Citizen Participation and Public Petitions Committee

6th Meeting, 2021 (Session 6), Wednesday 3 November 2021

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

Note by the Clerk

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

Introduction

1. This is a new petition that has been under consideration since 23 August 2021.

2. A SPICe briefing has been prepared to inform the Committee's consideration of the petition and can be found at **Annexe A**.

3. While not a formal requirement, petitioners have the option to collect signatures on their petition. On this occasion, the petitioner elected not to collect signatures.

4. The Committee seeks views from the Scottish Government on all new petitions before they are formally considered. A response has been received from the Scottish Government and is included at **Annexe B** of this paper.

5. A submission has been provided by the petitioner. This is included at **Annexe C.**

Background Information

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

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

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

SPICe Briefing

9. The SPICe briefing accompanying this petition highlights that 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).

10. It notes that the petitioner is concerned that there is a deficiency in the legislation concerning death certification in relation to deaths that are referred by a doctor to the Procurator Fiscal, rather than those where a death is certified and registered in the normal way.

11. The petitioner highlights Section 4(6)(e) of the Certification of Death (Scotland) Act 2011 which states that the MCCD is not eligible for review where the cause of death has been or is being investigated by a Procurator Fiscal.

12. The briefing notes that the Scottish Parliament's Health and Sport Committee considered the Certification of Death (Scotland) Bill in 2011 and that the policy memorandum accompanying the Bill clearly states that one of the key aims of the Bill was to 'introduce a single system of independent, effective scrutiny applicable to deaths that do not require PF [Procurator Fiscal] investigation'.

13. The SPICe briefing suggests that the reason PF-referred deaths were not considered as part of the Bill may be due to possible confusion caused by any overlap, i.e. because an investigation by the Procurator Fiscal is, in essence, partly a medical review of the circumstances of someone's death.

14. The briefing notes that the Crown Office Procurator Fiscal Service produces guidance for medical practitioners to help them decide whether a death should be reported to them.

Scottish Government Submission

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

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

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

18. DCRS cannot, however, review the quality of care provided to the deceased person prior to their death.

19. The Scottish Government states that the Crown Office and Procurator Fiscal Service (COPFS) is responsible for the investigation of all sudden, unexpected or unexplained deaths in Scotland, noting that in many cases investigated by COPFS, the MCCD will be provided by a pathologist, who is an independent doctor and specialist in causes of death.

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

21. The submission concludes by stating that the Scottish Government does not intend to amend the Certification of Death (Scotland) Act 2011 to enable DCRS to review cases previously investigated by COPFS.

Petitioner Submission

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

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

24. The petitioner references section 17 of the Burial and Cremation Review Group and its finding that COPFS investigates around 10% of deaths reported to it because they fall into a variety of defined criteria.

25. The petitioner suggests that 'there are thousands of deaths every year in Scotland which are referred to the Procurator Fiscal but not investigated' and as such 'none of these are eligible for medical review by the DCRS'.

26. The petitioner goes on to suggest that 'every death certificate should potentially be available for scrutiny by a second doctor independent of the certifying doctor.'

Action

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

Clerk to the Committee

PE1894: PERMIT A MEDICAL CERTIFICATE OF CAUSE OF DEATH (MCCD) TO BE INDEPENDENTLY REVIEWED

Petitioner

Kenneth Robertson

Date Lodged

23 August 2021

Petition summary

Calling on the Scottish Parliament to urge the Scottish Government to change the Certification of Death (Scotland) Act 2011 to permit a medical certificate of cause of death (MCCD) to be independently reviewed by a Medical Reviewer from the Death Certification Review Service, where the case has already been reviewed by the Procurator Fiscal but not by a medical professional expert.

Previous action

I have written to my constituency MSP, Mr Jackson Carlaw, drawing his attention to the fact that a weakness exists in the 2011 Act which prevents independent medical review of MCCDs where the death has been reported to the Procurator Fiscal for any reason.

He suggested one avenue to consider pursuing would be a public petition.

Background information

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

It is self-evident that review by a legal expert is not equivalent to review by a medical expert. Furthermore, explanatory notes for the Act state that certificates for any deaths referred to the Procurator Fiscal are excluded from medical review.

