Justice Committee

Inquiries into Fatal Accidents and Sudden Deaths etc. (Scotland) Bill

Healthcare Improvement Scotland response

Introduction

Healthcare Improvement Scotland is the national healthcare improvement organisation for Scotland. We have a vital role in supporting healthcare providers to deliver safer, more effective and more person-centred care and to achieve Scotland’s 2020 vision for health and social care.

Healthcare Improvement Scotland has been given the responsibility of designing a new system to review Medical Certificates of Cause of Death to improve public confidence and simplify and strengthen the governance in this area.

The Certification of Death (Scotland) Act 2011 introduces a number of changes to the current system. In particular, it introduces checks on the accuracy of Medical Certificate of Cause of Death (MCCDs) by setting up a new national review system.

From 13 May 2015 Healthcare Improvement Scotland will implement the Death Certification Review programme and run the service, with the review of MCCDs carried out by experienced and trained doctors.

Comments

General:

1. In general, there may be circumstances where it would be appropriate to instigate some sort of governance review short of a FAI so that lessons may be learned in a less adversarial manner which most observers would say has increasingly been adopted despite the historical aspiration of a FAI being an inquisitorial approach.

The relevant sections of the Bill to our role are sections 6 and 7, relating to Inquiries into deaths occurring abroad and our observations below relate to these:

2. Specifically, sections 6 and 7 are arguably most likely to impact on the MCCD system, under section 6, sub-section 3 (a) (i) and (b) of the Bill, where the Lord Advocate considers the criteria of when an inquiry is to be held.

3. Our service is concerned with ensuring the quality of the MCCD and seeking information in pursuit of the verification of the MCCD. The legislation has a number of catch all sections which mandate LA inquiry: 3(a)(i) ‘unexplained death’, 3(b) ‘circumstances of the death have not been sufficiently established in the course of an investigation’. Paradoxically this seems to promote a higher level of scrutiny and investigation in Scotland in comparison to that required of the Coroner in England and Wales where the statutory requirement is that of ‘the cause of death is unknown’ (Coroners and Justice Act 2009 s1(2)(c).
4. When the Bill comes into force we need to be clear how the Death Certification Reviewer Service (DCRS) fits into the safeguarding work of the legislation. The situation where the documentation is not in order (in the sense that the cause of death is insufficiently established for the purposes of a MCCD – our only metric) seems to present a fairly clear requirement to refer to the Procurator Fiscal (or perhaps request a Post Mortem - but if there is a likelihood that we will refer, a fiscal Post Mortem will likely be preferable). I would however anticipate that this could be quite a frequent occurrence, obviously depending on the jurisdiction of death.

5. It is certainly possible that DCRS will experience an increase in cases we refer to the PF and also, possibly, the number of autopsies we instruct which is currently budgeted for 12 per year.

6. Notwithstanding the proposals, COPFS may be reluctant to actually take on extra-jurisdictional cases because of the difficulties in effectively investigating them, especially in the current financial climate.

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