the deceased’s care prior to the deceased’s death,

(c) the funeral director responsible for the funeral arrangements of the deceased,

(d) the person having charge of the place of disposal of the body of the deceased,

(e) such other persons as the Scottish Ministers may by order specify.

(6) For the purposes of subsection (1), an eligible medical certificate of cause of death is a medical certificate of cause of death other than—

(a) a certificate relating to a body in respect of which a direction has been given by a Health Board under section 90(2) of the Public Health etc. (Scotland) Act 2008 (aspt 5) (restrictions on release of infected etc. bodies from hospital),

(b) a certificate which has been referred under section 24A of the 1965 Act (duty to refer certain certificates of cause of death for review),

(c) a certificate which has already been (or is being) reviewed under section 8(1) following an application made under subsection (1),

(d) a certificate which is a replacement certificate attested and transmitted in response to an invitation to do so under section 10 or 11,

(e) a certificate where the cause of death of the deceased person has been (or is being) investigated by a procurator fiscal,

(f) a certificate attested prior to the coming into force of this section.

(7) The Scottish Ministers may by order suspend the application of this section—
(a) during an epidemic, or
(b) where the Scottish Ministers consider, on reasonable grounds, that it is necessary
to do so to prevent, or to prevent the spread of, infectious diseases or
contamination.

The Scottish Ministers may by regulations make provision about applications under
subsection (1) including, in particular, provision about—
(a) the procedure for making applications,
(b) the form and content of applications,
(c) the action to be taken by medical reviewers in respect of applications.

Stay of registration of death pending review

In section 25B of the 1965 Act (registration of deaths)—
(a) in subsection (1), after “subsection (2)” insert “and (2A)”, and
(b) after subsection (2) insert—
“(2A) The registrar is not to register a death in respect of which the certificate of
cause of death has been referred under section 24A or where the Registrar
General has been notified under section 4(4) of the 2010 Act of an application
for review having been made until the first occurrence of any of the following
events—

(a) a medical reviewer, under section 7(2)(b) of the 2010 Act (request for
review not to stay registration), notifying the registrar that it is
appropriate in the circumstances to register the death before the review is
complete,

(b) the certificate or its replacement being approved by a medical
reviewer—

(i) under section 9 of the 2010 Act (action following satisfactory
review), or

(ii) under section 10 of that Act (action following unsatisfactory
review: medical reviewer),

(c) the certificate or its replacement being approved by the senior medical
reviewer under section 11 of the 2010 Act (action following
unsatisfactory review: senior medical reviewer),

(d) the senior medical reviewer, under section 11(8)(a), (9)(a) or 12(5)(a) of
the 2010 Act, signifying that the review has been conducted,

(e) a medical reviewer, under section 12(2)(a) of the 2010 Act (action where
relevant medical practitioner is unavailable or incapacitated), signifying
that the review has been conducted, or

(f) a procurator fiscal approving the certificate or providing a replacement
certificate attested by a registered medical practitioner.”.

Request for review not to stay registration

After section 24A of the 1965 Act insert—

“24B Request for review not to stay registration
(1) This section applies where a certificate of cause of death is referred under section 24A(1).

(2) A district registrar for a registration district must, following a request by a qualified informant, refer the certificate to a medical reviewer for a determination under section 7 of the 2010 Act (medical reviewer to determine whether review to stay registration).

(3) Such a referral must include a statement by the qualified informant of the circumstances which the qualified informant believes justify registering the death before the review is complete.

(4) The qualified informant must also provide such other information as the medical reviewer may reasonably require.”.

7 Medical reviewer to determine whether review to stay registration

(1) This section applies where a medical reviewer receives a referral under section 24B(2) of the 1965 Act (request for review not to stay registration).

(2) The medical reviewer must—

(a) determine whether it is appropriate to register the death to which the referral relates before the review of the certificate under section 8(1) or, as the case may be, any further review under section 11(2)) is completed, and

(b) notify the relevant registrar of the determination.

(3) The medical reviewer may determine under subsection (2)(a) that it is appropriate to register the death before the review (or further review) is completed only where the medical reviewer is satisfied that—

(a) the circumstances of the case justify such registration, and

(b) there are no obvious indications that the medical certificate of cause of death is not in order.

(4) The medical reviewer may make such enquiries as the medical reviewer considers appropriate when making a determination under subsection (2)(a).

8 Review of medical certificates of cause of death

(1) A medical reviewer must review any medical certificate of cause of death—

(a) referred under section 24A of the 1965 Act, or

(b) in respect of which an application has been made under section 4(1) (other than one which has been rejected as vexatious under section 4(3)).

(2) In conducting a review, the medical reviewer may—

(a) examine the health records of the deceased person to whom the certificate relates,

(b) seek the views of the medical practitioner who attested the certificate,

(c) make such other enquiries and examine such other things as the medical reviewer considers appropriate.

(3) Following a review under subsection (1) the medical reviewer must come to a view on whether the certificate is in order.
(4) For the purposes of this Act, a certificate is in order 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.

(5) The Scottish Ministers may by regulations make further provision about the review of certificates including, in particular, action to be taken by medical reviewers when conducting a review or by senior medical reviewers when conducting a further review.

9 Action following satisfactory review

(1) Subsection (2) applies where, following a review under section 8(1), a medical reviewer is of the view that a medical certificate of cause of death is in order.

(2) The medical reviewer must approve the certificate and notify the relevant registrar accordingly.

10 Action following unsatisfactory review: medical reviewer

(1) This section applies where, following a review under section 8(1), a medical reviewer is of the view that a medical certificate of cause of death is not in order.

(2) The medical reviewer must—

(a) inform the relevant medical practitioner of that view and the reasons for coming to that view, and

(b) invite the relevant medical practitioner to attest and transmit to the medical reviewer a replacement certificate which takes account of the reasons.

(3) If the relevant medical practitioner attests and transmits a replacement certificate which in the view of the medical reviewer is in order, the medical reviewer must approve the replacement certificate and transmit it to the relevant registrar.

(4) If the relevant medical practitioner attests and transmits a replacement certificate which in the view of the medical reviewer is not in order, the medical reviewer must refer the review to the senior medical reviewer.

(5) If the relevant medical practitioner declines to attest and transmit a replacement certificate in response to the invitation under subsection (2)(b), the medical reviewer must—

(a) approve the certificate and notify the relevant registrar accordingly, or

(b) refer the review to the senior medical reviewer.

11 Action following unsatisfactory review: senior medical reviewer

(1) This section applies where a review is referred to the senior medical reviewer under section 10(4) or (5)(b).

(2) The senior medical reviewer may conduct a further review of the certificate.

(3) If the senior medical reviewer conducts a further review under subsection (2), the senior medical reviewer may exercise the powers conferred on a medical reviewer by section 8(2).
(4) The senior medical reviewer must come to a view on whether the certificate is in order (and for that purpose references in section 8(4) to a medical reviewer are to be read as references to the senior medical reviewer).

(5) If the senior medical reviewer comes to the view that the certificate is in order, the senior medical reviewer must approve the certificate and notify the relevant registrar and the relevant medical practitioner accordingly.

(6) If the senior medical reviewer comes to the view that the certificate is not in order, the senior medical reviewer must—

(a) inform the relevant medical practitioner of that view and the reasons for coming to that view, and

(b) invite the relevant medical practitioner to attest and transmit to the senior medical reviewer a replacement certificate which takes account of the reasons.

(7) If the relevant medical practitioner attests and transmits a replacement certificate which in the view of the senior medical reviewer is in order, the senior medical reviewer must approve the replacement certificate and transmit it to the relevant registrar.

(8) If the relevant medical practitioner attests and transmits a replacement certificate which in the view of the senior medical reviewer is not in order, the senior medical reviewer must—

(a) signify that a review has been conducted and notify the relevant registrar accordingly, or

(b) refer the certificate to the procurator fiscal for investigation into the cause of death of the deceased person to whom the certificate relates.

(9) If the relevant medical practitioner declines to attest and transmit a replacement certificate, the senior medical reviewer must—

(a) approve the certificate, or otherwise signify that a review has been conducted, and notify the relevant registrar accordingly, or

(b) refer the certificate to the procurator fiscal for investigation into the cause of death of the deceased person to whom the certificate relates.

(10) Subsection (11) applies where—

(a) the senior medical reviewer has come to the view that the certificate or, as the case may be, its replacement, is not in order because the senior medical reviewer is not satisfied that information (other than the cause of death) contained in the certificate (or its replacement) is correct, or

(b) the relevant medical practitioner declines to attest and transmit a replacement certificate in response to the invitation under subsection (6).

(11) The senior medical reviewer may (in addition to the action to be taken under subsection (8) or (9)) take such steps as the senior medical reviewer considers appropriate to inform such persons as the senior medical reviewer considers appropriate of the relevant information.

(12) **Action where relevant medical practitioner is unavailable or incapacitated**

(1) Subsections (2) and (3) apply where—

(a) a medical reviewer has conducted a review under section 8(1),
(b) the medical reviewer has come to the view that a medical certificate of cause of death is not in order, and
(c) the relevant medical practitioner is unavailable or unable to attest and transmit a replacement certificate in accordance with section 10.

(2) The medical reviewer must—
(a) signify that a review has been conducted and notify the relevant registrar accordingly, or
(b) refer the certificate to the procurator fiscal for investigation into the cause of death of the deceased person to whom the certificate relates.

(3) Where the medical reviewer has come to the view that the certificate is not in order because the medical reviewer is not satisfied that information contained in the certificate (other than the cause of death) is correct, the medical reviewer may (in addition to the action to be taken under subsection (2)) take such steps as the medical reviewer considers appropriate to inform such persons as the medical reviewer considers appropriate of the relevant information.

(4) Subsections (5) and (6) apply where—
(a) a medical reviewer has referred a review to the senior medical reviewer under section 10(4) or (5)(b),
(b) the senior medical reviewer has come to the view that a medical certificate of cause of death is not in order, and
(c) the relevant medical practitioner is unavailable or unable to attest and transmit a replacement certificate in accordance with section 11.

(5) The senior medical reviewer must—
(a) signify that a review has been conducted and notify the relevant registrar accordingly, or
(b) refer the certificate to the procurator fiscal for investigation into the cause of death of the deceased person to whom the certificate relates.

(6) Where the senior medical reviewer has come to the view that the certificate is not in order because the senior medical reviewer is not satisfied that information contained in the certificate (other than the cause of death) is correct, the senior medical reviewer may (in addition to the action to be taken under subsection (5)) take such steps as the senior medical reviewer considers appropriate to inform such persons as the senior medical reviewer considers appropriate of the relevant information.

13 Duty to inform following review

(1) This section applies where a medical reviewer has conducted a review under section 8(1).
(2) The medical reviewer must, when a relevant requirement is first complied with in relation to the certificate to which the review relates, inform the persons mentioned in subsection (3) of the outcome of the review including, in particular, any changes made to the medical certificate of cause of death.
(3) The persons are—
(a) the person who gave information of the particulars required to be registered concerning the death to the district registrar under section 23(1) of the 1965 Act,
(b) in the case of a review conducted by virtue of section 4, the interested person (unless that is the same person as mentioned in paragraph (a)).

(4) In subsection (2), “relevant requirement” means a requirement imposed by any of the following sections—

(a) section 9(2),
(b) section 10(3) or (5)(a),
(c) section 11(5), (7), (8) or (9),
(d) section 12(2) or (5).

Powers of medical reviewers

10 14  Power to require documents

(1) A medical reviewer may for the purposes of—

(a) reviewing a medical certificate of cause of death under section 8(1) or, as the case may be, section 11(2), or
(b) determining whether it is safe to cremate the body of a person who died outwith Scotland under section 17(2),

require any person who is able, in the opinion of the medical reviewer, to produce relevant documents (including health records) to do so.

(2) Where a requirement under subsection (1) is imposed by the medical reviewer, the person in question must be given a notice specifying—

(a) the documents or types of documents which the person is required to produce,
(b) the date by which the person is required to produce them, and
(c) the name of the deceased person in respect of whom they are required.

(3) For the purposes of this section, a person is to be taken to comply with a requirement to produce a document if that person produces a copy of, or an extract of the relevant part of, the document.

(4) In this section, references to the medical reviewer include references to the senior medical reviewer.

15  Documents: offences

(1) Any person to whom a notice under section 14 is given commits an offence if the person—

(a) deliberately alters, suppresses, conceals or destroys any document which that person is required to produce by the notice, or
(b) refuses or fails to produce any such document.

(2) It is a defence for a person charged with an offence under subsection (1)(b) to prove that there was a reasonable excuse for the refusal or failure.

(3) A person is not obliged under section 14 to produce any document which that person would be entitled to refuse to produce in a court in Scotland.
(4) A person who commits an offence under this section is liable on summary conviction to a fine not exceeding level 5 on the standard scale or to imprisonment for a period not exceeding 3 months.

(5) Where an offence under this section which has been committed by a body corporate is proved to have been committed with the consent or connivance of, or to be attributable to any neglect on the part of—
   (a) a director, manager, secretary or other similar officer of the body corporate, or
   (b) any person who was purporting to act in any such capacity,

that person, as well as the body corporate, commits the offence and is liable to be proceeded against accordingly.

Duty to report suspicions of criminality

16 Involvement of procurator fiscal

(1) A medical reviewer (including the senior medical reviewer) must report any suspicion of criminality arising from the review of a medical certificate of cause of death (or a number of such reviews) to the procurator fiscal.

(2) A medical reviewer (including the senior medical reviewer), having reported a suspicion under subsection (1), must follow the directions of the procurator fiscal as to the appropriate action to take.

Deaths outwith Scotland

16A Verification of foreign death certificates

(1) This section applies where—
   (a) a person (“A”) died outwith the United Kingdom, and
   (b) the body of A is to be disposed of in Scotland.

(2) A medical reviewer must, on the request of a relevant person, determine whether the documentation relating to A’s death is in order.

(3) Documentation is in order if it appears to the medical reviewer to be—
   (a) authentic, and
   (b) equivalent to the certificates or other documentation required under section 27A of the 1965 Act (offence of disposal of body without authorisation) for the interment, cremation or disposal by other means of the body of a person who died in Scotland.

(4) If the medical reviewer determines that the documentation is in order, the medical reviewer must give the relevant person a certificate specified for the purposes of this section under section 27A(2) of the 1965 Act.

(5) In making a determination under subsection (2), a medical reviewer may make such enquiries as the medical reviewer considers appropriate.

(6) For the purposes of subsection (2), a relevant person is—
   (a) a person who wishes to arrange the interment, cremation or disposal by other means of A’s body, or
Medical reviewers to authorise cremation

(1) This section applies where—
   (a) a person (“A”) died outwith Scotland, and
   (b) it is intended that A be cremated in Scotland.

(2) A medical reviewer must, on an application by a person who wishes to arrange the cremation of A, determine whether it is safe for A’s body to be cremated.

(3) If the medical reviewer determines that it is safe for A’s body to be cremated, the medical reviewer must give the applicant a certificate authorising the cremation.

(4) The Scottish Ministers may by regulations make provision about—
   (a) the form and content of applications under subsection (2),
   (b) the procedure to be followed by medical reviewers in relation to applications under subsection (2),
   (c) the form and content of the certificate authorising the cremation to be given under subsection (3).

Post-mortem examination of person who died outwith United Kingdom

(1) This section applies where—
   (a) a person (“A”) dies outwith the United Kingdom,
   (b) the body of A is to be disposed of in Scotland, and
   (c) no cause of death is available.

(2) A medical reviewer may, on an application by a relevant person—
   (a) assist the relevant person in making arrangements for a post-mortem examination of A’s body for the purpose mentioned in section 23(a) of the Human Tissue (Scotland) Act 2006 (asp 4), and
   (b) meet the cost of such an examination.

(3) For the purposes of subsection (2), a relevant person is a person who, under section 30, 32 or 33 of the Human Tissue (Scotland) Act 2006, may authorise a post-mortem examination of A’s body.

(4) The Scottish Ministers may by regulations make provision about the form and content of applications under subsection (2).

Other functions of medical reviewers

Training and information functions

(1) A medical reviewer (including the senior medical reviewer) has the functions mentioned in subsection (2).

(2) The functions are—
   (a) to collate and analyse information relating to or contained in medical certificates of cause of death,
(b) to provide training, guidance and support to persons who are required to complete medical certificates of cause of death,

c) to provide guidance and support to district registrars in relation to medical certificates of cause of death,

d) to liaise with such persons as the medical reviewer considers appropriate with a view to improving—

(i) the accuracy of the information (and in particular the causes of death) recorded in medical certificates of cause of death, and

(ii) the administrative processes relating to the disposal of bodies.

20 **Duty to co-operate**

Health Boards, Special Health Boards, the Common Services Agency for the Scottish Health Service and medical reviewers (including the senior medical reviewer) are to co-operate with one another in the exercise of their respective functions in relation to—

(a) the completion and review of medical certificates of cause of death (including in particular the recording of causes of deaths),

(b) the collation and analysis of information relating to the causes of death,

(c) the disposal of bodies.

21 **Guidance**

In exercising functions under this Act, medical reviewers (including the senior medical reviewer) must have regard to any guidance issued by the Scottish Ministers for the purposes of or in connection with this Act.

22 **Annual report**

(1) The senior medical reviewer must—

(a) prepare a report for each financial year on the activities of medical reviewers (including the senior medical reviewer) during the year, and

(b) provide such further information as the Scottish Ministers may reasonably require.

(2) As soon as reasonably practicable after the end of each financial year, the senior medical reviewer must—

(a) send a copy of the report to the Scottish Ministers, and

(b) arrange for it to be published.

(3) The Scottish Ministers may by regulations—

(a) make further provision about the information to be contained in a report,

(b) require reports to be prepared on a more frequent basis,

(c) specify other persons to whom a copy of the report must be sent.

35 **Fees**

23 **Fees in respect of medical reviewer functions**

(1) The Scottish Ministers may charge a fee in respect of—
(a) the review functions,
(b) the functions exercised by the Common Services Agency for the Scottish Health Service in connection with the review functions,
(c) an application under section 17(2).

(2) The persons liable for the fee in respect of the functions mentioned in subsection (1)(a) and (b) are the personal representatives of every person whose death requires to be registered in accordance with Part 3 of the 1965 Act; and any such fee is to be treated as part of the general testamentary and administration expenses of the estate of the deceased.

(3) The Scottish Ministers may by regulations make provision about the charging of fees under subsection (1).

(4) Regulations made under subsection (3) may in particular—
(a) set the amount of any such fee,
(b) make provision about the arrangements for collection of any such fee (including specifying persons (or types of person) who must collect the fee on behalf of the Scottish Ministers),
(c) specify circumstances in which no fee is payable.

(5) The Scottish Ministers, in setting the amount of fees under this section, must not set a fee in excess of the reasonable costs of the exercise of the functions in respect of which the fee is to be charged.

(6) Before making any regulations under subsection (3) the Scottish Ministers must consult such persons as they consider appropriate.

(7) In subsection (1), the review functions are the functions of the medical reviewers (including the senior medical reviewer) under this Act (other than sections 16A, 17 and 18).

Disposal of bodies

24 Prohibition on disposal of body without authorisation

After section 27 of the 1965 Act insert—

“27A Offence of disposal of body without authorisation

(1) A person having charge of a place of interment, cremation or other means of disposal of human bodies who inter, cremates or otherwise disposes of the body of a still-born child or a deceased person (or who knowingly permits such interment, cremation or disposal) without the certificates or other documentation specified under subsection (2)(a) for such purpose commits an offence.

(2) The Scottish Ministers may by regulations made by statutory instrument—
(a) specify the certificates or other documentation required for the interment, cremation or other disposal of the body of a still-born child or a deceased person,
(b) make provision about the form and content of such certificates (other than those which are to be prescribed by the Registrar General under this Act).
(3) A person who commits an offence under subsection (1) is liable on summary conviction to a fine not exceeding level 3 on the standard scale.

(4) It is a defence for a person charged with an offence under subsection (1) to prove that there was a reasonable excuse for the interment, cremation or disposal of a body (or for that person permitting such interment, cremation or other disposal) without the certificates or other documentation specified under subsection (2)(a).

(5) Where an offence under subsection (1) which has been committed by a body corporate is proved to have been committed with the consent or connivance of, or to be attributable to any neglect on the part of—

(a) a director, manager, secretary or other similar officer of the body corporate, or

(b) any person who was purporting to act in any such capacity,

that person, as well as the body corporate, commits the offence and is liable to be proceeded against accordingly.

(6) The power conferred by subsection (2)—

(a) may be exercised so as to make different provision for different purposes,

(b) includes power to make such incidental, consequential, transitional, transitory or saving provision as the Scottish Ministers think necessary or expedient.

(7) A statutory instrument containing regulations under subsection (2) is subject to annulment in pursuance of a resolution of the Scottish Parliament.

(8) In subsections (1), (2) and (4) reference to a body includes reference to a part of a body.”.

Certifying medical practitioner to provide additional information

(1) In section 21(2)(a) of the 1965 Act (certificates relating to still-births), after “death” insert “, any other relevant medical information”.

(2) In section 24(1) of that Act (certificates of cause of death)—

(a) after the words “death of” where they first appear insert “, and any relevant medical information about,”;

(b) after the words “belief the cause of death” insert “and such other medical information as may be prescribed”.

Still-birth declarations

In section 21 of the 1965 Act (still-births)—

(a) in subsection (2), paragraph (b) and the word “or” immediately preceding it is repealed,

(b) in subsection (3)(a), the words “paragraph (a) of” are repealed.
General

27 Ancillary provision

(1) The Scottish Ministers may by order make such supplementary, incidental, consequential, transitional, transitory or saving provision as they consider necessary or expedient for the purposes of, in consequence of, or for giving full effect to, any provision of this Act.

(2) An order under this section may modify any enactment, instrument or document.

28 Orders and regulations

(1) Subject to subsection (4), any power conferred by this Act on the Scottish Ministers to make an order or regulations—

(a) must be exercised by statutory instrument,

(b) includes power to make supplementary, incidental, consequential, transitional, transitory or saving provision,

(c) may be exercised so as to make different provision for different purposes.