In Scotland, anyone can refer a death to the Procurator Fiscal, however, there is no obligation to investigate. An investigation may also only involve asking the certifying doctor if they are willing to certify the cause of death

to the best of their knowledge and belief, which is what is required from a medical practitioner.

I believe that this creates a dangerous loophole that could be exploited to cover up sub-standard care.

Annexe A

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 <u>not</u> 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 Accindent 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

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20/09/2021

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Scottish Government submission of 22 September 2021
PE1894/A: Permit a medical certificate of cause of death (MCCD) to be independently reviewed

The death of a loved one is stressful at any time. When someone dies, it is crucial that services work together in a coordinated and appropriate way to reduce the burden on bereaved people.

The Death Certification Review Service (DCRS) was established on 13 May 2015 with the aims of improving the quality and accuracy of Medical Certificates of Cause of Death (MCCD); improving public health information about causes of death in Scotland; and improving clinical governance issues identified during the death certification review process. The statutory guidance, which is published by the Scottish Government, provides information on the key operational principles for the purposes of the Certification of Death (Scotland) Act 2011 and can be found here.

To achieve its aims, each year, DCRS, part of Healthcare Improvement Scotland, checks the accuracy of approximately 12% of all Medical Certificates of Cause of Death (MCCDs) in Scotland. In addition, DCRS carries out Interested Person Reviews in cases where questions or concerns about the content of an MCCD remain after an individual has spoken to the certifying doctor, or if questions or concerns occur at a later stage. The purpose of an Interested Person Review is to check the accuracy of the information contained in the MCCD.
It is important to note that DCRS does not review the quality of care provided to the deceased prior to their death, neither does DCRS have any role in reviewing deaths where the cause of death of the deceased person has been (or is being) investigated by the Procurator Fiscal.

Investigating the quality of care that someone received prior to their death is the function of the clinical governance processes in health boards. Where an individual has a concern about the quality of care the deceased received, it is the role of the relevant health board to address and investigate the concerns about the care provided by them. The individual can also approach the Ombudsman if they are not satisfied by the processes followed by the health board.

Medical doctors are expected to report only certain deaths to the Crown Office and Procurator Fiscal Service (COPFS). The circumstances on which a death must be reported to COPFS can be found in sections 3 and 4 of Reporting deaths to the Procurator Fiscal Information and Guidance for Medical Practitioners.

COPFS is responsible for the investigation of all sudden, unexpected and unexplained deaths in Scotland. When a death is investigated by COPFS, in many cases the MCCD is provided by a pathologist, an independent doctor and specialist in causes of death. Where a medical practitioner is willing to certify a cause of death, the Procurator Fiscal will only permit that after having carried out whatever investigations are considered appropriate. It is for COPFS to decide which deaths it investigates and in how much detail, when a death is reported under the specified categories.

The role of the procurator fiscal in Scotland was not altered by the establishment of the Death Certification Review Service. The recommendations of the Burial and Cremation Review Group, chaired by Sheriff Brodie, were taken into account when developing the Certification of Death (Scotland) Act 2011. Section 17 of the report, available here, explains some of the rationale relating to the integration of any new procedures with the COPFS procedures and legislation – "*The Group acknowledged that any new death certification or procedure must integrate fully and easily into the relevant legislation and the current COPFS procedures as set out in the COPFS Book of Regulations, which is constantly under review.*"

The Procurator Fiscal undertakes their own review and determines whether or not the case warrants further investigation. Given that COPFS is independent and has the responsibility to investigate these cases, it would not be appropriate for DCRS to review MCCDs in cases already investigated by COPFS.

As noted above, it is not the role of DCRS to review or investigate the care provided to an individual prior to their death. The systems and process for investigating such matters are provided within the clinical governance processes of the relevant health board. When a death is investigated by COPFS, it is for COPFS to determine the level of investigation required in each specific case and it would not be appropriate for DCRS to review cases already investigated by COPFS.

The Scottish Government does not intend to amend the Certification of Death (Scotland) Act 2011 Act to enable DCRS to review cases previously investigated by COPFS.

