Healthcare Improvement Scotland | DCRS Death Certification Review Service

Death Certification Review Service

Annual Report 2021 – 2022

NHS SCOTLAND

Published October 2022

www.healthcareimprovementscotland.org

Contents

Senior Medical Reviewer Overview

Dr George Fernie
Senior Medical Reviewer

While we continue to live with considerations and pressures associated with the Covid-19 pandemic, we are in a very different situation to last year and the Death Certification Review Service returned successfully to business as usual on 7 March 2022.

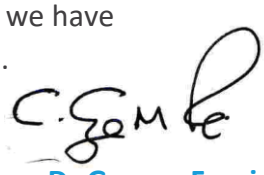
This meant a reintroduction of an enhanced Level 1 review because of changes effected at the start of the pandemic and bringing back the more detailed Level 2 reviews which require the service to source additional corroborative material. Simultaneously, we established direct access to clinical portals (electronic patient medical records) in most of the West of Scotland which has helped reduce administration for both the service and Health Boards.

Whilst I always have a sense of guilt in talking about any benefits we have accrued from the pandemic which resulted in so many early and unexpected deaths, we have through necessity made changes that resulted in more effective working and are now reaping benefits. In particular, we refined the new case management system with positive outcomes not just for our team but also for those that have lost a loved one.

Whilst considering my last festive message to the DCRS team, it was with a sense of foreboding, having seen the modelling of the likely impact of the Omicron variant. I recall trying to reassure them with the words of a songwriter of my own generation that 'all things must pass'. As it happened, the benefits of the vaccination programme and adherence to the general measures advised, combined to produce a far better outcome in 2022 than could have been anticipated. Some of the DCRS team, myself included, being belatedly infected with SARS-CoV-2 recently, reminds us of the devastation caused by this virus although very different to the experiences of patients in early 2020.

Preliminary figures suggested that the improvement previously achieved was maintained which, in the circumstances, was remarkable and a testament to the professionalism of all doctors who produce and review certificates of death.
To you all I should like to express my profound gratitude.

We have much to look forward to going ahead and, importantly, we have robust systems in place and know what we would like to achieve.



Dr George Fernie
Senior Medical Reviewer

Highlights

Public Assurance

5,444 MCCDs reviewed in 2021-2022

5,444

Clinical Support

2,279 enquiry calls received and responded to in 2021-2022

2,279

Improvement

51.3% fewer MCCDs with errors since DCRS began

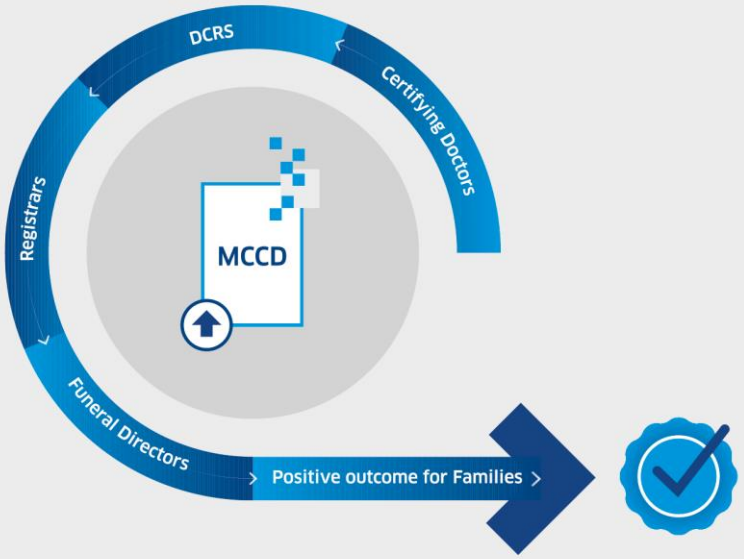
51.3%

Responsibility

91% of doctors believe that correct MCCDs are important

91%

Partnership Working



Impact for families

Average time to complete a review

Level 1 - less than **4 hours**
Level 2 - just over **9 hours**

L1 <4 hours
L2 >9 hours

Improving the Quality and Accuracy of Medical Certificates of Cause of Death (MCCD)