(1A) An order made under section 4(7)—

(a) must be laid before the Parliament, and

(b) ceases to have effect at the expiry of a period of 28 days beginning with the date on which it was made unless, before the expiry of that period, the order has been approved by resolution of the Parliament.

(1B) In reckoning for the purposes of subsection (1A)(b) any period of 28 days, no account is to be taken of any period during which the Parliament is—

(a) dissolved, or

(b) in recess for more than 4 days.

(1C) Subsection (1A)(b) is without prejudice to anything previously done by reference to an order under section 4(7) or to the making of a new order under that provision.

(2) No order is to be made under section 27 containing provisions which add to, omit or replace any part of the text of an Act, unless a draft of the statutory instrument containing the regulations or order has been laid before, and approved by resolution of, the Parliament.

(3) Subject to subsection (4), any other statutory instrument containing an order or regulations is subject to annulment in pursuance of a resolution of the Parliament.

(4) Subsections (1) and (3) do not apply in relation to an order made under section 31(3).

29 Minor and consequential modifications

Schedule 2 (which makes minor modifications and modifications consequential on this Act) has effect.

30 Interpretation

(1) In this Act (unless the context otherwise requires)—

“the 1965 Act” means the Registration of Births, Deaths and Marriages (Scotland) Act 1965 (c. 49);
“the 1978 Act” means the National Health Service (Scotland) Act 1978 (c. 29);
“funeral director” means a person whose business consists of or includes the arrangement and conduct of funerals;
“Health Board” means a Health Board constituted under section 2 of the 1978 Act;
“health record” means a record which—
(a) consists of information relating to the physical or mental health of an individual, and
(b) has been made by or on behalf of a health professional in connection with the care of that individual;
“medical certificate of cause of death” means a certificate mentioned in section 24 of the 1965 Act;
“medical reviewer” means a person appointed under paragraph 7A(1) of Schedule 5A to the 1978 Act;
“registration district” has the meaning given in section 5 of the 1965 Act;
“Registrar General” has the meaning given in section 1(2) of the 1965 Act;
“relevant registrar” means—
(a) the district registrar for a registration district—
(i) to whom a medical certificate of cause of death was transmitted under section 24 of the 1965 Act,
(ii) in the presence of whom a death registration form (within the meaning of section 23(1A) of the 1965 Act) was attested under section 23(1A)(a)(ii) of that Act, or
(iii) to whom a death registration form was submitted under section 23(1A)(b) of that Act, or
(b) where the information mentioned in paragraph (a) is not known to the medical reviewer (or, as the case may, the senior medical reviewer), the Registrar General;
“relevant medical practitioner” means the registered medical practitioner who attested the certificate of cause of death under section 24 of the 1965 Act;
“senior medical reviewer” means the person appointed under paragraph 7A(2) of Schedule 5A to the 1978 Act;
“Special Health Board” means a Special Health Board constituted under section 2 of the 1978 Act.

(2) Unless the context otherwise requires, any undefined expression used in this Act but defined in section 56 of the 1965 Act is to be construed in accordance with section 56 of the 1965 Act.

31 Short title and commencement

(1) This Act may be cited as the Certification of Death (Scotland) Act 2010.

(2) This section and sections 27 and 28 come into force at the beginning of the day after the day on which the Bill for this Act receives Royal Assent.
(3) The remaining provisions of this Act come into force on such day as the Scottish Ministers may appoint by order made by statutory instrument.

(4) An order made under subsection (3)—

(a) may make transitional, transitory or saving provision,

(b) may make different provision for different purposes or different areas.
SCHEDULE 1
(introduced by section 1)

STATUS AND APPOINTMENT OF MEDICAL REVIEWERS

1 Schedule 5A to the 1978 Act (Healthcare Improvement Scotland) is amended as follows.

2 After paragraph 7 insert—

“Medical reviewers

7A(1) HIS must appoint persons employed under paragraph 7(5) to exercise the functions of medical reviewers; and when doing so those employees are to be known as medical reviewers.

(2) HIS must appoint a person employed under paragraph 7(5) to exercise the functions of the senior medical reviewer; and when doing so that employee is to be known as the senior medical reviewer.

(3) A person appointed as a medical reviewer or the senior medical reviewer must—

(a) be a medical practitioner;

(b) have been so throughout the 5 years prior to appointment; and

(c) have such other qualifications, training and experience as may be specified by regulations.

(4) A member of HIS may not exercise the functions of—

(a) a medical reviewer; or

(b) the senior medical reviewer.

(5) An employee of HIS (other than a medical reviewer) may not exercise any function of a medical reviewer other than those under section 16A.

(6) An employee of HIS (other than the senior medical reviewer) may not exercise the functions of the senior medical reviewer (except by virtue of arrangements made under paragraph 11(2B)).

(7) An appointment as a medical reviewer or the senior medical reviewer does not affect the appointed person’s status as employed under paragraph 7(5).”.

3 In paragraph 11 (delegation of functions)—

(a) in sub-paragraph (1), for “and” where it first occurs substitute “to”,

(b) after sub-paragraph (2) insert—

“(2ZA) HIS may authorise an employee to carry out the functions of a medical reviewer under section 16A.

(2A) Any other function conferred on a medical reviewer or the senior medical reviewer may not, subject to sub-paragraph (2B), be delegated by HIS.

(2B) The senior medical reviewer may, with the approval of HIS, make arrangements for the functions of the senior medical reviewer to be carried out by a medical reviewer where the senior medical reviewer is absent or otherwise unavailable.”.
SCHEDULE 2
(introduced by section 29)
MINOR AND CONSEQUENTIAL MODIFICATIONS

Cremation Act 1902 (c. 8)

1 (1) The Cremation Act 1902 is amended as follows.

(2) In section 7 (regulations as to burning)—

(a) the words from “and” where it fifth occurs to “place” where it second occurs are repealed,

(b) the words from “Each” to “prescribe” are repealed.

(3) After section 7 insert—

“7A Forms of documentation for burning
The Scottish Ministers may make regulations prescribing the forms of notices, certificates and applications to be given or made before the burning of any human remains is permitted to take place.

7B Procedure for regulations
A statutory instrument containing regulations under section 7 or 7A is subject to annulment in pursuance of a resolution of the Scottish Parliament.”.

(4) In section 8(1) (penalties for breach of regulations, &c), after “incur” insert “other than an offence under section 27A(1) of the Registration of Births, Deaths and Marriages (Scotland) Act 1965 (c. 49) (offence of disposal of body without authorisation)”.

Cremation Act 1952 (c. 31)

1A In section 2(2) of the Cremation Act 1952 (procedure for regulations made under section 7 of the Cremation Act 1902) the words from “Any” to “and” are repealed.

Registration of Births, Deaths and Marriages (Scotland) Act 1965 (c. 49)

2 Section 21(5) of the 1965 Act (person having charge of place of interment to give notice of burial of still-born child without certificate) is repealed.

3 In section 24 of the 1965 Act (certificate of cause of death), after subsection (1), insert—

“(1A) A registered medical practitioner may, where invited to do so under section 10(2)(b) or 11(6) of the 2010 Act (action following unsatisfactory review), attest and transmit a replacement certificate to a medical reviewer or, as the case may be, the senior medical reviewer.”.

4 Section 27(2) and (3) of the 1965 Act (transmission of certificate of registration) is repealed.

5 In section 56(1) of the 1965 Act (interpretation)—

(a) before the entry for “birth” insert—

““the 2010 Act” means the Certification of Death (Scotland) Act 2010 (asp 00);”,
(b) after the entry for “local authority” insert—

“‘medical reviewer’ means a person appointed under paragraph 7A(1) of Schedule 5A to the National Health Service (Scotland) Act 1978 (c. 29);”,

(c) after the entry for “relative” insert—

“‘senior medical reviewer’ means a person appointed under paragraph 7A(2) of Schedule 5A to the National Health Service (Scotland) Act 1978 (c. 29);”.
Certification of Death (Scotland) Bill
[AS AMENDED AT STAGE 2]

An Act of the Scottish Parliament to make provision about the certification of death and still-birth certificates; to make provision for medical reviewers, the senior medical reviewer and their functions; and for connected purposes.

Introduced by: Nicola Sturgeon
On: 7 October 2010
Bill type: Executive Bill
CERTIFICATION OF DEATH (SCOTLAND) BILL
[AS AMENDED AT STAGE 2]

REVISED EXPLANATORY NOTES

CONTENTS

1. As required under Rule 9.7.8A of the Parliament’s Standing Orders, these revised Explanatory Notes are published to accompany the Certification of Death (Scotland) Bill (introduced in the Scottish Parliament on 7 October 2010) as amended at Stage 2. Text has been added or deleted as necessary to reflect the amendments made to the Bill at Stage 2 and these changes are indicated by sidelining in the right margin.

INTRODUCTION

2. These Explanatory Notes have been prepared by the Scottish Government in order to assist the reader of the Bill and to help inform debate on it. They do not form part of the Bill and have not been endorsed by the Parliament.

3. The Notes should be read in conjunction with the Bill. They are not, and are not meant to be, a comprehensive description of the Bill. So where a section or schedule, or a part of a section or schedule, does not seem to require any explanation or comment, none is given.

SUMMARY OF THE BILL

4. The Bill introduces a new system of scrutiny of medical certificates of cause of death. It creates the post of medical reviewer and senior medical reviewer whose functions are to review for accuracy the certificates referred to them from a variety of sources. A number of certificates will be referred at random by district registrars. The Registrar General will be responsible for ensuring that certificates are referred according to the chosen selection scheme. Persons with some connection to the deceased can apply for a review and certificates may also be selected by the medical reviewers themselves for scrutiny.

5. Medical reviewers will be involved in the training of doctors in the completion of medical certificates of cause of death and information derived from reviews will directly feed into that training.

6. The Bill provides for the form of medical certificates of cause of death to be amended to show additional relevant medical information to indicate, for example, whether it is safe to dispose of the body by cremation. The Bill also provides for the form of still-birth certificates to
be amended to show additional relevant medical information, to indicate whether the body presents a risk to public health.

7. Where a person has died outwith Scotland and the body is to be cremated in Scotland, medical reviewers will determine whether it is safe to cremate the body. They may also assist persons to make arrangements for a post-mortem examination (including meeting the cost of the examination) in such cases from outwith the UK if no cause of death is available. Medical reviewers’ assistants will verify foreign death certificates and give authorisation for disposal.

8. A fee may be charged to pay for the review system and in cases where authority to cremate a body from outwith the UK is required.

9. It will be an offence to dispose of a body or body parts without authorisation.

**COMMENTARY ON SECTIONS**

**Medical reviewers**

**Section 1: Medical reviewers**

10. This section introduces medical reviewers and the senior medical reviewer who will exercise their functions on behalf of Healthcare Improvement Scotland (HIS), a body set up in Schedule 5A to the National Health Service (Scotland) Act 1978. They will be appointed by and be employees of HIS. This section also gives effect to schedule 1 to the Act which provides further detail regarding the status and appointment of medical reviewers and the senior medical reviewer.

**Referral of medical certificates of cause of death for review**

**Section 2: Referral of certain certificates of cause of death for review**

11. Under the new system for scrutiny of medical certificates of cause of death, certificates will be sent for review from a variety of sources. One of these is the General Register Office for Scotland (GROS), which is responsible for the registration of deaths. GROS is expected to use computerised systems to identify a random selection of certificates for review.

12. Section 2 amends the Registration of Births, Deaths and Marriages (Scotland) Act 1965 (c.49) (“the 1965 Act”) by inserting a new section 24A. Section 24A(1) requires the Registrar General to ensure that randomly selected certificates of cause of death are referred to medical reviewers for review prior to the completion of the registration process (and therefore before the registrar's certificate of registration has been issued). Subsection (2) imposes a duty on the Registrar General to ensure that medical certificates of cause of death requested by medical reviewers under section 3 are referred for review. Subsection (3) allows a district registrar to refer a certificate for review, where he/she decides this is appropriate.

13. Some certificates, listed in subsection (4), are not eligible to be referred to the medical reviewer for investigation. The first category consists of cases where the body presents a risk to public health and a direction has been issued by a Health Board under section 90(2) of the Public
Health (Scotland) Act 2008 (asp 5) to the effect that an infectious or contaminated body may not be removed or may only be removed from a hospital by a specified person for immediate disposal. Also ineligible for review are any certificate which has already been referred for review, any replacement certificate (described in sections 10 and 11), certificates signed before section 2 comes into force and any certificate relating to a death which has already been (or is being) investigated by the procurator fiscal (this includes cases of notifiable deaths which have been formally reported to the procurator fiscal).

14. Subsection (5) gives the Scottish Ministers power to direct the Registrar General as to the minimum number of certificates to be referred in the random sample and the method of determining the random sample. The sample size and method could be amended from time to time for statistical reasons.

15. The Scottish Ministers have the power to suspend by order the referral of certificates to the medical reviewer during an epidemic or if it becomes necessary to do so for public health reasons in order to prevent the spread of infectious disease or contamination. Suspension of the referrals could be judged necessary in such situations to expedite the disposal of bodies and free up medical personnel. The power is subject to emergency affirmative procedure; this will allow an order to be made with immediate effect, but Parliamentary approval is required if it is to have effect for more than 28 days (not including periods when the Parliament is dissolved or in recess for more than 4 days).

Section 3: Medical reviewer requests

16. In addition to the random sample of certificates provided for in section 2, medical reviewers may request any medical certificate of cause of death for review, including certificates where the death has already been registered. This will allow medical reviewers to conduct additional scrutiny where they feel this is required e.g. in response to a particular issue of concern.

Section 4: Application for review of certificate by interested person

17. This section provides for a list of “interested persons” who may also apply to a medical reviewer for a review. These applications may relate to deaths either before or after they have been registered but applications must be made within three years of the date of death. A medical reviewer may reject an application that is considered vexatious.

18. The medical reviewer must notify the Registrar General of the application. The purpose of this is to stay the registration process, as provided for in section 5, where the death has not already been registered. This also provides the medical reviewer with a means for discovering whether the certificate has already been reviewed (and therefore is ineligible).

19. Subsection (5) sets out the list of interested persons, which may be added to by order of the Scottish Ministers. Interested persons either have some personal connection to the deceased or are in a position to have informed concerns about the accuracy of the medical certificate of cause of death.
20. Certain certificates are excluded from this type of review. These are cases where a Health Board direction has been issued regarding a contaminated or infectious body, where the certificate has already been referred or reviewed, a replacement certificate has already been issued under sections 10 or 11, or the death has been referred to the procurator fiscal.

21. Subsection (7) allows the Scottish Ministers to suspend applications for review from interested persons during an epidemic or when necessary to prevent or halt the spread of infectious diseases or contamination. This mirrors the provision in section 24A(7) of the 1965 Act (introduced by section 2) which allows for the suspension of referrals under that section in the same circumstances. Suspension of applications could be necessary in situations where there are large numbers of deaths and it becomes a priority to expedite the disposal of bodies and free up medical personnel. By virtue of section 28(1A), the same Parliamentary procedure applies to orders made under section 4(7) as applies to orders made under section 24A(7) of the 1965 Act.

22. Subsection (8) allows the Scottish Ministers to prescribe in regulations the content of and procedure for making “interested person” applications and the actions to be taken by medical reviewers in respect of such applications.

**Section 5: Stay of registration of death pending review**

23. Section 5 amends section 25B of the 1965 Act. The purpose of this section is to ensure that the registrar does not complete the registration of any death where the certificate of cause of death has been referred for review under the provisions in section 24A of the 1965 Act or where an application for review has been made under section 4 prior to the death being registered.

24. Registration must usually be suspended until the review has been completed. In certain circumstances, however, a medical reviewer may confirm that it is appropriate for the registration process to proceed prior to the review being completed (see sections 6 and 7). This is the process set out in section 6 which may apply in certain circumstances where speed is of the essence.

**Section 6: Request for review not to stay registration**

25. Section 6 provides for a request for the registration of a death not to be stayed. This is available where there has been a referral of the certificate under the random sampling provision in section 24A(1) of the 1965 Act, inserted by section 2. Requests for this process are to be made to the registrar who will then refer the case to the medical reviewer for a decision. The application must include a statement by the applicant of the circumstances that might justify use of the process. In practice a copy of the medical certificate of cause of death will be sent to the medical reviewer (the original certificate will follow the copy by the usual means).

**Section 7: Medical reviewer to determine whether review to stay registration**

26. It is for the medical reviewer to decide whether it is appropriate to register the death before the review is complete and to notify the registrar of the decision. The medical reviewer must be satisfied that the circumstances of the case justify this and that the certificate appears on the face of it to be in order. This process may reduce any delay to the funeral and so may be useful in cases where it has to take place more quickly than usual. The circumstances to be considered by medical reviewers will be set out in guidance.
Review of medical certificates of cause of death

Section 8: Review of medical certificates of cause of death

27. Section 8 provides that the medical reviewer must review the certificates of cause of death referred under section 24A of the 1965 Act or those referred to the medical reviewer under section 4 (provided they are not rejected as vexatious under section 4 subsection (3)).

28. Subsection (2) describes the conduct of a review. Medical reviewers may review the medical records of the deceased, discuss matters with the certifying doctor and make other enquiries as they consider appropriate. This might include speaking to other health professionals involved in the care of the deceased, speaking to relatives and, possibly, (arranging to) view the body before coming to a view as to whether the medical certificate of cause of death is in order.

29. Subsections (3) and (4) provide that medical reviewers must come to a view on whether the given cause of death is a reasonable conclusion and that other information in the certificate is correct.

30. Subsection (5) allows the Scottish Ministers to make further provisions regarding the conduct of reviews in regulations.

Section 9: Action following satisfactory review

31. If the medical reviewer is satisfied with the medical certificate of cause of death, then he or she must approve it and notify the relevant registrar (in practice, this will mean sending the certificate back to the relevant registrar for registration to occur).

32. The relevant registrar is defined in section 30 and will usually be the district registrar who has made the referral or, where that person is unknown to the medical reviewer (as might be the case in an interested person application), the Registrar General.

33. In cases where the registration of the death has been stayed, the registrar will then be free to complete it and notify the informant, that is the relative or other person who came to register the death.

Section 10: Action following unsatisfactory review: medical reviewer

34. Section 10 sets out the next steps if the medical reviewer is not satisfied that a medical certificate of cause of death is in order. The medical reviewer must inform the doctor who certified the cause of death, giving reasons for their view, and invite the doctor to replace the certificate which takes account of the reasons why the medical reviewer considers that the certificate is not in order, thus allowing the medical reviewer to then approve and notify the registrar. However, if the certifying doctor issues a replacement certificate which the medical reviewer considers is not in order then he or she must refer the review to the senior medical reviewer.

35. The certifying doctor may decline to issue a replacement certificate. In such cases the medical reviewer may be persuaded in discussion with the doctor that the cause of death does,
after all, represent a reasonable conclusion as to the cause of death or that the other information on the form is in fact correct. In such instances the medical reviewer can then decide to approve the certificate. If not persuaded, the medical reviewer must refer it to the senior medical reviewer.

Section 11: Action following unsatisfactory review: senior medical reviewer

36. This section applies where a medical reviewer has been unable to agree with the certifying doctor that a medical certificate of cause of death is in order and has referred the matter to the senior medical reviewer.

37. The senior medical reviewer must also come to a view on whether the given cause of death is a reasonable conclusion and that other information in the certificate is correct. To do so, he or she may conduct a further review of the certificate in the same manner as a medical reviewer.

38. If the senior medical reviewer is of the view that the certificate is in order, the certificate will be approved and sent to the relevant registrar for registration to proceed.

39. However, if the senior medical reviewer does not think that the certificate is in order, he or she must inform the doctor who certified the cause of death, giving reasons for their view, and invite the doctor to replace the certificate. There is no obligation on certifying doctors to change their opinion but they may agree to issue a replacement certificate which takes account of the reasons why the senior medical reviewer considers that the certificate is not in order, thus allowing the senior medical reviewer to then approve and notify the registrar. If the certifying doctor issues a replacement certificate but the senior medical reviewer does not agree with the revised cause of death information, or the certifying doctor does not issue a replacement certificate and the senior medical reviewer is not persuaded of the doctor’s original view as to the cause of death, the senior medical reviewer must refer the certificate to the procurator fiscal for investigation.

40. In cases where the senior medical reviewer agrees with the cause of death, but believes that other information contained in the certificate, or its replacement, is incorrect (such as whether a pacemaker is fitted), or where the doctor will not issue a replacement certificate, the senior medical reviewer can take steps to alert whomever he or she considers appropriate as to what he or she believes to be the relevant information. This might typically be the family of the deceased or the person in charge of the burial or cremation of the deceased.

41. The senior medical reviewer can also take such steps when referring a certificate to the procurator fiscal.

Section 12: Action where relevant medical practitioner is unavailable or incapacitated

42. This section deals with the situation where the relevant doctor is unavailable or unable to issue a replacement certificate, for example, when that doctor is unwell. If a medical reviewer is not satisfied as to the cause of death given in the certificate but the relevant doctor is not available or is incapacitated and so could not issue a replacement certificate, the death must be referred to the procurator fiscal for investigation. If there is some other defect in the certificate
not related to the cause of death, the medical reviewer can take steps to alert whomever he or she considers appropriate as to what he or she believes to be the relevant information. If the doctor becomes unavailable after a certificate has been referred to the senior medical reviewer, who is not satisfied that the certificate is in order, the senior medical reviewer can take the same actions as the medical reviewer.

Section 13: Duty to inform following review

43. Specified persons are to be informed of the outcome of a review including any changes made to the medical certificate of cause of death. An interested person who made an application under section 4 will be informed as will the person who gave information in order to register the death. Such notification will take place after a review has been conducted and the registrar has been notified or when the case has been referred to the procurator fiscal.

Powers of medical reviewers when conducting review

Section 14: Power to require documents

44. Medical reviewers and the senior medical reviewer have the power to require any person who, in their opinion, may have relevant documents, including medical records, to provide them with those documents for the purpose of reviewing an MCCD, or determining under section 17(2) whether it is safe to cremate the body of a person who died outwith Scotland. Medical reviewers (and the senior medical reviewer) must make a request for these documents in a formal notice in accordance with subsection (2). Copies or extracts of the document are sufficient.

