SPICe The Information Centre
An t-Ionad Fiosrachaidh

BRIEFING FOR THE CITIZEN PARTICIPATION AND PUBLIC PETITIONS COMMITTEE ON PETITION PE1894:

PERMIT A MEDICAL CERTIFICATE OF CAUSE OF DEATH (MCCD) TO BE INDEPENDENTLY REVIEWED, LODGED BY KENNETH ROBERTSON

BACKGROUND

Registration of deaths, death certifcates and reviews

In Scotland, deaths have to be registered with a Registrar within eight days of death and require a medical certificate of cause of death (MCCD). If someone dies in hospital then a post-mortem might be suggested to understand more about the person's illness for example. Otherwise, a person can donate their body for medical use/research, be buried or cremated according to their wishes.

According to NHS National Education for Scotland (Support Around Death (SAD))

> "The Certification of Death (Scotland) Act 2011 was designed to introduce a system of independent scrutiny of death certificates. This aims to improve the quality and accuracy of the information on MCCDs and to improve public health information.
>
> The act introduces a system of review of MCCDs by Medical Reviewers through random scrutiny of a representative sample of all MCCDs that are not reported to the procurator fiscal, or involving stillbirth. Each review examines the

appropriateness and accuracy of the completed certificate. They do not examine the clinical care prior to death.”

The Act also allows for an “interested person’’ such as a relative to request an Interested Person Review within three years of a death (after which a person’s health records are destroyed), and providing that the death certificate has not already been reviewed. In addition, a Targeted Review will be conducted in response to any identified pattern of death certification that raises concern. For example, to look at the trends of a particular condition causing deaths

There are two different levels of review, which vary in the detail to which the cases are examined.

NHS Healthcare Improvement Scotland (NHS HIS) have produced a FAQ document about death certification, Medical Certificates of Cause of Death (MCCD), how the law was changed by the 2011 Act and how MCCDs are reviewed. NHS HIS are the body that runs the independent review service. To the question ‘*Will HIS review all MCCD’s?*’ the response given was:

> “No. The system initiated on 13 May 2015 randomly selected about 10% of all deaths for Level 1 review, with additional Level 2 reviews. This did not include sudden or suspicious deaths, which are reported to the Procurator Fiscal (PF), or stillbirths. This meant that about 6,000 MCCDs a year were reviewed out of the 55,000 deaths that occur in Scotland annually.”

There is a SPICe blog on how deaths are recorded and certified in Scotland (written in the context of COVID-19 deaths).

Deaths reported to the Procurator Fiscal

The Crown Office and Procurator Fiscal Service (COPFS) provide information on deaths that are referred to the Procurator Fiscal (PF).

When a death is deemed sudden, suspicious, accidental, unexpected or unexplained it has to be reported to the Procurator Fiscal (PF) who has a duty to investigate the circumstances, and to decide whether criminal proceedings or a Fatal Accident Inquiry are appropriate. According to the Scottish Government web pages, in most cases reported to the PF, it is quickly established that death was due to natural causes.

A post-mortem (or autopsy) does not necessarily follow a death reported to the PF: a medical practitioner may have ascertained the cause of death and issued a MCCD. Investigations then continue into the circumstances of the death. However, if a post-mortem is deemed necessary, and instructed by the PF, consent of the next of kin is **not** required. The post-mortem will be carried out by a specially qualified medical practitioner, a pathologist. Sometimes, following post-mortem, the cause of death might be changed and a new death certificate issued.

The powers of the PF to conduct death investigations are based in the traditional and common law (the law developed through decisions by judges in individual cases). They aren't codified anywhere so that you can point to a particular procedure they need to go through.

Petitioner concerns

The petitioner is concerned that there is a deficiency in the legislation concerning death certification. He is concerned about those deaths that are referred by a doctor to the PF, not those where a death is certified and registered in the normal way.

In particular, he is interested in Section 4(6)(e) of the Certification of Death (Scotland) Act 2011.

This part of the legislation states that only eligible medical certificates can be called for review by an 'interested person'. Section 4 (6)(e) states that where the cause of death has been or is being investigated by a procurator fiscal, then the certificate is **not classed** as eligible for review as described above.

The Certification of Death (Scotland) Bill was scrutinised by the Health and Sport Committee in 2011. The rationale for the Bill was that the legislation required updating because much of it was over 100 years old, and the process of review, started in 2005, coincided with the inquiry into Dr Harold Shipman.

The Policy Memorandum (PM) for the Bill clearly states that one of the three overarching aims of the Bill was

> "To introduce a single system of independent, effective scrutiny **applicable to deaths that do not require a PF investigation**;"

This shows that PF-referred deaths were not being considered as part of the Bill and that such consideration in respect of this Bill was not Scottish Government policy at the time. This could have

been because of possible confusion that could be caused by any overlap: an investigation by the PF is, in essence, partly a medical review of the circumstances of someone's death.