Petitioner submission of 6 October 2021

PE1894/B: Provide clear direction and investment for autism support

Dame Janet Smith, in the Shipman Inquiry third report 2003 (available from https://www.gov.uk/government/publications/the-shipman-inquiry-third-report-death-certification-and-the-investigation-of-deaths-by-coroners), said:

The fact that the system of death certification of the cause of death depends on a single doctor does not give rise only to the risk of concealment of crime or other wrongdoing by that doctor. There may be occasions when a doctor knows that a death may have been caused or contributed to by some misconduct, lack of care or medical error on the part of a professional colleague.

The Death Certification Review Service (DCRS) introduced a level of independent scrutiny of the cause of death notified by the certifying doctor to improve the quality and accuracy of the medical certificate of cause of death (MCCD) and thereby help to deter criminal activity and poor medical practice. The Crown Office and Procurator Fiscal Service (COPFS) is unable to provide that level of independent scrutiny because the Procurator Fiscal is not medically qualified and it is self-evident that determination of the cause of death is essentially a medical matter. The Procurator Fiscal is therefore entirely dependent upon the pathologist, or a Medical Reviewer from the DCRS, for independent medical advice. At present, deaths that are reported to the Procurator Fiscal are not reviewed by DCRS as is confirmed in A Guide to Death Certification Review in Scotland (available from https://www.sad.scot.nhs.uk/media/16242/a-guide-to-death-certification-review-v20.pdf). Yet, only 10% of deaths which are reported to the Procurator Fiscal are investigated according to the Report and Recommendations of the Burial and Cremation Review Group. Section 17 of the report explains:

The COPFS currently investigates around 10% of deaths reported to it because they fall into a variety of defined criteria e.g. unexpected or suspicious deaths, deaths in the workplace.

If this figure is to be relied upon then 90% of deaths which are reported, that is to say referred, to the Procurator Fiscal are not investigated and, subsequently, there is no independent medical scrutiny of the cause of death. In these cases, it must be presumed that the Procurator Fiscal permits the medical practitioner to certify the cause of death to the best of their knowledge and belief after asking a few questions. It should be noted that Dr

Shipman always held that the deaths of his murdered patients were expected to him.

In 2012/13, the latest year for which figures are available (https://www.crownoffice.gov.uk/foi/responses-we-have-made-to-foi-requests/40-responses2014/685-post-mortems), 11,021 death reports were received by the Procurator Fiscal and 5,177 deaths resulted in a Procurator Fiscal instructed post-mortem examination which equates to approximately 47% of reported deaths being autopsied. Consequently, it is clear that there are thousands of deaths every year in Scotland which are referred to the Procurator Fiscal but not investigated and none of these are eligible for medical review by the DCRS.

This unsatisfactory situation has arisen because of an Explanatory Note (available from https://www.legislation.gov.uk/asp/2011s/11/notes/content), which has never been approved by the Scottish Parliament but is attached to the Certification of Death (Scotland) Act 2011. Explanatory Note 19 states:

Certain certificates are excluded from this type of review. These are cases where [...] the death has been referred to the procurator fiscal.

This is a reference to section 4(6)(e) of the 2011 Act which states:

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

There is an obvious inconsistency here because the 2011 Act only prevents deaths which have been or are being investigated by the Procurator Fiscal from being reviewed by the DCRS whereas the Explanatory Note, which does not form part of the Act, prevents the DCRS from reviewing deaths which are merely referred, that is to say reported, to the Procurator Fiscal. In Scotland, anyone can report a death to the Procurator Fiscal and the DCRS is then prevented from checking that the relative MCCD is in order.

In order to provide reassurance to the public, I consider it necessary that every death certificate should potentially be available for scrutiny by a second doctor independent of the certifying doctor. At present, many thousands of cases which are referred to the Procurator Fiscal are exempted from any medical scrutiny because they are not subject to a full and proper investigation. The 2018 Briefing note on investigation of deaths and FAI (available from https://www.crownoffice.gov.uk/media-site-news-from-copfs/1819-briefing-note-on-investigation-of-deaths-and-fai) states:

In all cases investigated by the Crown, a medical certificate of cause of death is issued by a medical professional, normally by a pathologist, following a post-mortem examination instructed by the Procurator Fiscal.

In my view, this should clearly be the standard required for an investigation under the 2011 Act and all other deaths should be available for review by the DCRS.