Section 15: Documents: offences

45. This section creates an offence where a document referred to in section 14 either is not provided and there is no reasonable excuse for the failure to produce it or it has been deliberately altered, suppressed concealed or destroyed. There is no obligation to produce a document that a person would be entitled to refuse to produce in court. The penalty for the offence is level 5 on the standard scale or imprisonment for up to 3 months.

46. This section applies to individual persons and organisations. Subsection (5) of section 15 confirms that in cases where the offence is committed by a body corporate, the person in charge of that body (for example, the manager of a private nursing home) commits the offence, as well as the body corporate.

Duty to report suspicions of criminality

Section 16: Involvement of procurator fiscal

47. This section requires the medical reviewer or senior medical reviewer to report any suspicion of criminal activity to the procurator fiscal and follow any directions from the procurator fiscal after a suspicion has been reported.

48. The role of the procurator fiscal in Scotland is not altered by the establishment of the system of medical reviewer scrutiny.
Deaths outwith Scotland

Section 16A: Verification of foreign death certificates

49. This section gives medical reviewers the power to check foreign death certificates. Section 24 makes it an offence for persons having charge of a cemetery or crematorium to dispose of a body without the required documentation; in cases where the death occurred outside the UK, the document required for disposal will be a certificate issued by a medical reviewer. Medical reviewers - or their assistants - will check whether the relevant documents are authentic and equivalent to the documentation which would be required to dispose of the body of a person who died in Scotland and, if so, will issue the aforementioned certificate. In carrying out this function, medical reviewers have the power to make such enquiries as they consider appropriate.

Section 17: Medical reviewers to authorise cremation

50. Medical reviewers have the additional function of ensuring that it is safe to cremate the body of anyone who died overseas and who is to be cremated in Scotland. Medical referees at crematoria currently perform this function but this role will be abolished when the new system is introduced. This means, for example, that the medical reviewer will check medical records to see if the person has any implants or a pacemaker that would need to be removed prior to cremation. In carrying out this function, section 14 also gives medical reviewers powers to require documents or require a person (such as a family member or funeral director) to produce relevant documents (including access to health records). The offence provision in section 15 in relation to the provision of such documents applies.

51. Anyone wishing to arrange the cremation of a body in such a case must apply to the medical reviewer. The form and content of the application and authorisation and any further procedure to be followed by medical reviewers may be specified in regulations by the Scottish Ministers.

Section 18: Post-mortem examination of person who died outwith United Kingdom

52. The persons mentioned in subsection (3) may apply to the medical reviewer for assistance, including financial assistance, to arrange a post-mortem examination in situations where the body of someone who died outwith the UK has been returned to Scotland for disposal. The persons who can make an application under subsection (3) are the same persons who are entitled to authorise a post-mortem under sections 30, 32 or 33 of the Human Tissue (Scotland) Act 2006. An application may only be made under this section for the purpose of providing information about the cause of death where none is available. It will allow the small number of families in this position an opportunity to have the cause of death established.

Other functions of medical reviewers

Section 19: Training and information functions

53. This section sets out additional functions of the medical reviewer and senior medical reviewer. These are: collating and analysing information relating to medical certificates of cause of death; providing guidance, training and direct support to doctors and other healthcare professionals; providing guidance and support to district registrars in relation to certificates; and liaison with other persons or organisations. The purpose of this is to improve the quality of
medical certificates of cause of death and the administrative processes for dealing with the disposal of bodies.

Section 20: Duty to co-operate

54. The new system of scrutiny has to connect with agencies and systems in the NHS. The Common Services Agency, for example will provide statistical support services for the review system. This section provides that NHS Boards, the Common Services Agency for the Scottish Health Service and medical reviewers (including the senior medical reviewer) have a duty to co-operate with one another in connection with the review of medical certificates of cause of death, the information gathered and analysed and the administrative processes for the disposal of bodies.

Section 21: Guidance

55. This section requires medical reviewers (including the senior medical reviewer) to have regard to guidance issued by the Scottish Ministers in the exercise of their functions under the Act. Guidance can help to ensure consistency of approach, for example, in situations where medical reviewers (or the senior medical reviewer) may be exercising discretion.

Section 22: Annual report

56. This section requires the senior medical reviewer to prepare and publish an annual report for the Scottish Ministers on the activities of medical reviewers. The Scottish Ministers may by regulation make further provision for additional information to be included, for greater frequency of reporting, or to specify additional people who must receive copies.

Fees

Section 23: Fees in respect of medical reviewer functions

57. This section allows for a fee to be charged in two situations. One is a charge to cover the costs of the new system of scrutiny of medical certificates of cause of death including the associated statistical support provided by the Common Services Agency. This fee may be charged to the personal representatives of the deceased and will be payable out of the deceased’s estate.

58. The other fee is for the application for authorisation to cremate the body of a person who died outwith Scotland. The medical reviewer has to determine whether it is safe to do so in such cases (section 17).

59. The Scottish Ministers may make regulations about the charging of fees, the arrangements for collection and any circumstances in which no fee is payable. The maximum fee which can be charged under section 17 cannot exceed the reasonable costs of the review or, as the case may be, the reasonable costs of determining whether it is safe to cremate the body of a person who died outwith Scotland. No fee is to be charged in respect of the function of verifying foreign certificates under section 16A.
Disposal of bodies

Section 24: Prohibition on disposal of body without authorisation

60. This section inserts a new section 27A into the 1965 Act making it an offence to dispose of the body of a still-born child or a deceased person without authorisation. The offence is committed by a person in charge of a place where the disposal of human bodies takes place, for example, a superintendent of a crematorium or burial ground. The Scottish Ministers may by regulation prescribe the types of documentation required and make provision for the form and content of such documents, except where these are already prescribed by the Registrar General. For instance, it is likely that in many cases one of the documents required will be the registration certificate issued by the district registrar.

61. The penalty for the offence is a fine not exceeding level 3 on the standard scale. When the offence has been committed by a body corporate, its officers can also be convicted.

62. Under subsection (4) a defence is available to a person charged with such an offence, if that person can prove that there was a reasonable excuse for disposing of a body without the relevant authorisation.

Section 25: Certifying medical practitioner to provide additional information

63. This section paves the way for replacing the current death certification system. It amends section 21(2)(a) and section 24(1) of the 1965 Act. These sections provide respectively for a prescribed still-birth certificate and the medical certificate of cause of death. They are amended to allow “any relevant medical information” to be added to the certificates. The purpose of this section is to widen the information that doctors may be required to provide on the still-birth certificate and medical certificate of cause of death. In relation to the latter, for example, this will allow a requirement to be added for certifying doctors to confirm that there are no implants requiring removal before cremation or that the body is not infectious. Medical reviewers will perform this task for bodies returned from outwith Scotland (see section 17). The function of checking for implants is performed by medical referees at crematoria. This role will be abolished with the setting up of the new system.

Section 26: Still-birth declarations

64. Section 26 repeals paragraph (b) of section 21(2) of the 1965 Act (still-births). This paragraph provides for a declaration that the child was not born alive and that no medical practitioner or midwife was present. Such cases will in future be referred to the procurator fiscal.

General

Sections 27-31

65. Sections 27 and 28 set out various general provisions.

66. Section 29 introduces Schedule 2.
67. Section 30 sets out definitions for key words and phrases. This includes the medical certificate of cause of death, the form used by the certifying doctor which gives details of the person who has died and the cause of death. It is these certificates that will be scrutinised by medical reviewers under the new system.

68. Section 31 provides for the short title and commencement.

Schedule 1

69. Schedule 1 amends Schedule 5A to the National Health Service (Scotland) Act 1978 in order to provide for the appointment of persons to carry out the functions of the medical reviewers and senior medical reviewer. Other members or employees of Healthcare Improvement Scotland are expressly prevented from exercising those functions, with the exception of the function of verifying foreign certificates under section 16A; it is envisaged that this function will be performed by medical reviewers’ assistants.

70. The minimum qualification required for medical reviewers or the senior medical reviewer is to have been a medical practitioner for 5 years prior to appointment. The Scottish Ministers have the power to prescribe in regulations additional requirements for qualifications, training or experience.

71. The functions of the medical reviewer and senior medical reviewer may not be delegated, with the exception of the function of medical reviewers of verifying foreign certificates under section 16A, which can be exercised by another employee of Healthcare Improvement Scotland.

72. In addition, the senior medical reviewer is entitled, with the agreement of Healthcare Improvement Scotland, to arrange for one of the medical reviewers to carry out his or her functions if he or she is absent or unavailable. This would enable a deputy to cover for the senior medical reviewer during times of illness or annual leave, for example.

Schedule 2

73. Schedule 2 (which is introduced in section 29) makes consequential amendments to the 1965 Act by updating definitions in that Act to reflect the new system set out in the Bill and allowing doctors to sign a replacement medical certificate of cause of death. Section 21(5) and section 27(2) and (3) of the 1965 Act are repealed. Sections 21(5) and 27(3) require a person having charge of a burial ground to give notice to the registrar where a still-born child is buried without a still-birth certificate or a body is buried without a death certificate. In addition, section 27(2) requires a person to transmit the certificate of registration to the person in charge of the place of interment or cremation. These sections are replaced with a new section 27A in the 1965 Act inserted by section 24.

74. The Cremation Act 1902 (c.8) is also amended to prevent an overlap of offence provisions between section 8 of that Act and the new section 27A(1) of the 1965 Act. The regulation making power in the Cremation Act 1902 is amended (section 7) to remove aspects of the power which will become redundant as a result of the Bill. It also makes the power to prescribe the form of notices, certificates and applications discretionary rather than mandatory, and this power is introduced as a new section. Section 2(2) of the Cremation Act 1952 currently
provides that regulations made under section 7 of the 1902 Act are subject to negative Parliamentary procedure; the relevant part of section 2(2) is repealed, and a provision has instead been added to the 1902 Act to confirm that regulations made under sections 7 and 7A are subject to negative procedure.
INTRODUCTION

1. This Supplementary Financial Memorandum is published to accompany the Certification of Death (Scotland) Bill (introduced in the Scottish Parliament on 7 October 2010) as amended at Stage 2. It has been produced in accordance with Rule 9.7.8B of the Parliament’s Standing Orders. It does not form part of the Bill and has not been endorsed by the Parliament. It should be read in conjunction with the original Explanatory Notes and other accompanying documents published to accompany the Bill (As Introduced) (SP Bill 58A-EN).

2. This document provides projected costs relating to the proposals outlined to the Health and Sport Committee on 15 December. The proposals would provide the following enhancements to the medical reviewer (MR) model:

3. Firstly, the introduction of a new level of real-time scrutiny - to be called level 1 reviews - to be applied to 25% of all deaths in Scotland, selected randomly by the GROS computer system (based on 2009 figures, this would mean around 13,500 level 1 reviews). Level 1 reviews will be conducted by MRs and will involve checking the MCCD and speaking to the certifying doctor to obtain background clinical information. The MR will discuss any concerns with the certifying doctor (or another doctor in the team) by phone and any disagreements will be covered by the same procedure as currently set out in the Bill. This will allow the MR to check the quality of the certificate and the stated cause of death and to query anything unusual. It will allow discrepancies to be picked up and can act as a trigger for a comprehensive level 2 review if considered necessary or where there is any ongoing disagreement.

4. Secondly, an increase of random real-time level 2 reviews (i.e. comprehensive scrutinies) from 500 to 1,000 cases annually. The random sample’s increased size to 1,000 cases will provide a benchmark for the proportion of queried MCCDs to within a 2% margin of error. The key purpose of this sample is to provide a quality benchmark at an all-Scotland level and to measure improvements. Data from all the reviews will feed into a comprehensive audit and quality improvement programme based on triangulating a number of data sources - including Hospital Standardised Mortality Ratios, coding checks from GROS and statistical analysis from the national statistician.

COSTS ON THE SCOTTISH ADMINISTRATION

5. The costings are based on assumptions made of likely workload and tasks initially agreed by an independent Review Group which met between 2005 and 2007. Assuming that 1,000

\[1\] Information about the Burial and Cremation Review Group is available on the Scottish Government website: http://www.scotland.gov.uk/Topics/Health/burialcremation/intro. It submitted a report to the Scottish Government
level 2 cases are sampled, a further 500 are referred for review by “interested persons” and an estimated 500 cases are selected for targeted reviews, a total of around 2,000 deaths would be subject to level 2 reviews annually, or around 38-40 cases per week. It is estimated that reviewing one case would take a MR around half a working day (level 2) and 30 minutes (level 1). Level 1 reviews would mean 13,464 deaths are reviewed annually (based on 2009 figures).

6. Our consideration of the numbers of MRs that require to be appointed has taken into account these proposed additions to their role. As previously stated, each MR would have around two days a week for: conducting additional targeted reviews; giving more general guidance; and fulfilling an education and training role - the updated financial model assumes their time is equally divided between targeted reviews and the other activities (guidance, education and training) i.e. one day each a week. Account has also been taken of absence due to sickness, leave commitments and the time each MR will require to devote to continuing professional development, to duties related to appraisal and revalidation and to reports to/liaison with the senior MR whose key functions will be to provide management of the MRs, a second opinion for reviews, and training and education. As before, each MR will have an assistant.

7. The increase in costs from the Financial Memorandum arise from the proposals which require an increased number of MRs and assistants to conduct both the new level 1 reviews and the increased number of level 2 reviews proposed (a total of c. 2,000). At a minimum, 10 whole-time equivalent MRs will now be employed, an increase of 4 from the original model. The annual recurring costs associated with the enhanced model are estimated at £1,830k with a further £222k start-up costs to be incurred in the first year of operation - these costs are detailed in the ‘0% column’ of Table 1 below.2

8. It is possible that MRs may refer a level 1 review for a more comprehensive level 2 review. Any additional level 2 reviews may necessitate the employment of additional MRs and increase costs above the level set out in paragraph 6. The proportion of additional level 2 reviews arising from level 1 reviews will not be known until the system is in operation, but information from the test sites will provide good estimates and numbers are expected to decrease over time as quality improves. Table 1 below summarises the estimated costs for different proportions of level 1 reviews recommended for more comprehensive level 2 reviews. The recurring costs:

- without any additional level 2 reviews subsequent to the level 1 activity would be £1,830k pa
- if 5% of level 1 reviews resulted in comprehensive level 2 reviews, the additional costs would be £310k pa
- if 10% resulted in further level 2 reviews, the additional costs would be £470k pa
- if 25% resulted in further level 2 reviews, the additional costs would be £1,130k pa.

which was published in 2008 which is also available on the Scottish Government website: http://www.scotland.gov.uk/Publications/2008/03/25113621/0.

2 The estimated financial costs are at 2010-11 price levels.
Table 1 Recurring and start-up costs (excluding test sites) including level 1 reviews and scenarios for upgrades from level 1 to level 2 reviews

<table>
<thead>
<tr>
<th>% Upgrade after level 1</th>
<th>0%</th>
<th>5%</th>
<th>10%</th>
<th>25%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of MRs (FTE)</td>
<td>10</td>
<td>12</td>
<td>13</td>
<td>17</td>
</tr>
</tbody>
</table>

Recurring costs

- MR costs (£000)
  - 0%: £1,260
  - 5%: £1,510
  - 10%: £1,630
  - 25%: £2,130

- Total medical staff (£000)
  - 0%: £1,410
  - 5%: £1,660
  - 10%: £1,780
  - 25%: £2,280

- Analytical staff (£000)
  - 0%: £70
  - 5%: £70
  - 10%: £70
  - 25%: £70

- Support staff (£000)
  - 0%: £240
  - 5%: £280
  - 10%: £300
  - 25%: £380

- Total staff costs (£000)
  - 0%: £1,720
  - 5%: £2,010
  - 10%: £2,150
  - 25%: £2,730

Total running costs* (£000)

- 0%: £110
- 5%: £130
- 10%: £150
- 25%: £230

Start-up costs**

- Total start-up costs (£000)
  - 0%: £222
  - 5%: £232
  - 10%: £232
  - 25%: £242

TOTAL COSTS (£000)***

- 0%: £2,052
- 5%: £2,372
- 10%: £2,532
- 25%: £3,202

*Total running costs include employee IT and telephony costs, document transit and expense claims.

**Total start-up costs include initial accommodation, GRO IT changes & support and promotional costs, development of training module. Start-up costs currently do not include recruitment costs. These can be non-linear depending on the number of posts advertised (multiple posts announced in one advertisement) and can range anywhere between £2,000 and £20,000.

*** All costs are presented at 2010-11 price levels.

9. The number of MRs would not appear in legislation and the proposed test sites will provide further information about the exact number required. These costs are therefore estimates at present and will ultimately depend on the number of MRs appointed.

10. The associated costs would not necessarily rise linearly with sample size due to the flexibility between review and training time incorporated into the model, due to non-linear changes in the travel costs and transport charges, and due to possible economies of scale arising from conducting more than the currently assumed number of reviews per week. Each added MR post (including an additional medical assistant) would increase the start-up costs by approximately £2,500 and the annual costs by c. £150,000, made up of salary and on-costs for the MR and the medical assistant, as well as IT and telephony running costs.

Staff, Accommodation, IT Changes Etc. Costs

11. The cost assumptions for staff, accommodation, IT changes, training etc. costs are unchanged.

Test Sites

12. Provided that primary legislation is completed in the 2010-11 legislative session, secondary legislation may be consulted on and go through the Scottish Parliament in 2011-12. Following that, a further transitional period of at least one year will be required for test sites to trial the new system, before full implementation in 2013-14. Two test sites in two different areas of the country are anticipated. These would offer a comparison between rural and urban populations, including remote rural and faith group issues. To include the enhancements we
propose to extend the test sites to run for nine months, with monitoring and evaluation running in parallel. Table 2 below summarises the revised estimated costs associated with the test sites.

**Table 2 Test sites summary costs 2012-13 inc level 1 reviews**

<table>
<thead>
<tr>
<th>Staff costs</th>
<th>£110,200</th>
</tr>
</thead>
<tbody>
<tr>
<td>Promotional costs</td>
<td>£1,000</td>
</tr>
<tr>
<td>Evaluation costs</td>
<td>£40,000</td>
</tr>
<tr>
<td>Running costs*</td>
<td>£11,900</td>
</tr>
<tr>
<td>Initial accommodation costs</td>
<td>£5,000</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td><strong>£168,100</strong></td>
</tr>
</tbody>
</table>

* Running costs include transport costs; travel expenses; IT and telephone charges for staff.

13. The cost estimates for the test sites are made up as follows: staff costs for two part-time (0.5 FTE) MRs and two assistants for nine months; promotional costs for initially affected registrar offices (£1,000); evaluation (£20,000 for each test site, based on previous evaluation expenditure for commissioned work); running costs including document transit / transport, with the remainder available for incidental costs including administrative and running costs; and accommodation costs.

**Recouping the Costs of the new System**

14. The initial set-up costs of the new enhanced system, estimated at c. £110,000, will be paid by the Scottish Government.

15. The Financial Memorandum proposed that the new arrangements would be self-funding through charging a fee to the public. Ministers have undertaken to meet the additional recurring costs attached to the additional proposals from within existing Health and Wellbeing budgets. The proposed level of public fee is intended to remain at £22.08 plus an estimated handling charge of £8-10. The costs set out in Table 1 do not include handling charges which will be incurred in collecting the fee, although these will be met by the public and so lead to a direct increase in the proposed fee. The method for collecting the proposed fee is yet to be agreed and this will influence the level of handling charge.

16. The costs for the test sites will be paid by the Scottish Government from existing budgets and will not be recouped through the fee.

**Total Estimated Costs**

17. Table 3 below shows when individual costs will be incurred, with the national statistician costs being incurred first, followed by the costs of the test sites (the running costs comprise of transport and administrative costs), and one-off costs in 2012-13 for necessary IT and support costs arising from the additional reviews to implement changes to the electronic registration system and introduce signature tablets, before full introduction from 2013-14. The fee is set to cover the annual costs from 2013-14 onwards excluding the costs of the enhanced reviews detailed in this document. Nor will the proposed fee offset any costs incurred during 2011-2013.
This document relates to the Certification of Death (Scotland) Bill as amended at Stage 2 (SP Bill 58A)

Table 3 Year-on-year costs (inc test sites and level 1 reviews without upgrades)

<table>
<thead>
<tr>
<th></th>
<th>2011-12 Inception</th>
<th>2012-13 Test sites</th>
<th>2013-14 Year one</th>
<th>2014-15 onwards</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical &amp; support staff</td>
<td>£0</td>
<td>£94,000</td>
<td>£1,410,000</td>
<td>£1,410,000</td>
</tr>
<tr>
<td>Support staff</td>
<td>£0</td>
<td>£16,000</td>
<td>£240,000</td>
<td>£240,000</td>
</tr>
<tr>
<td>Analytical staff</td>
<td>£70,000</td>
<td>£70,000</td>
<td>£70,000</td>
<td>£70,000</td>
</tr>
<tr>
<td>Total staff costs</td>
<td>£70,000</td>
<td>£180,000</td>
<td>£1,720,000</td>
<td>£1,720,000</td>
</tr>
<tr>
<td>Total running costs*</td>
<td>£4,200</td>
<td>£16,100</td>
<td>£110,000</td>
<td>£110,000</td>
</tr>
<tr>
<td>Test sites</td>
<td>£0</td>
<td>£40,000</td>
<td>£0</td>
<td>£0</td>
</tr>
<tr>
<td>Initial accommodation</td>
<td>£5,000</td>
<td>£5,000</td>
<td>£30,000</td>
<td>£0</td>
</tr>
<tr>
<td>IT changes &amp; supports</td>
<td>£0</td>
<td>£122,000</td>
<td>£7,000</td>
<td>£0</td>
</tr>
<tr>
<td>GRO promotional</td>
<td>£0</td>
<td>£1,000</td>
<td>£10,000</td>
<td>£0</td>
</tr>
<tr>
<td>e-Learning modules</td>
<td>£0</td>
<td>£57,500</td>
<td>£0</td>
<td>£0</td>
</tr>
<tr>
<td>TOTAL COSTS</td>
<td>£79,200</td>
<td>£421,600</td>
<td>£1,877,000</td>
<td>£1,830,000</td>
</tr>
</tbody>
</table>

18. Assuming the annual number of deaths remains at a similar level to recent years, total fee income of c. £1,200k will be available towards the recurring costs of the model from 2013-14 onwards. The remaining annual recurring costs will be met by the Scottish Government. These will be at least £640k, assuming 0% upgrades from level 1 to level 2 reviews. The costs met by the Scottish Government will increase, depending on the proportion of level 1 reviews referred for level 2 review. Table 4 shows the level of recurring costs increases associated with the proportion of cases proceeding to level 2 for which the SG would be responsible with the level of fee proposed held constant at £22.08.