The petitioner is possibly concerned about situations where the circumstances of a death are not clear cut, and where there might be a difference in opinion on the cause of death, or a cause of death is not determined by the PF. There could be circumstances where a death is referred to the PF and where the family or next of kin don't understand why, or feel there is a need for an additional medical opinion – an "interested person" review.

Section 4(6)(e) could potentially be amended, but it would depend on whether the government view or policy has changed since the Act was passed.

COPFS publish guidance for medical practitioners, to help them to decide whether a death should be reported to the Service.

This guidance includes circumstances where it is **not** necessary to report a death:

3. "Common misconceptions

"the following are not reasons for rendering the death reportable:

- That the death occurred within 24 hours (or any other timescale) of admission to hospital;
- That the death occurred within 24 hours (or any other timescale) of an operation;
- That the deceased, who had a terminal illness died earlier than expected;
- That the deceased had not been seen by a GP for some time; and
- That a consultant has instructed that the death be reported without specifying the reasons why.

4.2 A death certificate may be issued if a medical practitioner is able to identify a cause of death to the best of his or her knowledge and belief. **Certainty is not required**."

If someone is not happy about the process for PF-reported deaths

It is possible to complain about the services of the Crown Office and Procurator Fiscal Service about any aspect of their service. However, making such a complaint about seeking a further medical opinion or review would not qualify as a complaint because review is not part of the process of death investigation. Lodging a complaint would not therefore address the perceived 'gap' in the legislation as outlined by the petitioner.

The Crown Office and Procurator Fiscal Service has a Family Liaison Charter for bereaved family members. This gives some helpful background on the death investigation process, as well as a range of commitments on communicating with the family. It is possible to ask for a review of the decision to hold, or not hold, an Fatal Accident Inquiry. But there is no mention of a right of review for a decision in relation to the cause of death.

Legislation covering sudden, suspicious, accidental or unexplained deaths

There is other legislation that covers unexplained and sudden deaths: Inquiries into Fatal Accidents and Sudden Deaths etc. (Scotland) Act 2016.

The SPICe Briefing for the Bill explains in detail what the Bill sought to do, and also covers two related petitions. These might be of interest in relation to this petition.

The main focus of the 2016 Act are Fatal Accident Inquiries, of which there are around 50 a year. These might be deaths that occur because of a workplace accident or in a prison for example. However, there is provision to hold a Discretionary Inquiry if the Lord Advocate considers the death was sudden, suspicious or unexplained, **and** that an FAI would be in the public interest. There is also provision to conduct further proceedings if there is new evidence and if it is in the public interest.

Records of Fatal Accident Inquiries are held by the National Records of Scotland

Fatal Accident Inquiries (taken from SPICe Briefing for Stage 3 of the Fatal Accidents and Sudden Deaths etc. (Scotland) Bill)

> "FAIs are held to establish the circumstances surrounding certain deaths. They are presided over by sheriffs. The

sheriff may make recommendations aimed at preventing future deaths in similar circumstances.

Under the current law, mandatory FAIs must be held where someone dies in legal custody, or in an accident related to their work.

An FAI can also be held where a death is sudden, suspicious, unexplained or gives rise to serious public concern. The Lord Advocate (through the Crown Office and Procurator Fiscal Service, or COPFS) has discretion to hold an FAI in these circumstances where he decides it is "expedient in the public interest".

The Lord Advocate also has discretion **not** to hold an FAI (even a mandatory FAI) if the circumstances of the death have been adequately established in related criminal proceedings.

It is not possible to challenge the Lord Advocate's decision not to hold an FAI by appealing. However, such decisions can be the subject of a judicial review. This looks at the procedural aspects of the decision-making process rather than the merits of the case."

Related petitions

PE 1567 (27 April 2015) called for changes to the way unascertained deaths, suicides and fatal accidents are handled.

PE 1501 (13 December 2013) called for a mandatory inquiry into deaths judged to be self-inflicted or accidental permissible.

Scottish Parliament Action

See Petitions highlighted above

Anne Jepson
Senior Researcher
20/09/2021

SPICe research specialists are not able to discuss the content of petition briefings with petitioners or other members of the public. However, if you have any comments on any petition briefing you can email us at spice@parliament.scot

Every effort is made to ensure that the information contained in petition briefings is correct at the time of publication. Readers should be aware however that these briefings are not necessarily updated or otherwise amended to reflect subsequent changes.

Published by the Scottish Parliament Information Centre (SPICe), an office of the Scottish Parliamentary Corporate Body, The Scottish Parliament, Edinburgh, EH99 1SP