Death Certification Review Service

The Certification of Death (Scotland) Act 2011[1] is the legislative framework within which the Death Certification Review Service operates. The role of the service[2] is to improve:

- quality and accuracy of MCCDs, giving the public confidence in the death registration process in Scotland.
- public health information about causes of death in Scotland, supporting consistency in recording that will help resources to be directed to the best areas in a more timely way.
- clinical governance, helping to improve standards in Scottish healthcare.

The service approach to improvement is education and partnership working. This has proved to be a successful combination resulting in more MCCDs over time, being 'in order'[3].

The Covid-19 pandemic increased public awareness and interest in death certification and ensuring accurate recording of a cause of death and a timely registration process was never more important.

Because of the pandemic, the service has worked closely with key stakeholders over the last two years, implementing a 'Hybrid' review process that provided the assurance the public expected alongside adjustments to the review selection rate that allowed front line services to focus on delivery of care.

> *It can seem a bit scary, almost as though you are bound to have got something wrong, but the possibility that you may be randomly chosen does focus the mind when completing the certificate.*
>
> ***Certifying doctor***

[1] https://www.legislation.gov.uk/asp/2011/11/pdfs/asp_20110011_en.pdf

[2] https://www.healthcareimprovementscotland.org/our_work/governance_and_assurance/death_certification/review_service_information.aspx

[3] The Certification of Death (Scotland) Act 2011, s8 (4) explains 'in order' as "where a medical reviewer is satisfied, on the basis of the evidence available to the medical reviewer, that:
a) the cause (causes) of death mentioned represents a reasonable conclusion as to the likely cause (causes) of death, and
b) the other information contained in the certificate is correct."
'Not in order' is when section s8 (4) of the Act is not satisfied.

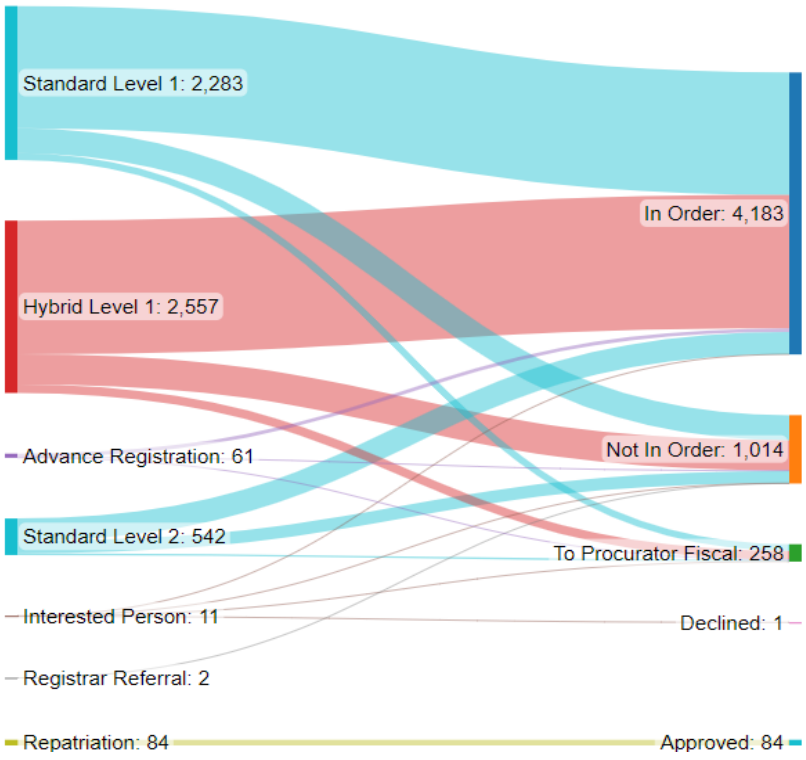
Case Overview

The service reviewed a total of **5,540** cases in 2021/22. Of which,

Randomised Reviews					
Hybrid	46.5%	**Standard Level 1**	41.6%	**Standard Level 2**	10.2%
Non Randomised review					
Repatriation	1.5%	**Interested Person**	0.19%	**Registrar Referral**	<0.1%

The diagram [4] below shows a breakdown by case type[5] and outcome of cases received.