Table 4 Possible recurring costs to SG associated with level 2 reviews following level 1

<table>
<thead>
<tr>
<th>% Upgrade to level 2 arising from level 1</th>
<th>0%</th>
<th>5%</th>
<th>10%</th>
<th>25%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Recurring costs to SG arising from level 1 reviews</td>
<td>£640,000</td>
<td>£950,000</td>
<td>£1,120,000</td>
<td>£1,780,000</td>
</tr>
</tbody>
</table>
19. Table 5 below summarises the year-on-year costs including the costs of the test sites to the Scottish Government.

Table 5 Year-on-year costs (inc test sites and level 1 reviews assuming 0% upgrades) to the SG, local authorities, other bodies, individuals and businesses

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Costs to SG</td>
<td>£79,200</td>
<td>£420,600</td>
<td>£1,877,000</td>
<td>£1,830,000</td>
</tr>
<tr>
<td>Costs to LAs, other bodies, individuals and businesses</td>
<td>£0</td>
<td>£0</td>
<td>£0</td>
<td>£0</td>
</tr>
</tbody>
</table>

COSTS ON OTHER BODIES, INDIVIDUALS AND BUSINESSES

20. There are no changes anticipated to the costs on local authorities, other bodies individual and business as a result of these proposals.

SAVINGS

21. There are no changes anticipated to the savings to the public as a result of these proposals.
CERTIFICATION OF DEATH (SCOTLAND) BILL

SUPPLEMENTARY DELEGATED POWERS MEMORANDUM

Purpose

1. This Memorandum has been prepared by the Scottish Government to assist the Subordinate Legislation Committee in its consideration of the Certification of Death (Scotland) Bill. This Memorandum describes provisions in the Bill conferring power to make subordinate legislation which were either introduced to the Bill or amended at Stage 2. The Memorandum supplements the Delegated Powers Memorandum on the Bill as introduced.

PROVISIONS CONFERRING POWER TO MAKE SUBORDINATE LEGISLATION INTRODUCED OR AMENDED AT STAGE 2

Section 2 – Power to suspend the referral of certificates during emergencies

New section 24A of the Registration of Births, Deaths and Marriages (Scotland) Act 1965

Power conferred on: Scottish Ministers
Power exercisable by: Order
Parliamentary procedure: Amended to emergency affirmative procedure

Amendment

2. The provision has been amended to replace negative resolution with emergency affirmative procedure. The amendment provides that the order ceases to have effect unless approved by the Scottish Parliament within 28 days of being made. It provides that in counting the period of 28 days, no account is to be taken of time when Parliament is dissolved or in recess for more than 4 days.

Reason for amendment

3. Emergency affirmative procedure has been suggested by the Subordinate Legislation Committee. The Scottish Government agrees that this is appropriate where the operation of primary legislation is sought to be suspended at short notice. The provision for discounting certain periods is necessary, so that in a continuing emergency, an order will not cease to have effect at a time when Parliament is dissolved or in recess.
Section 23(3) – Power to make provision about fees

Power conferred on: Scottish Ministers
Power exercisable by: Regulations
Parliamentary procedure: Amended to negative resolution

Amendment

4. Section 28 (2) has been amended with the effect that affirmative procedure has been replaced by negative resolution in respect of section 23(3).

Reason for amendment

5. The Scottish Government accepts the comment of the Subordinate Legislation Committee that the setting of application fees and arrangements for collection are more usually subject to negative resolution procedure.

Section 28(1A) – Power to suspend the application of section 4 during emergencies

Power conferred on: Scottish Ministers
Power exercisable by: Order
Parliamentary procedure: Amended to emergency affirmative procedure

Amendment

6. The provision has been amended so that negative resolution has been replaced by emergency affirmative procedure. The amendment provides that the order ceases to have effect unless approved by the Scottish Parliament within 28 days of being made. It provides that in counting the period of 28 days, no account is to be taken of time when Parliament is dissolved or in recess for more than 4 days.

Reason for amendment

7. Emergency affirmative procedure has been recommended by the Subordinate Legislation Committee. The Scottish Government agrees that this is appropriate where the operation of primary legislation is sought to be suspended at short notice. The provision for discounting certain periods is necessary, so that in a continuing emergency, an order will not cease to have effect at a time when Parliament is dissolved or in recess.

Schedule 2 – Power to make provision about documentation for cremation

Power conferred on: Scottish Ministers
Power exercisable by: Regulations
Parliamentary procedure: Negative resolution

Amendment

8. Schedule 2 amends section 7 (regulations as to burning) of the Cremation Act 1902 to repeal some wording contained in the power to make regulations about the documentation required before the burning of human remains takes place. Some of that wording is replaced in a
new section 7A and the procedure for any regulations is set out in a new section 7B. There is a consequential amendment of section 2(2) of the Cremation Act 1952, which sets out the current procedure for these regulations.

**Reason for amendment**

9. The power in section 7 obliges the Scottish Ministers to make regulations about forms of notices, certificates and applications that are required before cremation can take place. However, the Bill provides in section 24 (in an insertion into the Registration of Births, Deaths and Marriages (Scotland) Act 1965) that the documentation required for a disposal of a body, whether by burial, cremation or other means, may be prescribed by the Scottish Ministers. There is therefore no further need for mandatory regulations under the 1902 provision.

10. Instead, the replacement wording in the new section 7A is permissive. Many of the documents currently prescribed in regulations made under section 7 will no longer be required under the new system, which, in general, aims to have the same documentation for all types of disposal. There may, however, continue to be a need for some documents, for example an application form to the cremation authority, to comply with the registration requirements that are specific to the Cremation Acts. The replacement wording allows for this.

11. The procedure required for exercise of the power in section 7 of the 1902 Act is provided for in section 2(2) of the Cremation Act 1952. Since it is more helpful to have the procedure in the same Act as the power to make regulations, this part of the 1952 Act has been repealed and the 1902 Act has been amended to insert the new section 7B which provides for negative resolution procedure.

12. The current regulations are subject to negative resolution procedure and the replacement wording maintains this position. This allows for an appropriate level of scrutiny where the power will be used to prescribe documentation such as application forms and is therefore essentially administrative in character.
Dear Christine

HEALTH & SPORT COMMITTEE
CERTIFICATION OF DEATH (SCOTLAND) BILL - STAGE 2

I am writing to provide the further information requested by the Committee during stage 2 proceedings of the above Bill.

Explanation of the statistical basis for the random sampling approach

Firstly, you asked for information on the statistical basis for our proposals for improving the accuracy of cause of death information and, in particular, the mathematical assertion upon which the degree of confidence underpinning the proposals is based. I attach a letter from the Information Services Division (ISD) at NHS National Services Scotland who have been advising us on our sampling approach and who lead on Programme for Quality Improvement (see one page Annex). This is also where the national statisticians will be based who will, under the new system, provide medical reviewers with statistical information relevant to the exercise of their functions.

In relation to the additional 25% random level 1 reviews, I have previously written to the Committee to explain that a 'reasonableness test' has been applied in arriving at that figure, with the recognition that as the number of random reviews will be under Ministerial direction to the registrar, it can be changed upwards or downwards in light of the evidence that we gather from the practice of the new system, including the test sites. Level 1 reviews are intended for deterrence purposes and to provide public reassurance in the new system in line with the concerns raised by the Committee. Overall, taking into account both our proposals and cases reported to the procurator fiscal, around 50% of deaths in Scotland would in future be subject to scrutiny. That means that a doctor in Scotland has potentially a 1 in 2 chance of their certificate being subject to scrutiny.
Checks for implants prior to cremation in relation to deaths abroad

Secondly, you asked for additional information on how the medical reviewer will establish the presence of implants or other devices for deaths that have occurred abroad before a cremation takes place in Scotland to ensure that the body is safe to be cremated.

Currently, crematoria work with funeral directors who, as part of their tasks when preparing or ‘dressing’ the body, check for the presence of pacemakers (external wires etc); in some cases, this information will already have been volunteered by the family. Where such a device is present, the funeral directors will arrange for its removal. Any charge for this is added to the funeral director’s bill. This is current practice and the funeral industry is content for this to continue. Under the new system, for deaths occurring in Scotland, the task of first establishing whether such a device is present will be made easier because the MCCD form is to be revised to require the certifying doctor to include this information (section 25(2) of the Bill allows for such additional information to be included on the MCCD). In the event that such a device is present, that information will be entered on the registration certificate, a copy of which will be passed to funeral directors.

For cases where the death occurs outwith Scotland, that information may not be apparent from the documents provided and we have therefore made it a requirement for the person who wants to arrange the cremation to apply to the medical reviewer to authorise the cremation (this function is currently performed in such cases by medical referees whose posts will be abolished). The medical reviewer will establish the presence of relevant devices through the checking of medical records. Based on our experience of authorising cremations for deaths abroad, in the majority of cases, the deceased will have been resident in Scotland and been on holiday, working abroad or in some cases retired and living abroad and will be, or have been, registered with a medical practitioner in Scotland. Medical reviewers will have, in carrying out this function, wide powers to require the production of relevant documents. The medical reviewer will therefore establish, through the information on the application form, the contact details to access the relevant GP for the medical notes and/or to have a discussion with the GP or medical practice to establish whether or not implants such as pacemakers existed and have been removed, or if they still require to be removed prior to cremation. The medical reviewer will, if necessary, also be able to speak to relatives about the deceased’s medical history.

Healthcare professionals can currently obtain information on medical devices from the Medicines & Healthcare Products Regulatory Agency (MHRA) who regulates the safety of medical devices. There is a safety, warnings, alerts and recalls section on their website: http://www.mhra.gov.uk/Safetyinformation/Safetywarningsalertsandrecalls/index.htm

Dr Simpson suggested that a register of implants could be created. The Scottish Government has looked into this and has had preliminary discussions with officials from the Central Cardiac Audit Database, which is based in London. Currently not all devices are recorded on this database, nor does it extend to all areas of Scotland. This is something that could be explored at a future date, including the costs and benefits of providing and maintaining such a system.

Retained ashes

Thirdly, you mentioned that funeral directors expressed concern about the issue of ‘retained ashes’. At present there is no legislation regulating the collection or disposal of cremated
remains by funeral directors in Scotland. Current legislation only extends to burial and cremation authorities scattering or interring within designated areas of crematorium grounds.

Anecdotal evidence suggests that funeral directors often hold ashes in the hope that relatives will pay for further services to have them placed in a memorial garden, for example, only to find that families often fail to collect them. Funeral directors are then left with the problem of what to do with them. This is an issue which has concerned the funeral industry for many years. It is estimated there are around 100,000 retained ashes across the United Kingdom going back as far as the 1950s.

My officials have had ongoing discussions with members of the National Association of Funeral Directors (NAFD) on this issue, and recently attended a Cross Party Group on Funeral and Bereavement meeting where retained ashes was discussed.

As a result of these discussions it was agreed that as funeral directors are privately run businesses entering into private contractual arrangements, a change in legislation is not necessary or appropriate here; the matter should instead be addressed through good practice guidance to ensure consistency in practice across Scotland.

It would be good practice if in future funeral directors clarified this issue while entering into a contract with the person instructing the funeral. They could specify what was to be done with the ashes to establish how long they would be required to retain them in the event they were not collected. If this was agreed at the outset, they would be able to act according to that contract.

A commitment was given to NAFD that the Scottish Government would support them in the production of guidance to ensure that all funeral directors in Scotland had a common procedure to implement. It was also agreed it would be helpful to designate some suitable places for the respectful disposal of ashes which have already been retained for a number of years.

Definition of 'human remains'

Fourthly, the Committee asked whether the subordinate legislation which will be made under the revised regulation making powers in sections 7 and 7A of the Cremation Act 1902 will define 'human remains' as including parts of a body.

While the term 'human remains' is not defined in the 1902 Act, nor in the current regulations made under the 1902 Act, specific provision is included in the current regulations to deal with the cremation of 'body parts', and these are defined as "any organs and tissues removed from a deceased person during the course of a post mortem examination".

Under the new system, it is unlikely that any specific provision will require to be made in respect of body parts under the revised regulation making powers in the 1902 Act; new requirements for the disposal of bodies of deceased persons will instead be specified in regulations made under the new section 27A(2) of the Registration of Births, Deaths and Marriages (Scotland) Act 1965 (as inserted by section 24 of the Bill). These regulations will specify the particular documents required for the disposal of bodies and section 27A(8) confirms that such regulations can cover the disposal of body parts removed from a deceased person.

Regulations made under section 27A will therefore specify the documentation required for the disposal of:
- body parts of a deceased person used for anatomical examination under the Anatomy Act 1984;
- body parts removed from a deceased person and used for research, education, etc in accordance with section 3 of the Human Tissue (Scotland) Act 2006;
- body parts removed during a post-mortem in accordance with section 28 of the 2006 Act; and
- body parts removed during a post-mortem examination carried out under the authority of the procurator fiscal.

I hope that this information is helpful and clarifies matters. If the Committee requires any further information on any aspects, I would be happy to provide this to you.
STATISTICAL BASIS FOR RANDOM SAMPLING

This letter comments on the size of the random sample proposed for the scrutiny of medical certificates of death (MCCDs) forms by medical reviewers as part of annual audit cycle under the proposed new death certification system.

Sample Size

The appropriate size of the random sample for the annual audit cycle of the new death certification system is dependent upon the level of error one is prepared to accept in the measure of inaccuracy. The key purpose of the annual audit is to estimate the true level of inaccuracy among all death certificates and to monitor these estimates over time. In this way, the effectiveness of interventions made to improve accuracy (e.g. training programmes, guidance issued to doctors) can be assessed.

Any sample can be used to estimate the true proportion of all MCCDs that are inaccurately coded. In order to determine an appropriate sample size, other than the population size, two criteria usually need to be specified: the desired level of precision and the confidence limits which apply to this. The latter are usually set at 95%. In other words, if we were to repeat a test an infinite number of times, then 95% of the time we would make the correct conclusion about the range of values estimated for the error rate, and in 5% of tests the true value of the error rate would be outside the range estimated. This can occur because of random variation.

The level of precision is the range in which the true value for the whole population is estimated to be. Thus, if the sample identifies 15% of MCCDs to be inaccurately recorded with a precision rate of ±3%, then we can conclude that between 12% and 18% of all MCCDs are inaccurately recorded with 95% confidence.

The number of deaths in Scotland in 2009 was 53,856. On the basis of that population size, a sample of 500 would result in a level of precision for the proportion of inaccurately recorded MCCDs of at most ±4.4%, with 95% confidence. To reduce the sampling error to ±3%, again with a 95% confidence interval, would require a larger sample of just over 1,000 MCCDs and a sample of over 8,000 to reduce the error even further to ±1%. It can be seen that there are diminishing returns in terms of levels of precision as sample sizes increase. We believe that a sample size of approximately 1000, which would provide a level of precision of approximately +/- 3% would be reasonable for the stated purpose of the sample, i.e. to estimate the error level in MCCDs and to monitor this over time for improvement purposes.
Subordinate Legislation Committee

Remit and membership

Remit:

1. The remit of the Subordinate Legislation Committee is to consider and report on-

   (a) any-
    
   (i) subordinate legislation laid before the Parliament;
    
   (ii) Scottish Statutory Instrument not laid before the Parliament but classified as general according to its subject matter;
    
   (iii) Pension or grants motion as described in Rule 8.11A.1;

and, in particular, to determine whether the attention of the Parliament should be drawn to any of the matters mentioned in Rule 10.3.1;

(b) proposed powers to make subordinate legislation in particular Bills or other proposed legislation;

(c) general questions relating to powers to make subordinate legislation; and

(d) whether any proposed delegated powers in particular Bills or other legislation should be expressed as a power to make subordinate legislation.

(Standing Orders of the Scottish Parliament, Rule 6.11)

Membership:

Bob Doris (Deputy Convener)
Helen Eadie
Rhoda Grant
Alex Johnstone
Ian McKee
Elaine Smith
Jamie Stone (Convener)
The Committee reports to the Parliament as follows—

1. At its meetings on 8 March 2011, the Subordinate Legislation Committee considered the delegated powers provisions in the Certification of Death (Scotland) Bill as amended at Stage 2. The Committee submits this report to the Parliament under Rule 9.7.9 of Standing Orders.

2. The Scottish Government provided the Parliament with a supplementary delegated powers memorandum on the provisions in the Bill ("the supplementary DPM")¹.

3. The Committee is content with the powers at sections: 2(9) to (11), 28(1A) to (1C) and 28(3).

Delegated powers as amended – section 24A(7) of the 1965 Act (inserted by section 2) and section 4(7)

Stage 1 Report
4. At Stage 1, the Committee reported with recommendations in relation to the powers in sections 2 (suspension of referral of certificates for review during emergencies) and 4(7) (suspension of applications under section 4 during emergencies.

5. The Government responded to the Committee’s stage 1 Report in these terms—

“In relation to the delegated powers in sections 2 and 4(7), the Scottish Government confirms that it will seek to amend the Bill at Stage 2 to adopt the emergency affirmative procedure for these powers, discounting periods of recess.”

¹ Supplementary Delegated Powers Memorandum
Section 2 (suspension of referral of certificates for review during emergencies)

6. The Committee’s recommendation in relation to section 2 has been taken forward in the amendments at section 2(9) to (11).

Section 4(7) (suspension of applications under section 4 during emergencies)

7. The Committee’s recommendation in relation to section 4(7) has been taken forward in the equivalent amendments in section 28(1A) to (1C) (orders and regulations).

8. These amendments provide for the “emergency affirmative” procedure. A suspension order must be laid in Parliament and ceases to have effect at the end of 28 days beginning with the date on which it was made, unless before the end of that period, the order has been approved by resolution of the Parliament. (No account is taken of any period of dissolution, or recesses of more than 4 days.) The Committee is content that this addresses its concern about the procedure for scrutiny of suspension of the requirements for review of medical certificates.

Revocation of orders of suspension

9. The Committee notes that the Scottish Government’s amendments do not provide separately for the parliamentary procedure applicable to the revocation of a suspension order. The Committee notes that this would have the effect of requiring that revocation orders are approved within 28 days in order to continue in effect. A revocation order simply reinstates the requirements for the review of medical certificates set out in the Bill, therefore the Committee considers that it is not appropriate for such an order to be subject to a requirement for approval.

10. **The Committee therefore recommends that orders which revoke orders of suspension made under section 24A(7) of the Registration of Births, Deaths and Marriages (Scotland) Act 1965 or under section 4(7) of the Bill should be subject only to the requirements of section 30 of the Interpretation and Legislative Reform (Scotland) Act 2010 which sets the new default requirements for scrutiny of Scottish statutory instruments from 6 April 2011.**
Certification of Death (Scotland) Bill – Response from the Minister for Public Health

Background

1. The Subordinate Legislation Committee reported on the delegated powers in the Certification of Death (Scotland) Bill as amended at Stage 2 on 8 March 2010 in its 20th Report 2011.

2. In the report, the Committee recommended that orders which revoke orders of suspension made under section 24A(7) of the Registration of Births, Deaths and Marriages (Scotland) Act 1965 or under section 4(7) of the Bill should be subject only to the requirements of section 30 of the Interpretation and Legislative Reform (Scotland) Act 2010 (laid only).

Response from the Minister for Public Health

3. The Minister for Public Health has written advising the Committee, as a matter of courtesy, that she has brought forward amendments to achieve this intention. The only difference being that any revocation orders brought forward under these sections would be subject to the negative procedure.

4. The amendments were lodged on Wednesday 9 March and are attached, along with the letter, in the annex.

Recommendation

5. Members are invited to note the Minister’s response on this matter.

Irene Fleming
Clerk to the Committee
ANNEX

Correspondence from the Minister for Public Health dated 10 March 2011

CERTIFICATION OF DEATH (SCOTLAND) BILL - Stage 3

I write to advise the Committee that Government amendments have been lodged to the above Bill to be considered at stage 3 which adjust the procedure applicable to certain powers in the Bill. A copy of the amendments is attached to this letter.

It has come to my attention that the Subordinate Legislation Committee considered the Bill as amended at stage 2 at its most recent meeting and recommended that orders which revoke orders of suspension made under section 24A(7) of the Registration of Births, Deaths and Marriages (Scotland) Act 1965 or under section 4(7) of the Bill should be subject only to the requirements of section 30 of the Interpretation and Legislative Reform (Scotland) Act 2010.

Prior to learning of the Committee’s recommendation on this point, we had already given consideration to the procedure which should apply to orders which revoke orders of suspension and we came to the view that such orders should be subject to negative procedure. We considered that negative procedure was to be preferred over affirmative procedure in this circumstance as it would not be appropriate to take up Parliamentary time to deal with the revocation of a suspension order. We were also aware that this approach followed a recent precedent where negative procedure was used in a similar power in section 12(7) of the Patient Rights (Scotland) Bill, and that the Committee were content with that provision.

The deadline for lodging Government amendments was Wednesday 9th March and our amendments had already been lodged prior to the Committee’s report being made available. We were therefore unaware of the Committee’s recommendation on this point.

A further minor amendment is made to section 28 of the Bill; this is consequential on amendments made to section 28 at stage 2 and simply removes a reference to ‘regulations’ which is no longer relevant to section 28.

SHONA ROBISON
MINISTER FOR PUBLIC HEALTH
Section 2

Shona Robison

1 In section 2, page 2, line 31, after <(7)> insert <(other than one to which subsection (9B) applies)>.

Shona Robison

2 In section 2, page 2, line 35, at end insert—

<(9A) Subsection (9B) applies to an order made under subsection (7) consisting only of—

(a) provision revoking an earlier order made by virtue of subsection (7), or

(b) such provision and provision made by virtue of subsection (8)(a).

