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Pàrlamaid na h-Alba

Official Report

HEALTH AND SPORT COMMITTEE

Wednesday 1 December 2010

Session 3

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HEALTH AND SPORT COMMITTEE
35th Meeting 2010, Session 3

CONVENER

*Christine Grahame (South of Scotland) (SNP)

DEPUTY CONVENER

*Ross Finnie (West of Scotland) (LD)

COMMITTEE MEMBERS

Helen Eadie (Dunfermline East) (Lab)
*Rhoda Grant (Highlands and Islands) (Lab)
Michael Matheson (Falkirk West) (SNP)
*Ian McKee (Lothians) (SNP)
*Mary Scanlon (Highlands and Islands) (Con)
*Dr Richard Simpson (Mid Scotland and Fife) (Lab)

COMMITTEE SUBSTITUTES

Joe FitzPatrick (Dundee West) (SNP)
Mr Frank McAveety (Glasgow Shettleston) (Lab)
Nanette Milne (North East Scotland) (Con)
Jamie Stone (Caithness, Sutherland and Easter Ross) (LD)

*attended

THE FOLLOWING GAVE EVIDENCE:

Elizabeth Allan (City of Edinburgh Council)
Gerard Boyle (National Association of Funeral Directors)
Dr Colin Fischbacher (NHS National Services Scotland)
Professor Stewart Fleming (University of Dundee)
Ishbel Gall (Association of Anatomical Pathology Technology)
Jim Nickerson (Federation of Burial and Cremation Authorities)
Dr Jeremy Thomas (Scottish Pathology Network)

CLERK TO THE COMMITTEE

Douglas Wands

LOCATION

Committee Room 4

Scottish Parliament

Health and Sport Committee

Wednesday 1 December 2010

[The Convener *opened the meeting at 10:33*]

Subordinate Legislation

National Health Service (General Medical Services Contracts) (Scotland) Amendment Regulations 2010 (SSI 2010/394)

National Health Service (Primary Medical Services Section 17C Agreements) (Scotland) Amendment Regulations 2010 (SSI 2010/395)

The Convener (Christine Grahame): Good morning. I welcome to the 35th meeting this year everyone who has managed to get here through what we will just call the weather, which is, of course, the reason why we are starting 30 minutes late. I remind everyone to switch off mobile phones and other electronic equipment. We have received apologies—because of the weather—from Helen Eadie. Michael Matheson hopes to join us later.

The first item is consideration of two negative Scottish statutory instruments that introduce changes under part 2 of the Tobacco and Primary Medical Services (Scotland) Act 2010, relating to criteria for persons eligible to be a party to a general medical services contract or primary medical services contract in Scotland. Members have a cover note from the clerk summarising the purpose of each instrument. As the Subordinate Legislation Committee has made no substantive points on either of these instruments, I do not propose to go through them one by one. If members have no comments on the instruments, are we content not to make any recommendations on them?

Members *indicated agreement.*

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 buried. 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 or question whether it can go ahead. 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.

The Convener: You say that it is not necessary that the single medical practitioner examine the alleged deceased, but I take it that it is discretionary?

Ishbel Gall: It is discretionary.

The Convener: So a GP could take a view if he knew the patient really well—if, for example, they were terminally ill.

Ishbel Gall: 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.

The Convener: They might have seen them in the morning. My point is that it is a matter of facts and circumstances for the GP, is it not?

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?

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 ball park—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: 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.

Ian McKee (Lothians) (SNP): As you do not want me to give evidence, there is not much point in asking whether I want to come in on the point.

The Convener: Okay—I was just asking whether you had a question.

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 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.

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 supplementaries 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 being 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-unqualified 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.

The Convener: Not at all—although it is kind of you to say so.

Mary Scanlon: I refer to a question that I asked the bill team last week, about the money that is required to register a death. There seem to be serious concerns on the part of registrars that you do not wish to be the people who collect the charge for the registration of a death, which is subject to a statutory requirement. You feel that it is like a death tax. The evidence seems consistent: that registrars are very much against having to collect a fee for registering a death. 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

them to the attention of the doctor who is to sign the second part of the form. Is that not the case?

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.

The Convener: As there are no further questions, that concludes the session. I thank the witnesses very much for their attendance and for making it through to the committee.

Meeting closed at 12:27.

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