(9B) An order to which this subsection applies is subject to annulment in pursuance of a resolution of the Parliament.>

Section 28

Shona Robison

4 In section 28, page 15, line 15, after <4(7)> insert <(other than one to which subsection (1AB) applies)>.

Shona Robison

5 In section 28, page 15, line 19, at end insert—

<(1AA) Subsection (1AB) applies to an order made under section 4(7) consisting only of—

(a) provision revoking an earlier order under section 4(7), or

(b) such provision and provision made by virtue of section 28(1)(b).

(1AB) An order to which this subsection applies is subject to annulment in pursuance of a resolution of the Parliament.>

Shona Robison

6 In section 28, page 15, line 28, leave out <regulations or>
Certification of Death (Scotland) Bill

Marshalled List of Amendments selected for Stage 3

The Bill will be considered in the following order—

Sections 1 to 31
Schedules 1 and 2
Long Title

Amendments marked * are new (including manuscript amendments) or have been altered.

Section 2

Shona Robison
1 In section 2, page 2, line 31, after <(7)> insert <(other than one to which subsection (9B) applies)>

Shona Robison
2 In section 2, page 2, line 35, at end insert—

<(9A) Subsection (9B) applies to an order made under subsection (7) consisting only of—

(a) provision revoking an earlier order made by virtue of subsection (7), or
(b) such provision and provision made by virtue of subsection (8)(a).

(9B) An order to which this subsection applies is subject to annulment in pursuance of a resolution of the Parliament.>

Section 8

Ian McKee
3 In section 8, page 5, line 36, at end insert—

<( ) make enquiries of any other person who the medical reviewer considers may have information about the health of the deceased person (for example, a member of the deceased person’s family, a carer or a nurse),>
After section 23

Dr Richard Simpson

7 After section 23, insert—

<Conduct of pilot schemes

Conduct of pilot schemes

(1) For the purposes of any pilot scheme under this Act, the Scottish Ministers may provide for medical certificates of cause of death to be created in an electronic form.

(2) Medical certificates of cause of death created in an electronic form must have an electronic signature from the medical practitioner who attested to the certificate.

(3) For the purposes of any pilot scheme under this Act, whether or not the medical certificates of cause of death are to be created electronically, the medical certificate of cause of death must include the following information in relation to the deceased person—
   (a) ethnicity,
   (b) the presence or otherwise of a healthcare associated infection,
   (c) where the deceased person is to be cremated, a record of the next of kin’s acceptance that as far as they are concerned the information contained in the medical cause of death certificate is correct, and
   (d) such other information as the Scottish Ministers consider would assist in—
      (i) epidemiology,
      (ii) informing the deceased person’s family of the need for familial screening,
      (iii) promoting patient safety,
      (iv) other matters of public confidence or public health.

(4) In this section “electronic signature” has the meaning attributed to it in section 7(2) of the Electronic Communications Act 2000.>

Section 28

Shona Robison

4 In section 28, page 15, line 15, after <4(7)> insert <(other than one to which subsection (1AB) applies)>.

Shona Robison

5 In section 28, page 15, line 19, at end insert—

<(1AA)Subsection (1AB) applies to an order made under section 4(7) consisting only of—
   (a) provision revoking an earlier order under section 4(7), or
   (b) such provision and provision made by virtue of section 28(1)(b).

(1AB)An order to which this subsection applies is subject to annulment in pursuance of a resolution of the Parliament.>
In section 28, page 15, line 28, leave out <regulations or>
Groupings of Amendments for Stage 3

This document provides procedural information which will assist in preparing for and following proceedings on the above Bill. The information provided is as follows:

- the list of groupings (that is, the order in which amendments will be debated).
- the text of amendments to be debated at Stage 3, set out in the order in which they will be debated. **THIS LIST DOES NOT REPLACE THE MARSHALLED LIST, WHICH SETS OUT THE AMENDMENTS IN THE ORDER IN WHICH THEY WILL BE DISPOSED OF.**

**Groupings of amendments**

**Group 1: Procedure for revoking orders suspending the referral and review of medical certificates of cause of death**
1, 2, 4, 5, 6

**Group 2: Conduct of review of medical certificates of cause of death**
3

**Group 3: Creation and content of medical certificates of cause of death in any pilot scheme under this Act**
7
Certification of Death (Scotland) Bill - Stage 3: The Bill was considered at Stage 3.

The following amendments were agreed to without division: 1, 2, 3, 4, 5 and 6.

Amendment 7 was moved and, with the agreement of the Parliament, withdrawn.

Certification of Death (Scotland) Bill - Stage 3: The Minister for Public Health and Sport (Shona Robison) moved S3M-8126—That the Parliament agrees that the Certification of Death (Scotland) Bill be passed.

After debate, the motion was agreed to (DT).
The Deputy Presiding Officer (Alasdair Morgan): The next item of business is stage 3 proceedings on the Certification of Death (Scotland) Bill. By this point in the session, members should know which documents they need in front of them, so I will not tell them again.

Section 2—Referral of certain medical certificates of cause of death for review

The Deputy Presiding Officer: Group 1 is on the procedure for revoking orders that suspend the referral and review of medical certificates of cause of death. Amendment 1, in the name of the minister, is grouped with amendments 2 and 4 to 6.

The Minister for Public Health and Sport (Shona Robison): Amendments 1, 2, 4 and 5 relate to the procedure that surrounds orders for the suspension of the review system during periods of epidemics or other similar emergencies. As the bill stands, to revoke such orders when the period of emergency is over, it would be necessary to use the same emergency affirmative procedure as applies to the making of such orders. The amendments will enable negative procedure to be used to revoke such orders, which we consider is more appropriate.

Amendment 6 is consequential on amendments that were made to section 28 at stage 2. It will simply remove a reference to “regulations” that is no longer relevant to that section.

I move amendment 1.

Amendment 1 agreed to.

Amendment 2 moved—[Shona Robison]—and agreed to.

Section 8—Review of medical certificates of cause of death

The Deputy Presiding Officer: Group 2 is on conduct of review of medical certificates of cause of death. Amendment 3, in the name of Ian McKee, is the only amendment in the group.

Ian McKee (Lothians) (SNP): I realise that section 8(2)(c) is rather a catch-all provision, but it is important that it be a little bit more specific. Accordingly, I have lodged amendment 3, because I think that interrogating relatives, carers or anyone who was involved in looking after the deceased in the final days of their terminal illness is important in ensuring the death certificate’s accuracy. Of course, in the vast majority of such instances, their evidence will corroborate the information on the certificate; nevertheless, even then, that confirmatory evidence will be welcome.

However, in a proportion of cases, remarks by such witnesses on, for example, the mode of death or the symptoms exhibited before death, or even just casual comments about medication that was taken or treatment given could prompt a medical reviewer to follow a new line of investigation that might result in a more accurate certificate at the end of the process. Such contact would also serve to reassure the relatives or carers that such matters are not treated lightly and might even allow them to come forward with concerns that would otherwise never be mentioned.

I move amendment 3.

Ross Finnie (West of Scotland) (LD): I have much enjoyed working with Ian McKee and wholly support the substance of his amendment 3. However, it is a pity that it is ungrammatical. Given that the subject of the sentence in section 8(2) is “the medical reviewer”, the use of the subjective pronoun “who” instead of the objective pronoun “whom” in the amendment is, I think, much to be regretted.

The Deputy Presiding Officer: Do you wish to add anything, Mr McKee?

Ian McKee: I just want to confirm Ross Finnie’s admirable point. I had a little help in drafting the amendment, but obviously one needs to look a little bit harder at any help that one receives.

Amendment 3 agreed to.

After section 23

The Deputy Presiding Officer: Group 3 is on creation and content of medical certificates of cause of death and any pilot scheme under the act. Amendment 7, in the name of Richard Simpson, is the only amendment in the group.

Dr Simpson: Amendment 7, which follows on from the Health and Sport Committee’s stage 1 report and observations that I have made at each
stage of the bill’s progress, has two interconnected purposes. First, I wish to test whether the minister has taken on board the need for urgency in moving from a 19th century paper-based system to a 21st century electronic system, and I hope that she will indicate either now or in the following debate progress in and the potential timelines for developing an electronic system. I believe that any hasty move to a set of paper pilots that would have to be followed by an electronic certification system pilot would be a duplication that we can ill afford and might indeed be counterproductive. That would be true in times of plenty, but these are times of austerity and the waste involved could be significant.

The second purpose of amendment 7 is to point out that this is an opportunity to modernise the certification process not only by making it electronic but by ensuring that the data can truly inform our health planning. Despite certain doubts about the potential to analyse certification in electronic form, I believe that individual doctors could be shown to be outliers on the basis of the cumulative analysis of their certificates.

At present, the ability to link data from such sources to 2001 census data is inadequate, and I hope that the minister will take note of the difficulties in that respect for future reference. Cumbersome bureaucratic elements make that linking difficult to deal with. That is important, because the 2001 census is one of the main sources of ethnicity data, and we know that we will be able to plan our services better if we have good recorded ethnicity data.

I will give an example that was given in a debate that the minister, Ross Finnie and I were involved in last night. According to research, there is a much higher level of diabetes in the south Asian community, but we do not know whether that finding is valid in a Scottish context. If we had good electronic data in which ethnicity was always recorded, we would have the opportunity to examine that matter.

Another issue is health care acquired infection. Having notes on death certificates that say whether health care acquired infection was present and whether it contributed directly or indirectly to the death is important in ensuring that the excellent progress that has been made in dealing with MRSA and Clostridium difficile is maintained in dealing with VRE, NDM-1 and all the other new challenges that are now coming along and rearing their ugly heads. Things can be done much more easily on electronic forms. It would simply be a matter of saying whether there was or was not infection; if there was, there would be further drop-down boxes for answers. That is difficult to do with paper.

The consent of next of kin suggestion is to ensure that, in the reduced review climate, which remains one of the committee’s concerns, the next of kin acknowledge that they are content with the death certificate. Such an approach would be welcome. I realise that there is the opportunity in the bill for kin to require or request a review, but the proposal would go further than that—it would trigger the next of kin to think and to indicate whether they were content. They might not have thought of the matter, but if they were asked to think of it they could say, “Well, now you come to mention it, actually we’re really not that happy because something has been omitted from the death certificate.”

The final proposal would allow ministers to add any information that they thought was useful. Familial screening is mentioned. If there was electronic linkage, there would be the ability to ensure, for example, that familial hypercholesterolaemia, which is currently poorly screened for, was screened for. We could have a system that automatically sent a trigger to the general practitioner when a person with a condition for which familial screening was appropriate had died, to suggest that family members be contacted and screened.

I would make it an absolute requirement that the community health index number be entered. That is fundamental to the data linkage system that we must have in Scotland. Without a CHI number, a big piece of the jigsaw is missing. Requiring it is of great importance. I recognise that there is a difficulty with that, as the hospital side is not yet 100 per cent using CHI numbers and junior doctors are filling in things. Nevertheless, having access to the emergency care record that every doctor should have access to, that should be available for every patient, and that should have the CHI number recorded on it will allow us to have a modern, 21st century system.

As I will say in the final debate, I remain disappointed by the bill. It was introduced as a result of Shipman, for many good reasons, but by moving so quickly to a paper-based system we have failed to take the opportunities that we need to take.

I move amendment 7.

**Shona Robison:** I do not support amending the bill to introduce discretionary powers to create electronic medical certificate of cause of death forms for use during the test site phase. That would be unnecessary, and would be likely to delay the start of the test sites in the new system. I have already made a commitment to exploring the feasibility of electronic MCCDs. Such a feasibility study would examine various options, including the different information technology solutions that
are available and the different methods of verifying the identity of the certifying doctor.

As we all know, devising IT systems can be complex, costly and time consuming, with long lead-in periods. We are talking about a new IT system for which the business case has not yet been made and the costs, practical considerations and timescales have not yet been fully explored. I do not wish to jeopardise the implementation of the new death certification system. It is fair to say that the new processes that the bill will introduce mark a significant departure from current practice. There is a risk that trying to test the operation of a completely new process at the same time as introducing a new electronic system would be overly complex and that the operational difficulties of one might have a negative impact on the other. For that reason, we think that it is sensible to test the operation of the system outlined in the bill first. Only then will we be able to judge whether it is necessary to introduce electronic completion of MCCDs. However, as I have said, I see the potential benefits of electronic completion of MCCDs and I undertake to consider the feasibility of introducing such a system.

Amendment 7 would require additional information to be added to the MCCD for use during the piloting of the test sites. I cannot support that. Again, there is a risk that making the inclusion of that information mandatory would result in complications and cause delays during the testing of the new system. For example, in cases in which the deceased was to be cremated, the amendment would require the recording of the next of kin’s acceptance that the information on the MCCD form was correct. Delays could quite easily result if there were difficulties locating the next of kin or it was not known at the point of completion of the MCCD whether the deceased wished to be cremated.

Further, it would potentially be insensitive to pressure the next of kin to make a decision about the adequacy of the MCCD so close to the death. That is why we have provided an opportunity in the bill for certain family members to apply within three years of the death to have the MCCD reviewed by an independent medical reviewer. Also, we do not think that it is appropriate to require the other additional information to be included in every MCCD used during the piloting of the test sites. That would make completion of the forms more complex and time consuming, which might have a negative impact on the main objective of testing the system that is set out in the bill. The bill makes provision to allow additional medical information to be included in MCCDs. The General Register Office for Scotland has recently consulted on that issue. There is therefore no need for that information to be added to MCCDs for the purposes of the test sites. The results from the test sites may lead to some of the changes that Richard Simpson is arguing for today.

For those reasons, I oppose amendment 7.

Mary Scanlon (Highlands and Islands) (Con): I understand the minister’s response and appreciate what she said at stage 2. None of us would wish to delay funerals, which would be difficult for families. I also appreciate what the minister said about the proposals being costly and complex and having a long run-in period. However, we had 100 years prior to the bill to change practice. This is the first change in 100 years. We have had 12 years of a Scottish Parliament. Perhaps Richard Simpson has a good point.

I also have a more general point, on an issue that the Health and Sport Committee has considered over the years. Generally speaking, the national health service is extremely slow to adapt to e-health, telehealth, clinical portals and any other electronic system. I still have to write a letter to my doctor or turn up in person at the surgery in order to get a prescription—something that for many years could have been done electronically. Even the electronic bed management system is operated differently in different health boards.

While I have sympathy for Richard Simpson’s point, I understand the minister’s response. When we are faced with legislation in future, surely it is incumbent on the bill team, ministers and all of those who prepare bills to ask themselves, “Can we introduce technology at this point that would make things better now and in future, and that could be utilised to the benefit of all?”

My final point is one that I will also mention in my summing up. I am not yet sure that we have secured the provision of full and accurate information on the death certificate, although that is a proposition of the bill. It would be helpful if an electronic system managed to integrate information on hospital-acquired infections, as well as any other information that is useful to future public health planning.

10:30

Dr Simpson: I am slightly disappointed by the minister’s response, but I will seek to withdraw amendment 7. Subsection (1) of the amendment states:

“the Scottish Ministers may provide for medical certificates of cause of death to be created in an electronic form.”

We already have an electronic form—we are not starting from scratch. ISD Scotland enters the data in an electronic form. The Health and Sport
Committee received evidence from Colin Fischbacher that he must make 2,000 inquiries a year about deaths, although he does not get information back, because there is no compulsion to change the current paper reporting, which is bizarre. Nevertheless, a system exists that ends up with an electronic form.

Given that we start from that point and given—I assume—that all deaths will have to be coded, it does not seem that we should not make progress. That is why I am disappointed. In rejecting my amendment, the minister used words like “will” and “can in the future look at”. The committee said clearly in its report, which was published on 21 January, that technology was important for the future. I believe that the minister should have said, “We have already commenced the process of examining the issue.” However, I will seek to withdraw amendment 7.

Amendment 7, by agreement, withdrawn.

Section 28—Orders and regulations

Amendments 4 to 6 moved—[Shona Robison]—and agreed to.

The Deputy Presiding Officer: That ends consideration of amendments.

Certification of Death (Scotland) Bill

The Deputy Presiding Officer (Alasdair Morgan): The next item of business is a debate on motion S3M-8126, in the name of Shona Robison, on the Certification of Death (Scotland) Bill.

10:32

The Minister for Public Health and Sport (Shona Robison): We are debating a bill that will provide us with a proportionate and robust approach to the scrutiny of death certification. The proposals will lead to a modern Scottish death certification system that is sensitive to bereaved families’ needs.

The bill will introduce a single system of independent scrutiny of medical death certificates that will apply to deaths that do not require a procurator fiscal investigation. The system is based on one of the models that the independent expert burial and cremation review group proposed. The review group was established in 2005 and reported in 2007. Last year, I consulted on all its recommendations. The bill relates to the certification of death aspects.

Most consultation respondents supported our preferred model, which forms the basis of the bill. They included all the respondents who represented patients and consumers, as well as the majority of local authorities and of public bodies and half the medical respondents, including the Royal College of Physicians of Edinburgh, the Royal College of Physicians and Surgeons of Glasgow and the General Medical Council.

The new system will replace the current crematoria medical referee system and the associated forms and will therefore abolish all the cremation fees that families pay to doctors. The bill will remove the historical differences between cremation and burial, which were introduced when medicine was less advanced and when it was believed that more stringent measures were needed for cremations, because the evidence of the body would be destroyed.

In fact, as the independent expert review group concluded, after a body has been embalmed and buried, often little forensic information is available even when the body is exhumed, particularly if it is exhumed after a significant time. This is why we came to the view that the additional checks in cremation cases led to expenses and delays without providing benefits for families or value for money.

No death certification system can guarantee to prevent criminal activity such as that which Harold
Shipman carried out, but our proposals are robust and have been designed to deter malpractice and provide public reassurance. It is important that the new death certification system will benefit bereaved families, to whom we owe a duty to ensure that any new system will minimise distress, avoid undue delay to funerals and be affordable.

Nowadays, the majority of families opt for cremation. Once the new system commences, they will no longer have to pay cremation fees, which are currently £147 plus an additional fee for the medical referee. Instead, a universal fee of about £30 will be charged. In addition, individuals will for the first time be empowered to request a review of the information in the certificate if they have concerns.

I stress that, at the heart of the future Scottish system, the emphasis will be on improving the quality of death certification. To that purpose, the independent medical reviewers will undertake 1,000 random comprehensive reviews, as well as additional targeted reviews. Actions following those reviews will be part of a quality improvement programme, and will include direct feedback to the certifying doctors, further investigations of the case, links with clinical governance, and training and educational activities.

The role of the new national statistician will be important. Regular statistical tests will be run on all death data and any unusual results will be identified and reported to the medical reviewers. Furthermore, following concerns expressed in the committee about deterrence and public reassurance, medical reviewers will also randomly scrutinise 25 per cent of all deaths—around 13,500 in all—by way of shorter level 1 reviews. That means that, when those deaths are combined with the number of cases that are reported to the procurator fiscal each year, around 50 per cent of deaths in Scotland will be subject to scrutiny. In other words, a doctor will have a 1 in 2 chance of their certificate being scrutinised.

At stage 2, we introduced amendments in response to concerns raised by the Health and Sport Committee and by stakeholders about where responsibility for checking foreign certificates associated with deaths overseas should lie. I reflected on that matter and listened to stakeholder concerns about the proposals in the bill to give that function to superintendents at local burial grounds and crematoria. The bill was then amended at stage 2 to require the medical reviewers office to carry out that function instead.

The bill’s fee provisions have been amended to allow for fees to be set below cost recovery. That follows a commitment that I made earlier, when I outlined additional reviews that will give rise to increased costs but which are to be paid for by the Scottish Government rather than through fees. The fee therefore will remain at around £30 per case, including costs for collecting the charge. We also amended the bill to clarify that we do not intend to charge a fee for the checking of foreign certificates.

If the bill is approved today, we will consult further on operational matters and the secondary legislation that will be required to implement the system. We acknowledge the need to continue to work with stakeholders, including the general public, on the test sites—which are scheduled for the following year—before the implementation of the new system, which is scheduled to take place during 2013-14. Of course, it is not just a matter of legislation and guidance; good communication and awareness raising will also be key activities in the next phases. I believe that we have a solid base on which to build and I look forward to the work coming to fruition.

I thank the Health and Sport Committee for its sterling work on this bill. As ever, the process has been very constructive. I also thank the committee’s clerks, who worked very hard, and I put on record my thanks to the bill team, who took on a significant piece of work with this bill.

I move.

That the Parliament agrees that the Certification of Death (Scotland) Bill be passed.

10:38

Dr Richard Simpson (Mid Scotland and Fife) (Lab): I would like to add to the minister’s thanks by thanking the witnesses who appeared before the committee. They were extremely helpful. In the Scottish Parliament, we go through a particular process with bills. First, there is a review by an expert group—in this case, there was a United Kingdom review of death certification, which led to changes being made in England. The review is followed by a consultation document, and then by a committee’s taking of evidence. It is often during those face-to-face evidence sessions that significant problems become apparent in the bill proposal. We probably need to examine carefully how often that has happened, and to consider what might have been done during the consultation process.

The major flaw with this bill was the level of scrutiny. Originally, the bill arose as a result of the Shipman case. Although the committee and the Government agreed that no system could ever have prevented someone as devious and psychopathic as Shipman from operating, public confidence must be retained. As the bill has gone through its stages, we have reached a point at which 50 per cent of death certificates will be scrutinised. That is a satisfactory move, but we will have to review and examine it in future. In
England, a 100 per cent review rate has been adopted, but the costs of that are very much greater. We have a lower-cost system, but it has yet to be demonstrated that it will fully retain the confidence of the public.

The procurator fiscal review—half of cases are to be so reviewed—can be quite cursory, I remember, and I will be interested to hear the views of my colleague Dr McKee on that, if he speaks in the debate. I found that there were occasions on which a death occurred somewhat more suddenly than had been expected, although there were no suspicious circumstances. Nevertheless, because the death had occurred more suddenly, or because we did not have adequate information, since the person was a visitor to our committee—I mean a visitor to our practice area—

Stewart Stevenson (Banff and Buchan) (SNP): Committees have that effect.

Dr Simpson: Yes. Thank you, Stewart—I have lost my train of thought now.

In the case of a sudden death where we did not know a lot about the patient and we did not have a huge amount of information, our phone call to the procurator fiscal would prompt the question whether we had any real concerns. My response would typically be, “No, I have no real concerns,” so we would then be told, “Thank you very much—go ahead and do the certificate.” That is not a review.

We will need to consider the provisions carefully. We will need to consider the training of procurators fiscal and of doctors so as to ensure that, if we are to rely on half of all reviews being undertaken by the procurator fiscal, an adequate process is followed.

I do not wish to reiterate all the arguments that I advanced in earlier debates on the electronic aspect, but I remain disappointed that, in her opening speech at this final stage of the bill, the Minister for Public Health and Sport yet again did not mention electronic certification. I urge the Government and the minister, even at this very last, drying stage of the present Government—I had to get that in—to commit civil servants to commence consideration of the electronic aspect during the forthcoming interregnum period. We have had two months already; let us have some urgency on the matter. Let us consider what currently exists in the Information Services Division and let us begin now to examine the possibilities for developing a modern system. Although the minister said in her speech that we have a modern system, it is not—it is a revised system, based on an old paper system, with all that system’s flaws.

I still have concerns about the signature on the certificates. Previously, two thirds of them would be reviewed by a second and third doctor. Now, a junior hospital doctor will be able to sign the certificates, and no further review will occur in 50 per cent of cases—although it will vary from individual to individual.

I would like the guidance or the regulations to provide for a system that specifies that no foundation year 1 or foundation year 2 doctor should be able to sign the certificates; only those with specialist training in the hospital—what used to be called registrars—should be able to do that. Alternatively, there should be a counter-signature from the responsible consultant, to make sure. Furthermore, doctors should go through a specific training module.

All of that underlies my concern about retaining public confidence, which is fundamental to the revised system. Two thirds of individuals will welcome the fact that costs will go down from £160 to £30. On the subject of costs, I ask the minister to clarify something that she said earlier when she sums up: that there will not be a charge in relation to overseas deaths. I assume that there will still be a £30 charge—or will there be no charge whatever for people who die abroad? If that is the case, we will perhaps, as with the Eskimos, start to ask our elderly relatives to go to another country, albeit briefly, so as to save some money. That will not happen, of course, but I ask about the possibility of there being no charge. The system for overseas deaths that is now being put in place is a good one, with the central review, which I think will work well.

We have dealt reasonably well with expedited certification for faith burials, particularly for Jewish and Muslim groups. As we come to scrutinise the regulations and guidance, we will have to invite the Subordinate Legislation Committee to examine the matter carefully, with our colleagues in the Jewish and Muslim faith groups, so that the regulations ensure that the post hoc review system will be appropriate.

The bill has been amended appropriately, and I am glad that the Government responded entirely appropriately to the committee’s initial serious concerns. We will now have a modern, proportionate system—except for the fact that it should have been an electronic system from the outset.

10:45

Mary Scanlon (Highlands and Islands) (Con): I thank the witnesses, in particular Professor Stewart Fleming and Ishbel Gall, who scrutinised the bill effectively at all stages.
I am pleased that we have reached stage 3, at the tail end of the parliamentary session, but I remain uncertain whether the bill will lead to a system that is more robust than the current arrangements and more likely to identify a potential Harold Shipman or even provide us with more information on cause of death, as Professor Fleming said when he gave evidence and as Richard Simpson said in the debate. Although I remain unconvinced by the bill, I am a non-clinical member of the Health and Sport Committee. I am concerned, however, that the two highly experienced doctors on the committee also have reservations about it.

The bill has changed radically since it was introduced, as a result of the evidence that the committee heard and the minister’s evidence at the end of stage 1. That demonstrates how poorly the measures on certification of death in the bill as introduced reflected 21st century life, and it calls into question the extent to which the minister and the bill team took on board the written evidence that was submitted during the consultation. The committee heard the same concerns expressed in oral evidence at stage 1.

Although up to 1,000 level 2 reviews will be more detailed than is currently the case, level 1 review and certification, which it is alleged will cover up to 25 per cent of deaths, will be significantly less detailed than is currently required. The minister has assured us that the number of level 1 and level 2 reviews can be adjusted up or down and that the matter will be covered in guidance.

However, the bill will be passed in the final days of this session of the Parliament. In May we will have new committees with responsibility for health and subordinate legislation, and, perhaps, a new health minister. The members who agree to the statutory instruments that provide for the guidance will likely be unaware of the serious critical written and oral evidence that has been provided and there is the potential for the number of reviews to be adjusted downwards to the unacceptable levels that were provided for in the bill as introduced.

We have been given assurances on the two pilots that will take place prior to full implementation. However, given discomfort at a review rate of 4 per cent of death certificates—that is up from the 2 per cent in the bill as introduced—will the minister consider having one of the pilots review 4 per cent and the other review a much higher number, for example 10, 20 or perhaps 30 per cent of certificates? Such an approach would enable the new system to be evaluated and might be better than having two pilots—one in an urban area and one in a rural area—in which the rate would be exactly 4 per cent.

Currently, 62 per cent of deaths in Scotland result in cremation. Three doctors check the death certificate in cremation cases, two of whom are not part of the professional practice of the first doctor. After the bill is passed, not three doctors but one doctor will check the death certificate—yet we are told that that is an improvement.

How many of the 25 per cent of deaths that are currently referred to the procurator fiscal are subject to medical examination and review? I understand that the number is likely to be low, and clarity on the issue would be helpful. Will the minister respond in writing on that?

The Scottish Conservatives will support the bill, given that further changes will be made through guidance. We trust that the reservations that have been expressed throughout the bill’s passage will be taken on board by the Government and whatever Administration is tasked with issuing guidance after the election in May.

10:49

Ross Finnie (West of Scotland) (LD): The bill was interesting. When it first came before the Health and Sport Committee, there was a sense that it was a relatively simple matter and that it would be disposed of relatively quickly. However, it proved to be rather different once we got into the detail.

As the minister pointed out, the proposal was based on extensive work by a review group and the model that the Government chose was one of those that the group put forward. I am bound to repeat the comment that I made at stage 2, which supports Richard Simpson’s comment, that the review group itself pointed in the direction of using electronic recording. I can see that there are difficulties when, at a rather late stage in the proceedings, members make clever suggestions that are difficult to encapsulate, but electronic recording was part of the review group’s recommendations, so I share the disappointment that attention was not given at an earlier stage to the possibility of, and the benefits that might accrue from, adopting such a system.

The second issue that quickly arose was the level of scrutiny. I do not necessarily share the view that it is possible to find a Shipman. None of the reviews says that it is and nobody seriously suggests that an individual who is determined wilfully to avoid any form of checking will be subjected to such a test under any system. However, as Richard Simpson made clear, there is a need for public confidence. The comparison was between the level of scrutiny that was applied to cremation cases and the level that was applied to burial cases. The evidence was clear and we were left uncomfortable about the level of review.
I am grateful to the Government for increasing its level of scrutiny. I am also grateful to the minister for writing to the convener of the committee setting out a matter that caused me some concern, which was the statistical basis for the ramblings—sorry, I mean the random sampling approach; it is quite difficult to say. The statistical basis for that random sampling, which was conducted by the Information Services Division at NHS National Services Scotland, is set out clearly in the letter and the accompanying one-page note.

Having considered that information, I am greatly encouraged by the combination of preparation for, and review of, the system. However, the minister must be clear that, because of the very different way in which the system will operate, it is imperative that there be clear, open and transparent review and that the results of any such review be published.

I am not sure about the level of doctors’ competence. I do not know whether they have the competence to fill in a death certificate when they qualify or whether they need many years’ experience before they can fill one in. That is a matter about which only medical people can tell me. However, death certification is important and I share Richard Simpson’s view that it is a question of establishing public confidence.

The minister dealt with other matters satisfactorily in her response to the committee’s recommendations. Those concerned not only the medical review, but bringing medical reviewers into the ambit of the check on overseas deaths. She also responded to the evidence about the necessity to expedite procedures to meet the requirements of faith groups. Those responses made substantial improvements to the bill.

The changes that have been introduced radically change the bill, which is much stronger as a result of the committee process. We need to monitor progress carefully in certain areas, but I am satisfied that the bill is worthy of support at decision time.

10:54

Ian McKee (Lothians) (SNP): There is some belief that the bill is a dull affair and that it is just rather technical. However, information from death certification can have a major effect on future health expenditure. If a series of recordings showed that one condition or another was on the increase, but the recordings were inaccurate and the information incorrect, huge sums of money might be spent on the wrong priority.

It is important that we get things as right as we can, although, short of allowing for 100 per cent post-mortem examinations—and even then—there will always be inaccurate certificates whatever we do. From that perspective, I welcome the bill, as it aims to improve the accuracy of death certification by education and supervision and includes disposal by burial in its remit. There are some points of concern, however, which I raise in the light of my years of experience of the issue.

The bill provides for the appointment of medical reviewers and the minister has informed us that those might be part-time appointments. I think it vital that they are part-time appointments. That will mean that more individuals can be medical reviewers for the same financial outlay, so the geographical spread can be greater, meaning that the reviewer will have more local knowledge. It is important that a medical reviewer keeps up to date with clinical practice, which will be much more difficult, if not impossible, for someone who spends the entire time following up death certificates.

I have a major concern about the number and type of reviews that are implied by the financial memorandum and about which we have been informed by the minister. First, 25 per cent of deaths will be covered by a level 1 review, which seems to be little more than a telephone conversation with the certifying doctor. Although careful questioning might reveal one or two important background factors that can then be included in a certificate, we must bear it in mind that a doctor who has been rather casual in filling in a certificate—let alone one who has been negligent or worse—will have a vested interest in giving answers that back up the original certificate.

The same criticism applies to placing undue reliance on the fact that a procurator fiscal has been informed. Here, I agree entirely with Richard Simpson—I think that we are the only two people in the chamber who have practical experience of these matters—because most interchanges with a procurator fiscal are cursory telephone exchanges, with permission to go ahead with the certificate without much interviewing. There is a risk of a folie à deux in such situations, with neither professional wishing to go too deeply into the issue.

The level 2 investigations are much more comprehensive, but my concern here is about the small proportion intended—about 4 per cent, we are told. I know that the minister has reassured us that the statistics show that that figure is enough to give an accurate estimate of the total number of identifiably inaccurate certificates overall. As Ross Finnie said, that is true, but the present system for cremation, where in effect all disposals are subject to something very similar to a level 2-type procedure, identifies not only inaccurate certificates, but the deaths to which they relate. That allows the inaccuracies to be corrected, which will not be the case for at least the 50 per cent or more of certificates that are to be allowed...
through totally unchecked under present plans—and probably not for many of the rest.

Store is set by the two proposed pilots, but in a small pilot the number of level 2 investigations will be very small and I doubt that the evidence will be robust enough to draw accurate inferences about the reliability of the results. I agree to an extent with Mary Scanlon that it would be more informative to have two pilots, one of which reviewed 4 per cent of death certificates at level 2 while the other reviewed an increased proportion—for a small pilot, that could be 100 per cent—so that we could see the differences in results, if there were any.

We have been told that the reforms have their origin in the Shipman scandal but that no system could guarantee to prevent another such scandal. That is undoubtedly true, but that is no reason to replace the existing system of death certification with one that is less effective, simply to be able to charge smaller fees. I support the bill and will vote for it, as none of what I perceive to be defects are in the bill. If we truly wish death certificates to be more, rather than less, accurate in future, however, I am convinced that the proportion of level 2 assessments will have to be considerably increased.

10:59

Rhoda Grant (Highlands and Islands) (Lab): I am very pleased that we have reached stage 3 of the bill and that its consideration is coming to an end. I tend to disagree with Ian McKee, in that I think that the bill is very technical, but I agree that it is incredibly important.

As was said at stage 2 and again today, the Shipman inquiry led to the bill and our work on it to see how it would affect the issues raised. It was acknowledged early in the process that it would be impossible to stop another Shipman, but the bill might act as a deterrent. I hope that it will also lead to better recording of the reasons for death.

I have a number of points on the pilots and implementation, and I make no apology for repeating much of what I said in the stage 1 debate. When I raised issues to do with the collection of fees by registrars and asked what would happen if a death were registered by a police officer or a neighbour, the minister said that she hoped that she could send out a reassuring message on that but, rather than reassurance, we need a clear solution. I ask her to bring forward such a solution, which should be available not only to people such as police officers, who might be asked to register a death, but to the likes of neighbours and friends of the deceased, who might wish to help a bereaved family in that way.

I welcomed the minister’s assurance in the stage 1 debate that non-payment of the fee would not delay certification, but clear guidance must be provided so that registrars know what to do in the process.

Another issue that I raised in the stage 1 debate was that of the delay that might be caused by a death being reviewed, which could be extremely distressing for cultural and religious reasons. The minister said that she would look at having test sites to see how the policy would work, and she suggested Glasgow as a possible test site for dealing with issues regarding faith groups. I welcome that commitment, but I ask that another of the test sites be in one of our island authority areas, where the local culture is that the body would normally remain at home prior to the funeral. That would enable us to look into how the operational issues could be dealt with in those areas.

Given the timing of the bill and of the setting up of the pilots, it might not be possible to test the proposed system in the winter months, so I ask the minister to ensure that the people who work in the test site areas look at the implications of poor weather and possible transport disruption. Last weekend, I had an interesting experience travelling to Shetland, which took quite a while longer than I expected and included an overnight stay in Kirkwall in Orkney, as well as a visit to Aberdeen. That is frustrating enough for people who have plans, but it could be extremely distressing for a bereaved family that was waiting for a medical examiner to pitch up, as it could delay the making of funeral arrangements.

The possibility of such delays might lead to a requirement for refrigerated mortuaries on our islands and in our remote communities, and that would come with an additional cost. Winter conditions are challenging for obvious reasons, but ferries and planes can also be affected during the summer months, when it can be difficult to get on and off islands because of tourist travel. In that period, it is often difficult to book a ferry or a plane ticket.

We must ensure that the policy works in practice, otherwise it will lead to distress and possibly additional costs for authorities that attempt to implement the bill. We must also ensure that our remote, rural and island communities receive a service and safeguards that are equivalent to those that more urban areas receive. A process needs to be put in place that will deal with all those issues and deliver the same protection for all our communities.

The bill is technical, but it is important nonetheless, and we need to ensure that the system that it puts in place is right so that we can protect the people whom we seek to serve.
11:03

Stewart Stevenson (Banff and Buchan) (SNP): I have a few observations to make, some of which pick up points that others have made and some of which are new. Dr Ian McKee talked about the importance of death certification feeding into health care planning. That is correct, but we must not fail to take account of the need for death certification to feed into immediate response to possible epidemics. Professor Stewart Fleming did not make reference to that in his definition of the three aims of the certification process.

Ian McKee also talked—absolutely correctly—about folie à deux. It is worth saying that in aviation some 20 years ago we had precisely that situation in the cockpit, when a very senior captain would often not be told by a very junior but recently trained and high-quality first officer that they were getting it wrong. In designing the relationship between different players in the system, we must be aware of the influence that respect for experience and seniority has and must ensure that a junior person can point out freely and frankly to a more senior person that they are not up to the standard that is required. Folie à deux was killing people in aviation 20 years ago, but training has changed and it is not killing people now.

Last week, I had the very great pleasure to be in Giffnock synagogue to launch a Jewish education project on the internet. On that occasion, I received representations on the particular issues surrounding Jewish burial practice, which are equally applicable to people of the Muslim faith. It is important that we take account of the fact that those faiths use burial rather than cremation and make sure that we acknowledge that and preserve those traditions.

Rhoda Grant talked about testing. It is worth observing that testing has more limitations than one might imagine. About 30 years ago, IBM produced a computer that turned out to incorrectly multiply 10 by 10,000,008. Every other calculation appeared to be correct, but it was established that to use testing to see whether they were correct would require every model of that computer that had ever been produced to run through exhaustive tests for more than 1,000 years. It is important to get the design of the system correct.

We have heard some discussions about computers and I want to make some observations, of which members might or might not be aware, that indicate the need for some caution. For the registration of births, Registers of Scotland provides 200 characters for forenames and 50 characters for surnames. Approximately 19 per cent of current registrations are for people who have three or more forenames, so that issue is not insignificant because people have more complex names than they once had. Until a few months ago, I was refusing to take my parliamentary payslip—I was still taking the pay, of course—because my name was not right on the payslip. I am James Alexander Stewart Stevenson and the system provided for only two initials, thus omitting the initial that I use.

Joining computer systems together is often complex when we look at the metadata, to use the technical term, that are associated with information. I say that in the context of my genealogical researches on my great-grandfather who was a coal miner in Bannockburn. He first appears in the record in the 1841 census. The difficulty is that he is one of 328 Stevensons who were working in coal mining in Bannockburn in that year. Having the ability to distinguish names is very important indeed.

Equally, even if we impose rigorous standards for data collection and entry, there might be difficulties. When I worked in the Bank of Scotland, financial services legislation was introduced that required that we collect people’s dates of birth. Our tellers found themselves inhibited in asking ladies of a certain age what their date of birth was, but they had to put in a date so they just chose a random date. We ended up with something like 9 per cent of dates being 1 January. A further 2 per cent turned out to be the teller’s own birthday and, for a further small proportion, the teller simply entered that day’s date and discounted the number of years. Computer systems are not just mechanical systems; they have to interact with the human effects that often surround the collection of data.

If time permits, Presiding Officer—no; I see that you are signalling to me to wind up.

The Deputy Presiding Officer: That would be a sensible idea.

Stewart Stevenson: In that case, I will close. Clive James’s autobiography contains the wonderful phrase, “Don’t take life seriously; you won’t get out of it alive anyway.”

Today, we take death seriously and we are entirely correct to do so.

11:09

Jamie Stone (Caithness, Sutherland and Easter Ross) (LD): As I am not a member of the Health and Sport Committee, I come to the bill and the debate as a comparative layman. However, I am struck by a central theme that we have heard a lot about this morning, which is what Dr Simpson referred to as whether the next of kin are content with the death certificate. Public confidence
depends on whether people are content with the stated reason for death.

I go back a few years to a case that exemplifies the question of doubt. It started on the day in 1997 when the body of Kevin McLeod was pulled out of Wick harbour. Despite meetings with the police and other authorities, including the procurator fiscal, the doubt about and lack of confidence in the death certificate remains. Kevin McLeod’s death predated by two years my election as an MSP. However, like every other Highland member, I was aware of the case. Questions were raised on the matter in the chamber, but we still do not know whether Kevin McLeod accidentally fell to his death or whether he was murdered. That lack of confidence is exactly what this debate is about. I am aware that I have used an extreme example, but the failure to ascertain the facts means that Kevin McLeod’s family and friends and many people in the north of Scotland remain unhappy with the system. What we see in the bill goes a long way towards addressing the issue.

Dr Simpson mentioned training for medical professionals and procurators fiscal. I argue that such training should be extended slightly more widely than that, perhaps to include our police services. I do not wish to denigrate anyone, but doubt will remain until we can demonstrate to the public that things are being done to the highest possible standards and that our systems are watertight. We must get rid of that doubt. That is what the bill is mostly about.

Stewart Stevenson: Does the member accept that it is not possible to eliminate all doubt from death? I say that having been close to a suicide. To this day, more than a decade later, we do not know the cause. The medical record shows the correct reason for death, but the underlying cause is still not known. There will always be a small percentage of cases in which certainty simply cannot be given.

Jamie Stone: I accept that, but the point of raising Kevin McLeod’s death was to highlight a case in which the element of doubt is unacceptably high. In a proper democracy, that should be totally unacceptable.

I turn to the policy memorandum and two issues in particular to which my attention has been drawn. First, people rightly welcome the reduction in the cost of cremation but, as the policy memorandum points out, we must remember that in island, Highland and other remote areas the prevalence of burial is statistically higher than is the case in the rest of Scotland. We must guard against any possible increase in the cost of burial. I am not saying that that will necessarily happen, but we must be careful. Secondly, people have concerns about delay between death and the funeral and burial or cremation. Other members touched on that. As is the case in many other countries, the feeling in Scotland is that the dead being unburied is completely and utterly unacceptable. As other members rightly said, we must minimise distress to families. This is an important issue. I do not for one instance want to suggest that the bill may lead to delay, but we must guard against that.

Once we have agreed the bill at decision time—which I am sure that we shall—it will be for a future Government and the civil service to ensure that the driving principles behind the bill are met. Those principles are making things more efficient and increasing public confidence. We also want to avoid another Harold Shipman, although I accept that we can never rule that out entirely. We must increase public confidence at all times. That is the great goal that is to be attained.

I cannot wave a magic wand to find out the truth about Kevin McLeod’s death, but as long as such doubts remain, they should act as a spur to members. We must minimise doubt. It may or may not be up to my successor to take up the issue in a future session of the Parliament. I support the bill.

11:13

Mary Scanlon: Despite Stewart Stevenson’s incredible experience in business, innovation and enterprise throughout Scotland, he seems to think that modern technology is incapable of overcoming all the obstacles and difficulties that he raised. That is the challenge for technology. Someone having more than two or three Christian names—indeed, someone having 11 Christian names, having been named after a football team—should not be used as a reason not to utilise and embrace technology.

We need only consider telehealth and e-health, including the advent of clinical portals and electronic bed management, to see the advantages to the NHS of having such instant information and communication. Long-term self-management of many conditions also brings benefit to the NHS and the taxpayer, particularly in these difficult times. There is also the benefit to patients. We have to overcome these difficulties; obstacles cannot be put in the way.

Stewart Stevenson: I agree with every word that Mary Scanlon has said; I merely sound a note of caution that it is sometimes more difficult than people imagine to achieve that desired outcome. In particular, we must have systems that allow unstructured data to be entered in a way that enables them subsequently to be analysed, as we are unlikely to identify every bit of data that we want to collect at the outset. That is difficult to do, but it needs to be done.
Mary Scanlon: I appreciate that, but I am sure that people around Scotland like Stewart Stevenson, working in an advisory capacity, can keep everyone right.

My second point relates to the phone call to the doctor that is referred to on the first page of the supplementary financial memorandum to the bill, which states:

“The MR will discuss any concerns with the certifying doctor (or another doctor in the team) by phone and any disagreements will be covered by the same procedure as currently set out in the Bill.”

Had a medical reviewer phoned Harold Shipman, he might have said, “Well, she was getting old. She was over 80 and had been failing for a wee while,” and the medical reviewer might just have said, “That’s fine. Cheerio.” Is a phone call to the doctor who writes the certificate, with no further checks, enough? Having heard two doctors speak in the debate today, I still feel uncomfortable about that.

As a list MSP for the Highlands and Islands, I listened with interest to what Jamie Stone said about Kevin McLeod and the devastating impact of his death on his family. I have tried to help in that case and I appreciate what Jamie Stone said. We should all be aware of specific examples that lead to problems with death certification.

That takes me on to my next point, which I raised earlier. Sixty-two per cent of people in Scotland are cremated after their death; yet, in the future, only one doctor rather than three will check the death certificates and the evidence will be gone forever. In recent times, bodies have been exhumed and DNA samples have been taken for use in murder cases, et cetera. That is why I still have a level of discomfort about the proposal. I hope that the minister will raise the issue, as I am looking for assurances on the matter. I have been an MSP for 11 years, in which time many people have told me that their mother died of a hospital infection—that she did not die of whatever the certificate said. I welcome the fact that, under the bill, individuals and families will be able to request a review of their mother’s death or whatever. That is a step forward, as that is not possible at the moment. My concern is to ensure that hospital-acquired infections and things that contribute to someone’s death, although they may not be the actual cause of death, are taken into account.

I thank Ian McKee for his point about increasing the number of reviews. I also support Rhoda Grant’s proposal that there should be piloting on the islands, where the culture around death is very different.

Dr Simpson: The bill began rather like the Patient Rights (Scotland) Bill, looking rather flawed and weary, but it has been resurrected through the useful process that we have gone through. Nevertheless, doubts are still being expressed about whether the bill will introduce a fully robust system that will retain public confidence. The debate has been useful in suggesting that the pilot should be conducted almost as a research exercise, with not only 25 per cent of deaths being reviewed by medical reviewers, as is required by the act, and approximately 25 per cent of deaths being reviewed by procurators fiscal—accounting for 50 per cent of deaths—but 100 per cent of deaths being reviewed on a post hoc basis to determine whether the system that we are putting in place is error strewn.

If we are concerned about errors, we need look no further than two quotes from Professor Stewart Fleming. He told the committee that, “in cases in which a post mortem was performed after a death certificate had been completed, the inaccuracy rate was about 20 to 30 per cent.” He also said that, every year, around 30 “unnatural causes of death are picked up only at the confirmatory medical certificate on the cremation form.”—[Official Report, Health and Sport Committee, 1 December 2010; c 3756 and 3746.]

Some of those deaths might be due to road traffic accidents rather than something more serious but, nevertheless, they are missed.

Those are a few of the issues that we need to examine, apart from the general issues raised by the Harold Shipman case, which are almost a distraction. However, I should say that the care home deaths in England gave rise to considerable public concern. Therefore, an analysis on a geographic basis, which the bill provides for, is important. If there is a higher than normal proportion of deaths in one care home, that might lead to much more detailed scrutiny, which would be welcome.

I suggest to the minister that the details of the pilot should be brought before Parliament so that we have the opportunity to see precisely what is proposed. The Subordinate Legislation Committee or the committee that is responsible for health should have the opportunity to scrutinise them and make helpful comments to the minister and the team that is running the system.

Rhoda Grant raised the situation in remote and island communities. Clearly, those concerns are important. In her evidence to the committee, Ishbel Gall, from Aberdeen, gave us some classic illustrations of the practical difficulties that will need to be explored in the new system. A pilot, perhaps involving Aberdeen, that might address
the issues around the island communities would be useful because a lot of people from the island communities die in hospitals on the mainland. The majority of such certifications take place in hospitals—hopefully we can change that, but it is not happening so far.

Rhoda Grant also referred to the problem of fee collection, and I will be interested to hear the minister’s comment on that when she sums up.

Ian McKee stressed the importance of accurate data. In that regard, I conclude by repeating what I said at the start of stage 1, which is that—Stewart Stevenson’s concerns notwithstanding—electronic data are the way forward, because drop-down menus allow people to be interrogated in a much more detailed way when completing the certificate and, far from adding time, can save time.

With regard to the ISD checks, which I presume will still occur, will the minister ensure that the regulations make it compulsory for there to be a response to an inquiry? In other words, if Colin Fishbacher or his successor has a query about the certificate, the doctor should be required to respond; it should not be voluntary. With regard to public confidence, it will be interesting to see whether the number of queries drops from the current level of 2,000 to a much lower level. If, under the new system of ISD checks, the number of those queries drops as a result of the accuracy of the data, it is possible that the system will have the public confidence that we all desire.

The Deputy Presiding Officer: Wind up, please.

Dr Simpson: We have a better bill now, although it still needs to be reviewed and we will examine the pilots as they go through. I support the passing of the bill.

11:23

Shona Robison: The debate has shown that, although there are still differences of opinion on some matters, the Parliament has engaged positively with the bill and has raised some important issues, which is encouraging. I have listened with great interest to the many and varied points that have been made about the proposals and I will try to respond to as many of them as possible.

Richard Simpson has, with some justification, doggedly pursued the issue of electronic medical certificates of cause of death. I envisage that work will start very soon on scoping the feasibility study on electronic MCCDs, and in the spirit of consensus I say to Richard Simpson that some of his pointers on where the starting point should be—instead of starting from scratch—are very helpful. He also asked a specific question about the charge for overseas deaths, and I can confirm that the £30 fee will apply in those circumstances.

It is worth putting on record my response to Richard Simpson’s point about the CHI number, which he raised in debating the amendments. I confirm that the General Register Office for Scotland already plans to add that to the MCCD, which I hope the member will welcome.

Mary Scanlon made a number of points in her opening and closing remarks, and I will pick up on one in particular: health care associated infection. We should bear in mind that the MCCD is a record of the cause of death and as such should not list all the conditions that the patient had at the time of death.

Mary Scanlon will be aware that an inquiry is currently examining the outbreak of Clostridium difficile in the Vale of Leven hospital. The inquiry’s terms of reference require an investigation into the recording of deaths associated with C diff in the NHS for the purposes of death certification. It might be premature to pre-empt the outcome, but I am sure that Mary Scanlon and many others will consider the specific issue and any recommendations that emerge.

Mary Scanlon: I am trying to clarify two things. We all know that the cause of death is listed, but I have seen death certificates on which the major contributory factor is noted. That was the point that I was trying to make.

Shona Robison: There is a difference between that and a list of every condition, as I am sure we agree.

Ross Finnie made a number of points and I am pleased that he found the letter on the statistical basis of the findings helpful. He raised the need for scrutiny to be open and transparent. I point out to him that the senior medical reviewer must provide an annual review of medical reviewers’ activities, which, I hope, will aid the transparency of the process.

I acknowledge Ian McKee’s interest in these issues, which he has pursued rigorously through the bill’s various stages. I know that he is yet to be persuaded on some matters, and I hope that the test site process will offer him and the other members who have raised concerns some reassurance on those issues. Rhoda Grant suggested that one of the test sites should be in an island authority, and we can certainly consider that, although as yet no decisions have been made about definite locations. We will take on board and reflect on her point about the implications of poor weather and transport disruption.

Stewart Stevenson highlighted the importance of being responsive to faith group issues. I think
that that has been the case throughout the bill process, and our reassurances have been well received by the faith communities, which is to be welcomed.

Yet again, the bill process has in many ways demonstrated the work of the Parliament at its best. It has worked very effectively in taking through the bill, hearing the evidence and coming up with a series of recommendations that I have no doubt have improved the bill. I do not see that as a negative at all: it is very positive that the Parliament has had—as in so many cases—a positive impact on a piece of legislation by improving it.

We have an opportunity to reform and modernise death certification, and I invite the Parliament to agree the Certification of Death (Scotland) Bill, which I believe will achieve that.
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Schedule 1 — Status and appointment of medical reviewers
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Certification of Death (Scotland) Bill

[AS PASSED]

An Act of the Scottish Parliament to make provision about the certification of death and still-birth certificates; to make provision for medical reviewers, the senior medical reviewer and their functions; and for connected purposes.

Medical reviewers

1 Medical reviewers

(1) Medical reviewers are to exercise the functions conferred on them by this Act or any other enactment on behalf of Healthcare Improvement Scotland.

(2) The senior medical reviewer is to exercise the functions conferred on that person by this Act or any other enactment on behalf of Healthcare Improvement Scotland.

(3) Schedule 1 (which makes further provision about the appointment and status of medical reviewers) has effect.

Referral of medical certificates of cause of death for review

2 Referral of certain medical certificates of cause of death for review

After section 24 of the 1965 Act insert—

"24A Duty to refer certain certificates of cause of death for review

(1) The Registrar General must ensure that randomly selected certificates of cause of death are referred for review under section 8(1) of the 2011 Act prior to registration of the death to which each certificate relates.

(2) The Registrar General must ensure that certificates of cause of death of such descriptions as may be specified in a request by medical reviewers under section 3 of the 2011 Act are referred for review under section 8(1) of that Act.

(3) A district registrar for a registration district may refer for review under section 8(1) of that Act a certificate of cause of death where the district registrar considers it appropriate to do so.

(4) The following certificates may not be referred under subsections (1) to (3)—

(a) a certificate of cause of death relating to a body in respect of which a direction has been given by a Health Board under section 90(2) of the Public Health etc. (Scotland) Act 2008 (asp 5) (restrictions on release of infected etc. bodies from hospital),

(b) a certificate of cause of death which has already been referred under this section,
(c) a certificate of cause of death which has been (or is being) reviewed under section 8(1) of the 2011 Act following an application made under section 4(1) of that Act,

(d) a certificate of cause of death which is a replacement certificate attested and transmitted in response to an invitation to do so under section 10 or 11 of the 2011 Act,

(e) a certificate of cause of death where the cause of death of the deceased person has been (or is being) investigated by a procurator fiscal,

(f) a certificate of cause of death attested prior to the coming into force of this section.

(5) The Scottish Ministers may give directions to the Registrar General about the referral of certificates under this section; and the Registrar General must comply with any such direction.

(6) A direction under subsection (5) may in particular specify—

(a) the minimum number of certificates of cause of death which are to be selected for referral under subsection (1) in any year, and

(b) the method of determining which certificates are to be selected for referral under subsection (1).

(7) The Scottish Ministers may by order made by statutory instrument suspend the referral of certificates under this section—

(a) during an epidemic, or

(b) where the Scottish Ministers consider, on reasonable grounds, that it is necessary to do so to prevent, or to prevent the spread of, infectious diseases or contamination.

(8) An order made under subsection (7)—

(a) may include such supplementary, incidental, consequential, transitional, transitory or saving provision as the Scottish Ministers think necessary or expedient,

(b) may be exercised so as to make different provision for different purposes.

(9) An order under made subsection (7) (other than one to which subsection (9B) applies)—

(a) must be laid before the Scottish Parliament, and

(b) ceases to have effect at the expiry of a period of 28 days beginning with the date on which it was made unless, before the expiry of that period, the order has been approved by resolution of the Parliament.

(9A) Subsection (9B) applies to an order made under subsection (7) consisting only of—

(a) provision revoking an earlier order made by virtue of subsection (7), or

(b) such provision and provision made by virtue of subsection (8)(a).

(9B) An order to which this subsection applies is subject to annulment in pursuance of a resolution of the Parliament.
(10) In reckoning for the purposes of subsection (9)(b) any period of 28 days, no account is to be taken of any period during which the Scottish Parliament is—
   (a) dissolved, or
   (b) in recess for more than 4 days.

(11) Subsection (9)(b) is without prejudice to anything previously done by reference to an order under subsection (7) or to the making of a new order under that subsection.”.

3 Medical reviewer requests

(1) A medical reviewer may request that the Registrar General ensure that medical certificates of cause of death of such description as the medical reviewer may specify are referred for review under section 8(1).

(2) A request under subsection (1) may relate to a certificate in respect of which the death has been registered.

4 Application for review of certificate by interested person

(1) An interested person may apply to a medical reviewer for a review under section 8(1) of an eligible medical certificate of cause of death.

(2) An application under subsection (1)—
   (a) may relate to a certificate in respect of which the death has been registered,  
   (b) must be made within three years of the date of death of the deceased person to whom the certificate relates.

(3) Where the medical reviewer considers an application under subsection (1) to be vexatious, the medical reviewer may reject it.

(4) A medical reviewer must notify the Registrar General of an application received under subsection (1) (other than one which is rejected under subsection (3)).

(5) For the purposes of subsection (1), an interested person is—
   (a) a person who, under the 1965 Act, is required or stated to be qualified to give information concerning the deceased’s death,  
   (b) a health care professional (or other carer) who was involved with the deceased’s care prior to the deceased’s death,  
   (c) the funeral director responsible for the funeral arrangements of the deceased,  
   (d) the person having charge of the place of disposal of the body of the deceased,  
   (e) such other persons as the Scottish Ministers may by order specify.

(6) For the purposes of subsection (1), an eligible medical certificate of cause of death is a medical certificate of cause of death other than—
   (a) a certificate relating to a body in respect of which a direction has been given by a Health Board under section 90(2) of the Public Health etc. (Scotland) Act 2008 (asp 5) (restrictions on release of infected etc. bodies from hospital),  
   (b) a certificate which has been referred under section 24A of the 1965 Act (duty to refer certain certificates of cause of death for review),
(c) a certificate which has already been (or is being) reviewed under section 8(1) following an application made under subsection (1),

(d) a certificate which is a replacement certificate attested and transmitted in response to an invitation to do so under section 10 or 11,

(e) a certificate where the cause of death of the deceased person has been (or is being) investigated by a procurator fiscal,

(f) a certificate attested prior to the coming into force of this section.

(7) The Scottish Ministers may by order suspend the application of this section—

(a) during an epidemic, or

(b) where the Scottish Ministers consider, on reasonable grounds, that it is necessary to do so to prevent, or to prevent the spread of, infectious diseases or contamination.

(8) The Scottish Ministers may by regulations make provision about applications under subsection (1) including, in particular, provision about—

(a) the procedure for making applications,

(b) the form and content of applications,

(c) the action to be taken by medical reviewers in respect of applications.

5 Stay of registration of death pending review

In section 25B of the 1965 Act (registration of deaths)—

(a) in subsection (1), after “subsection (2)” insert “and (2A)”, and

(b) after subsection (2) insert—

“(2A) The registrar is not to register a death in respect of which the certificate of cause of death has been referred under section 24A or where the Registrar General has been notified under section 4(4) of the 2011 Act of an application for review having been made until the first occurrence of any of the following events—

(a) a medical reviewer, under section 7(2)(b) of the 2011 Act (request for review not to stay registration), notifying the registrar that it is appropriate in the circumstances to register the death before the review is complete,

(b) the certificate or its replacement being approved by a medical reviewer—

(i) under section 9 of the 2011 Act (action following satisfactory review), or

(ii) under section 10 of that Act (action following unsatisfactory review: medical reviewer),

(c) the certificate or its replacement being approved by the senior medical reviewer under section 11 of the 2011 Act (action following unsatisfactory review: senior medical reviewer),

(d) the senior medical reviewer, under section 11(8)(a), (9)(a) or 12(5)(a) of the 2011 Act, signifying that the review has been conducted,
(e) a medical reviewer, under section 12(2)(a) of the 2011 Act (action where relevant medical practitioner is unavailable or incapacitated), signifying that the review has been conducted, or

(f) a procurator fiscal approving the certificate or providing a replacement certificate attested by a registered medical practitioner.”.

6 Request for review not to stay registration

After section 24A of the 1965 Act insert—

“24B Request for review not to stay registration

(1) This section applies where a certificate of cause of death is referred under section 24A(1).

(2) A district registrar for a registration district must, following a request by a qualified informant, refer the certificate to a medical reviewer for a determination under section 7 of the 2011 Act (medical reviewer to determine whether review to stay registration).

(3) Such a referral must include a statement by the qualified informant of the circumstances which the qualified informant believes justify registering the death before the review is complete.

(4) The qualified informant must also provide such other information as the medical reviewer may reasonably require.”.

7 Medical reviewer to determine whether review to stay registration

(1) This section applies where a medical reviewer receives a referral under section 24B(2) of the 1965 Act (request for review not to stay registration).

(2) The medical reviewer must—

(a) determine whether it is appropriate to register the death to which the referral relates before the review of the certificate under section 8(1) or, as the case may be, any further review under section 11(2)) is completed, and

(b) notify the relevant registrar of the determination.

(3) The medical reviewer may determine under subsection (2)(a) that it is appropriate to register the death before the review (or further review) is completed only where the medical reviewer is satisfied that—

(a) the circumstances of the case justify such registration, and

(b) there are no obvious indications that the medical certificate of cause of death is not in order.

(4) The medical reviewer may make such enquiries as the medical reviewer considers appropriate when making a determination under subsection (2)(a).

8 Review of medical certificates of cause of death

(1) A medical reviewer must review any medical certificate of cause of death—

(a) referred under section 24A of the 1965 Act, or
(b) in respect of which an application has been made under section 4(1) (other than one which has been rejected as vexatious under section 4(3)).

(2) In conducting a review, the medical reviewer may—

(a) examine the health records of the deceased person to whom the certificate relates,

(b) seek the views of the medical practitioner who attested the certificate,

(ba) make enquiries of any other person who the medical reviewer considers may have information about the health of the deceased person (for example, a member of the deceased person’s family, a carer or a nurse),

(c) make such other enquiries and examine such other things as the medical reviewer considers appropriate.

(3) Following a review under subsection (1) the medical reviewer must come to a view on whether the certificate is in order.

(4) For the purposes of this Act, a certificate is in order 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.

(5) The Scottish Ministers may by regulations make further provision about the review of certificates including, in particular, action to be taken by medical reviewers when conducting a review or by senior medical reviewers when conducting a further review.

9 Action following satisfactory review

(1) Subsection (2) applies where, following a review under section 8(1), a medical reviewer is of the view that a medical certificate of cause of death is in order.

(2) The medical reviewer must approve the certificate and notify the relevant registrar accordingly.

10 Action following unsatisfactory review: medical reviewer

(1) This section applies where, following a review under section 8(1), a medical reviewer is of the view that a medical certificate of cause of death is not in order.

(2) The medical reviewer must—

(a) inform the relevant medical practitioner of that view and the reasons for coming to that view, and

(b) invite the relevant medical practitioner to attest and transmit to the medical reviewer a replacement certificate which takes account of the reasons.

(3) If the relevant medical practitioner attests and transmits a replacement certificate which in the view of the medical reviewer is in order, the medical reviewer must approve the replacement certificate and transmit it to the relevant registrar.

(4) If the relevant medical practitioner attests and transmits a replacement certificate which in the view of the medical reviewer is not in order, the medical reviewer must refer the review to the senior medical reviewer.
(5) If the relevant medical practitioner declines to attest and transmit a replacement certificate in response to the invitation under subsection (2)(b), the medical reviewer must—

(a) approve the certificate and notify the relevant registrar accordingly, or

(b) refer the review to the senior medical reviewer.

11 Action following unsatisfactory review: senior medical reviewer

(1) This section applies where a review is referred to the senior medical reviewer under section 10(4) or (5)(b).

(2) The senior medical reviewer may conduct a further review of the certificate.

(3) If the senior medical reviewer conducts a further review under subsection (2), the senior medical reviewer may exercise the powers conferred on a medical reviewer by section 8(2).

(4) The senior medical reviewer must come to a view on whether the certificate is in order (and for that purpose references in section 8(4) to a medical reviewer are to be read as references to the senior medical reviewer).

(5) If the senior medical reviewer comes to the view that the certificate is in order, the senior medical reviewer must approve the certificate and notify the relevant registrar and the relevant medical practitioner accordingly.

(6) If the senior medical reviewer comes to the view that the certificate is not in order, the senior medical reviewer must—

(a) inform the relevant medical practitioner of that view and the reasons for coming to that view, and

(b) invite the relevant medical practitioner to attest and transmit to the senior medical reviewer a replacement certificate which takes account of the reasons.

(7) If the relevant medical practitioner attests and transmits a replacement certificate which in the view of the senior medical reviewer is in order, the senior medical reviewer must approve the replacement certificate and transmit it to the relevant registrar.

(8) If the relevant medical practitioner attests and transmits a replacement certificate which in the view of the senior medical reviewer is not in order, the senior medical reviewer must—

(a) signify that a review has been conducted and notify the relevant registrar accordingly, or

(b) refer the certificate to the procurator fiscal for investigation into the cause of death of the deceased person to whom the certificate relates.

(9) If the relevant medical practitioner declines to attest and transmit a replacement certificate, the senior medical reviewer must—

(a) approve the certificate, or otherwise signify that a review has been conducted, and notify the relevant registrar accordingly, or

(b) refer the certificate to the procurator fiscal for investigation into the cause of death of the deceased person to whom the certificate relates.

(10) Subsection (11) applies where—
(a) the senior medical reviewer has come to the view that the certificate or, as the case may be, its replacement, is not in order because the senior medical reviewer is not satisfied that information (other than the cause of death) contained in the certificate (or its replacement) is correct, or

(b) the relevant medical practitioner declines to attest and transmit a replacement certificate in response to the invitation under subsection (6).

(11) The senior medical reviewer may (in addition to the action to be taken under subsection (8) or (9)) take such steps as the senior medical reviewer considers appropriate to inform such persons as the senior medical reviewer considers appropriate of the relevant information.

12 **Action where relevant medical practitioner is unavailable or incapacitated**

(1) Subsections (2) and (3) apply where—

(a) a medical reviewer has conducted a review under section 8(1),

(b) the medical reviewer has come to the view that a medical certificate of cause of death is not in order, and

(c) the relevant medical practitioner is unavailable or unable to attest and transmit a replacement certificate in accordance with section 10.

(2) The medical reviewer must—

(a) signify that a review has been conducted and notify the relevant registrar accordingly, or

(b) refer the certificate to the procurator fiscal for investigation into the cause of death of the deceased person to whom the certificate relates.

(3) Where the medical reviewer has come to the view that the certificate is not in order because the medical reviewer is not satisfied that information contained in the certificate (other than the cause of death) is correct, the medical reviewer may (in addition to the action to be taken under subsection (2)) take such steps as the medical reviewer considers appropriate to inform such persons as the medical reviewer considers appropriate of the relevant information.

(4) Subsections (5) and (6) apply where—

(a) a medical reviewer has referred a review to the senior medical reviewer under section 10(4) or (5)(b),

(b) the senior medical reviewer has come to the view that a medical certificate of cause of death is not in order, and

(c) the relevant medical practitioner is unavailable or unable to attest and transmit a replacement certificate in accordance with section 11.

(5) The senior medical reviewer must—

(a) signify that a review has been conducted and notify the relevant registrar accordingly, or

(b) refer the certificate to the procurator fiscal for investigation into the cause of death of the deceased person to whom the certificate relates.
(6) Where the senior medical reviewer has come to the view that the certificate is not in order because the senior medical reviewer is not satisfied that information contained in the certificate (other than the cause of death) is correct, the senior medical reviewer may (in addition to the action to be taken under subsection (5)) take such steps as the senior medical reviewer considers appropriate to inform such persons as the senior medical reviewer considers appropriate of the relevant information.

### Duty to inform following review

(1) This section applies where a medical reviewer has conducted a review under section 8(1).

(2) The medical reviewer must, when a relevant requirement is first complied with in relation to the certificate to which the review relates, inform the persons mentioned in subsection (3) of the outcome of the review including, in particular, any changes made to the medical certificate of cause of death.

(3) The persons are—

(a) the person who gave information of the particulars required to be registered concerning the death to the district registrar under section 23(1) of the 1965 Act,

(b) in the case of a review conducted by virtue of section 4, the interested person (unless that is the same person as mentioned in paragraph (a)).

(4) In subsection (2), “relevant requirement” means a requirement imposed by any of the following sections—

(a) section 9(2),

(b) section 10(3) or (5)(a),

(c) section 11(5), (7), (8) or (9),

(d) section 12(2) or (5).

### Powers of medical reviewers

### Power to require documents

(1) A medical reviewer may for the purposes of—

(a) reviewing a medical certificate of cause of death under section 8(1) or, as the case may be, section 11(2), or

(b) determining whether it is safe to cremate the body of a person who died outwith Scotland under section 17(2),

require any person who is able, in the opinion of the medical reviewer, to produce relevant documents (including health records) to do so.

(2) Where a requirement under subsection (1) is imposed by the medical reviewer, the person in question must be given a notice specifying—

(a) the documents or types of documents which the person is required to produce,

(b) the date by which the person is required to produce them, and

(c) the name of the deceased person in respect of whom they are required.
(3) For the purposes of this section, a person is to be taken to comply with a requirement to produce a document if that person produces a copy of, or an extract of the relevant part of, the document.

(4) In this section, references to the medical reviewer include references to the senior medical reviewer.

15 Documents: offences

(1) Any person to whom a notice under section 14 is given commits an offence if the person—
   (a) deliberately alters, suppresses, conceals or destroys any document which that person is required to produce by the notice, or
   (b) refuses or fails to produce any such document.

(2) It is a defence for a person charged with an offence under subsection (1)(b) to prove that there was a reasonable excuse for the refusal or failure.

(3) A person is not obliged under section 14 to produce any document which that person would be entitled to refuse to produce in a court in Scotland.

(4) A person who commits an offence under this section is liable on summary conviction to a fine not exceeding level 5 on the standard scale or to imprisonment for a period not exceeding 3 months.

(5) Where an offence under this section which has been committed by a body corporate is proved to have been committed with the consent or connivance of, or to be attributable to any neglect on the part of—
   (a) a director, manager, secretary or other similar officer of the body corporate, or
   (b) any person who was purporting to act in any such capacity,

that person, as well as the body corporate, commits the offence and is liable to be proceeded against accordingly.

Duty to report suspicions of criminality

16 Involvement of procurator fiscal

(1) A medical reviewer (including the senior medical reviewer) must report any suspicion of criminality arising from the review of a medical certificate of cause of death (or a number of such reviews) to the procurator fiscal.

(2) A medical reviewer (including the senior medical reviewer), having reported a suspicion under subsection (1), must follow the directions of the procurator fiscal as to the appropriate action to take.

Deaths outwith Scotland

16A Verification of foreign death certificates

(1) This section applies where—
   (a) a person (“A”) died outwith the United Kingdom, and
   (b) the body of A is to be disposed of in Scotland.
(2) A medical reviewer must, on the request of a relevant person, determine whether the documentation relating to A’s death is in order.

(3) Documentation is in order if it appears to the medical reviewer to be—
(a) authentic, and
(b) equivalent to the certificates or other documentation required under section 27A of the 1965 Act (offence of disposal of body without authorisation) for the interment, cremation or disposal by other means of the body of a person who died in Scotland.

(4) If the medical reviewer determines that the documentation is in order, the medical reviewer must give the relevant person a certificate specified for the purposes of this section under section 27A(2) of the 1965 Act.

(5) In making a determination under subsection (2), a medical reviewer may make such enquiries as the medical reviewer considers appropriate.

(6) For the purposes of subsection (2), a relevant person is—
(a) a person who wishes to arrange the interment, cremation or disposal by other means of A’s body, or
(b) the person having charge of the place where A’s body is to be interred, cremated or disposed of by other means.

17 Medical reviewers to authorise cremation

(1) This section applies where—
(a) a person (“A”) died outwith Scotland, and
(b) it is intended that A be cremated in Scotland.

(2) A medical reviewer must, on an application by a person who wishes to arrange the cremation of A, determine whether it is safe for A’s body to be cremated.

(3) If the medical reviewer determines that it is safe for A’s body to be cremated, the medical reviewer must give the applicant a certificate authorising the cremation.

(4) The Scottish Ministers may by regulations make provision about—
(a) the form and content of applications under subsection (2),
(b) the procedure to be followed by medical reviewers in relation to applications under subsection (2),
(c) the form and content of the certificate authorising the cremation to be given under subsection (3).

18 Post-mortem examination of person who died outwith United Kingdom

(1) This section applies where—
(a) a person (“A”) dies outwith the United Kingdom,
(b) the body of A is to be disposed of in Scotland, and
(c) no cause of death is available.

(2) A medical reviewer may, on an application by a relevant person—
(a) assist the relevant person in making arrangements for a post-mortem examination of A’s body for the purpose mentioned in section 23(a) of the Human Tissue (Scotland) Act 2006 (asp 4), and

(b) meet the cost of such an examination.

(3) For the purposes of subsection (2), a relevant person is a person who, under section 30, 32 or 33 of the Human Tissue (Scotland) Act 2006, may authorise a post-mortem examination of A’s body.

(4) The Scottish Ministers may by regulations make provision about the form and content of applications under subsection (2).

Other functions of medical reviewers

19 Training and information functions

(1) A medical reviewer (including the senior medical reviewer) has the functions mentioned in subsection (2).

(2) The functions are—

(a) to collate and analyse information relating to or contained in medical certificates of cause of death,

(b) to provide training, guidance and support to persons who are required to complete medical certificates of cause of death,

(c) to provide guidance and support to district registrars in relation to medical certificates of cause of death,

(d) to liaise with such persons as the medical reviewer considers appropriate with a view to improving—

(i) the accuracy of the information (and in particular the causes of death) recorded in medical certificates of cause of death, and

(ii) the administrative processes relating to the disposal of bodies.

20 Duty to co-operate

Health Boards, Special Health Boards, the Common Services Agency for the Scottish Health Service and medical reviewers (including the senior medical reviewer) are to co-operate with one another in the exercise of their respective functions in relation to—

(a) the completion and review of medical certificates of cause of death (including in particular the recording of causes of deaths),

(b) the collation and analysis of information relating to the causes of death,

(c) the disposal of bodies.

21 Guidance

In exercising functions under this Act, medical reviewers (including the senior medical reviewer) must have regard to any guidance issued by the Scottish Ministers for the purposes of or in connection with this Act.
22 **Annual report**

(1) The senior medical reviewer must—
   (a) prepare a report for each financial year on the activities of medical reviewers (including the senior medical reviewer) during the year, and
   (b) provide such further information as the Scottish Ministers may reasonably require.

(2) As soon as reasonably practicable after the end of each financial year, the senior medical reviewer must—
   (a) send a copy of the report to the Scottish Ministers, and
   (b) arrange for it to be published.

(3) The Scottish Ministers may by regulations—
   (a) make further provision about the information to be contained in a report,
   (b) require reports to be prepared on a more frequent basis,
   (c) specify other persons to whom a copy of the report must be sent.

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**Fees**

23 **Fees in respect of medical reviewer functions**

(1) The Scottish Ministers may charge a fee in respect of—
   (a) the review functions,
   (b) the functions exercised by the Common Services Agency for the Scottish Health Service in connection with the review functions,
   (c) an application under section 17(2).

(2) The persons liable for the fee in respect of the functions mentioned in subsection (1)(a) and (b) are the personal representatives of every person whose death requires to be registered in accordance with Part 3 of the 1965 Act; and any such fee is to be treated as part of the general testamentary and administration expenses of the estate of the deceased.

(3) The Scottish Ministers may by regulations make provision about the charging of fees under subsection (1).

(4) Regulations made under subsection (3) may in particular—
   (a) set the amount of any such fee,
   (b) make provision about the arrangements for collection of any such fee (including specifying persons (or types of person) who must collect the fee on behalf of the Scottish Ministers),
   (c) specify circumstances in which no fee is payable.

(5) The Scottish Ministers, in setting the amount of fees under this section, must not set a fee in excess of the reasonable costs of the exercise of the functions in respect of which the fee is to be charged.

(6) Before making any regulations under subsection (3) the Scottish Ministers must consult such persons as they consider appropriate.
(7) In subsection (1), the review functions are the functions of the medical reviewers (including the senior medical reviewer) under this Act (other than sections 16A, 17 and 18).

Disposal of bodies

24 Disposal of bodies

24 Prohibition on disposal of body without authorisation

After section 27 of the 1965 Act insert—

“27A Offence of disposal of body without authorisation

(1) A person having charge of a place of interment, cremation or other means of disposal of human bodies who inter, cremates or otherwise disposes of the body of a still-born child or a deceased person (or who knowingly permits such interment, cremation or disposal) without the certificates or other documentation specified under subsection (2)(a) for such purpose commits an offence.

(2) The Scottish Ministers may by regulations made by statutory instrument—

(a) specify the certificates or other documentation required for the interment, cremation or other disposal of the body of a still-born child or a deceased person,
(b) make provision about the form and content of such certificates (other than those which are to be prescribed by the Registrar General under this Act).

(3) A person who commits an offence under subsection (1) is liable on summary conviction to a fine not exceeding level 3 on the standard scale.

(4) It is a defence for a person charged with an offence under subsection (1) to prove that there was a reasonable excuse for the interment, cremation or disposal of a body (or for that person permitting such interment, cremation or other disposal) without the certificates or other documentation specified under subsection (2)(a).

(5) Where an offence under subsection (1) which has been committed by a body corporate is proved to have been committed with the consent or connivance of, or to be attributable to any neglect on the part of—

(a) a director, manager, secretary or other similar officer of the body corporate, or
(b) any person who was purporting to act in any such capacity, that person, as well as the body corporate, commits the offence and is liable to be proceeded against accordingly.

(6) The power conferred by subsection (2)—

(a) may be exercised so as to make different provision for different purposes,
(b) includes power to make such incidental, consequential, transitional, transitory or saving provision as the Scottish Ministers think necessary or expedient.

(7) A statutory instrument containing regulations under subsection (2) is subject to annulment in pursuance of a resolution of the Scottish Parliament.
In subsections (1), (2) and (4) reference to a body includes reference to a part of a body.”.

25 Certifying medical practitioner to provide additional information

(1) In section 21(2)(a) of the 1965 Act (certificates relating to still-births), after “death” insert “, any other relevant medical information”.

(2) In section 24(1) of that Act (certificates of cause of death)—

(a) after the words “death of” where they first appear insert “, and any relevant medical information about,”,

(b) after the words “belief the cause of death” insert “and such other medical information as may be prescribed”.

26 Still-birth declarations

In section 21 of the 1965 Act (still-births)—

(a) in subsection (2), paragraph (b) and the word “or” immediately preceding it is repealed,

(b) in subsection (3)(a), the words “paragraph (a) of” are repealed.

General

27 Ancillary provision

(1) The Scottish Ministers may by order make such supplementary, incidental, consequential, transitional, transitory or saving provision as they consider necessary or expedient for the purposes of, in consequence of, or for giving full effect to, any provision of this Act.

(2) An order under this section may modify any enactment, instrument or document.

28 Orders and regulations

(1) Subject to subsection (4), any power conferred by this Act on the Scottish Ministers to make an order or regulations—

(a) must be exercised by statutory instrument,

(b) includes power to make supplementary, incidental, consequential, transitional, transitory or saving provision,

(c) may be exercised so as to make different provision for different purposes.

(1A) An order made under section 4(7) (other than one to which subsection (1AB) applies)—

(a) must be laid before the Parliament, and

(b) ceases to have effect at the expiry of a period of 28 days beginning with the date on which it was made unless, before the expiry of that period, the order has been approved by resolution of the Parliament.

(1AA) Subsection (1AB) applies to an order made under section 4(7) consisting only of—

(a) provision revoking an earlier order under section 4(7), or

(b) such provision and provision made by virtue of section 28(1)(b).
(1AB) An order to which this subsection applies is subject to annulment in pursuance of a resolution of the Parliament.

(1B) In reckoning for the purposes of subsection (1A)(b) any period of 28 days, no account is to be taken of any period during which the Parliament is—

(a) dissolved, or

(b) in recess for more than 4 days.

(1C) Subsection (1A)(b) is without prejudice to anything previously done by reference to an order under section 4(7) or to the making of a new order under that provision.

(2) No order is to be made under section 27 containing provisions which add to, omit or replace any part of the text of an Act, unless a draft of the statutory instrument containing the order has been laid before, and approved by resolution of, the Parliament.

(3) Subject to subsection (4), any other statutory instrument containing an order or regulations is subject to annulment in pursuance of a resolution of the Parliament.

(4) Subsections (1) and (3) do not apply in relation to an order made under section 31(3).

29 Minor and consequential modifications

Schedule 2 (which makes minor modifications and modifications consequential on this Act) has effect.

30 Interpretation

(1) In this Act (unless the context otherwise requires)—

“the 1965 Act” means the Registration of Births, Deaths and Marriages (Scotland) Act 1965 (c. 49);

“the 1978 Act” means the National Health Service (Scotland) Act 1978 (c. 29);

“funeral director” means a person whose business consists of or includes the arrangement and conduct of funerals;

“Health Board” means a Health Board constituted under section 2 of the 1978 Act;

“health record” means a record which—

(a) consists of information relating to the physical or mental health of an individual, and

(b) has been made by or on behalf of a health professional in connection with the care of that individual;

“medical certificate of cause of death” means a certificate mentioned in section 24 of the 1965 Act;

“medical reviewer” means a person appointed under paragraph 7A(1) of Schedule 5A to the 1978 Act;

“registration district” has the meaning given in section 5 of the 1965 Act;

“Registrar General” has the meaning given in section 1(2) of the 1965 Act;

“relevant registrar” means—

(a) the district registrar for a registration district—
(i) to whom a medical certificate of cause of death was transmitted under section 24 of the 1965 Act,

(ii) in the presence of whom a death registration form (within the meaning of section 23(1A) of the 1965 Act) was attested under section 23(1A)(a)(ii) of that Act, or

(iii) to whom a death registration form was submitted under section 23(1A)(b) of that Act, or

(b) where the information mentioned in paragraph (a) is not known to the medical reviewer (or, as the case may, the senior medical reviewer), the Registrar General;

“relevant medical practitioner” means the registered medical practitioner who attested the certificate of cause of death under section 24 of the 1965 Act;

“senior medical reviewer” means the person appointed under paragraph 7A(2) of Schedule 5A to the 1978 Act;

“Special Health Board” means a Special Health Board constituted under section 2 of the 1978 Act.

(2) Unless the context otherwise requires, any undefined expression used in this Act but defined in section 56 of the 1965 Act is to be construed in accordance with section 56 of the 1965 Act.

31 Short title and commencement

(1) This Act may be cited as the Certification of Death (Scotland) Act 2011.

(2) This section and sections 27 and 28 come into force at the beginning of the day after the day on which the Bill for this Act receives Royal Assent.

(3) The remaining provisions of this Act come into force on such day as the Scottish Ministers may appoint by order made by statutory instrument.

(4) An order made under subsection (3)—

(a) may make transitional, transitory or saving provision,

(b) may make different provision for different purposes or different areas.
SCHEDULE 1
(introduced by section 1)

STATUS AND APPOINTMENT OF MEDICAL REVIEWERS

1 Schedule 5A to the 1978 Act (Healthcare Improvement Scotland) is amended as follows.

2 After paragraph 7 insert—

“Medical reviewers

7A(1) HIS must appoint persons employed under paragraph 7(5) to exercise the functions of medical reviewers; and when doing so those employees are to be known as medical reviewers.

(2) HIS must appoint a person employed under paragraph 7(5) to exercise the functions of the senior medical reviewer; and when doing so that employee is to be known as the senior medical reviewer.

(3) A person appointed as a medical reviewer or the senior medical reviewer must—

(a) be a medical practitioner;
(b) have been so throughout the 5 years prior to appointment; and
(c) have such other qualifications, training and experience as may be specified by regulations.

(4) A member of HIS may not exercise the functions of—

(a) a medical reviewer; or
(b) the senior medical reviewer.

(5) An employee of HIS (other than a medical reviewer) may not exercise any function of a medical reviewer other than those under section 16A.

(6) An employee of HIS (other than the senior medical reviewer) may not exercise the functions of the senior medical reviewer (except by virtue of arrangements made under paragraph 11(2B)).

(7) An appointment as a medical reviewer or the senior medical reviewer does not affect the appointed person’s status as employed under paragraph 7(5).”.

3 In paragraph 11 (delegation of functions)—

(a) in sub-paragraph (1), for “and” where it first occurs substitute “to”,
(b) after sub-paragraph (2) insert—

“(2ZA) HIS may authorise an employee to carry out the functions of a medical reviewer under section 16A.

(2A) Any other function conferred on a medical reviewer or the senior medical reviewer may not, subject to sub-paragraph (2B), be delegated by HIS.

(2B) The senior medical reviewer may, with the approval of HIS, make arrangements for the functions of the senior medical reviewer to be carried out by a medical reviewer where the senior medical reviewer is absent or otherwise unavailable.”.
SCHEDULE 2
(introduced by section 29)

MINOR AND CONSEQUENTIAL MODIFICATIONS

Cremation Act 1902 (c. 8)

1A In section 2(2) of the Cremation Act 1952 (procedure for regulations made under section 7 of the Cremation Act 1902) the words from “Any” to “and” are repealed.

Registration of Births, Deaths and Marriages (Scotland) Act 1965 (c. 49)

2 Section 21(5) of the 1965 Act (person having charge of place of interment to give notice of burial of still-born child without certificate) is repealed.

3 In section 24 of the 1965 Act (certificate of cause of death), after subsection (1), insert—

“(1A) A registered medical practitioner may, where invited to do so under section 10(2)(b) or 11(6) of the 2011 Act (action following unsatisfactory review), attest and transmit a replacement certificate to a medical reviewer or, as the case may be, the senior medical reviewer.”.

4 Section 27(2) and (3) of the 1965 Act (transmission of certificate of registration) is repealed.

5 In section 56(1) of the 1965 Act (interpretation)—

(a) before the entry for “birth” insert—

““the 2011 Act” means the Certification of Death (Scotland) Act 2011 (asp 00);”,

Cremation Act 1952 (c. 31)

1A In section 2(2) of the Cremation Act 1952 (procedure for regulations made under section 7 of the Cremation Act 1902) the words from “Any” to “and” are repealed.

Section 7A Forms of documentation for burning
The Scottish Ministers may make regulations prescribing the forms of notices, certificates and applications to be given or made before the burning of any human remains is permitted to take place.

Section 7B Procedure for regulations
A statutory instrument containing regulations under section 7 or 7A is subject to annulment in pursuance of a resolution of the Scottish Parliament.”.

(4) In section 8(1) (penalties for breach of regulations, &c), after “incur” insert “other than an offence under section 27A(1) of the Registration of Births, Deaths and Marriages (Scotland) Act 1965 (c. 49) (offence of disposal of body without authorisation)”.

Cremation Act 1902 (c. 8)

1 (1) The Cremation Act 1902 is amended as follows.

(2) In section 7 (regulations as to burning)—

(a) the words from “and” where it fifth occurs to “place” where it second occurs are repealed,

(b) the words from “Each” to “prescribe” are repealed.

(3) After section 7 insert—

“7A Forms of documentation for burning
The Scottish Ministers may make regulations prescribing the forms of notices, certificates and applications to be given or made before the burning of any human remains is permitted to take place.

7B Procedure for regulations
A statutory instrument containing regulations under section 7 or 7A is subject to annulment in pursuance of a resolution of the Scottish Parliament.”.

(4) In section 8(1) (penalties for breach of regulations, &c), after “incur” insert “other than an offence under section 27A(1) of the Registration of Births, Deaths and Marriages (Scotland) Act 1965 (c. 49) (offence of disposal of body without authorisation)”.

Cremation Act 1952 (c. 31)

1A In section 2(2) of the Cremation Act 1952 (procedure for regulations made under section 7 of the Cremation Act 1902) the words from “Any” to “and” are repealed.
(b) after the entry for “local authority” insert—

““medical reviewer” means a person appointed under paragraph 7A(1) of Schedule 5A to the National Health Service (Scotland) Act 1978 (c. 29);”,”

(c) after the entry for “relative” insert—

““senior medical reviewer” means a person appointed under paragraph 7A(2) of Schedule 5A to the National Health Service (Scotland) Act 1978 (c. 29);”.”
Certification of Death (Scotland) Bill

[AS PASSED]

An Act of the Scottish Parliament to make provision about the certification of death and still-birth certificates; to make provision for medical reviewers, the senior medical reviewer and their functions; and for connected purposes.

Introduced by: Nicola Sturgeon
On: 7 October 2010
Bill type: Executive Bill