Sankey diagram of number of cases and breakdown of case type and outcome in 2021/22[6]



The reviews I have been involved in have always been informative.

Certifying doctor

[4] The Sankey diagram should be read from left to right. It shows how one category is broken down into components, then how a second and subsequent categories are broken down. The diagram shows the size of the connecting paths between the categories.

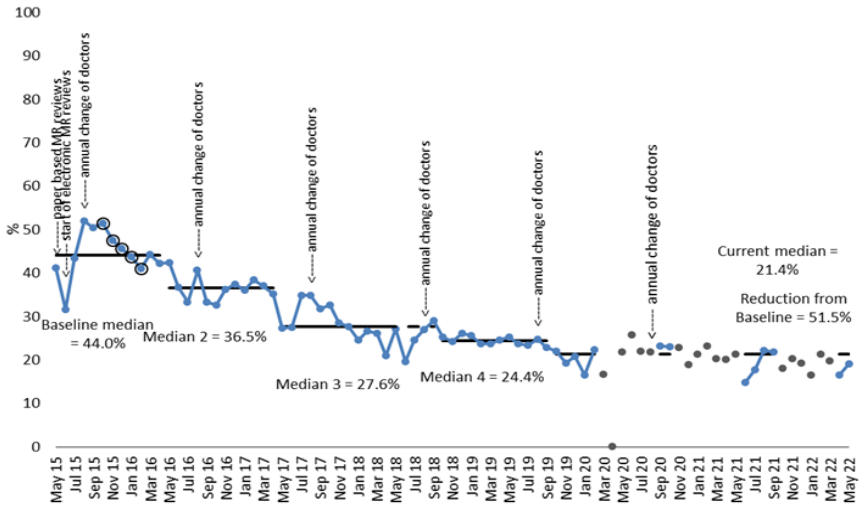
[5] Level 1 reviews consist of a review of the MCCD and a discussion with the certifying doctors, Level 2 reviews also require a review of patient medical records.

[6] See Appendix for full breakdown of cases over last 3 years

Random Review Outcomes

The monthly percentage of randomly selected[7] MCCDs found to be 'not in order' has seen a sustained improvement to a temporary current median of 21.5%, a provisional **improvement of 51.3%** from the baseline level of 44.0%.

Run chart of monthly percentage MCCDs 'not in order' for Scotland

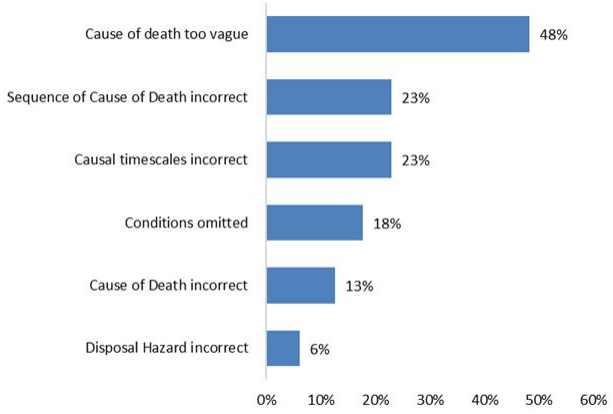


Note: *Run chart analysis includes periods when the service is operating as 'business as usual' (blue dots). Analysis pertaining to hybrid reviews (grey dots) can be found in the next section of the report.*

Clinical Improvements

In 2021/22, there were 1,009 MCCDs 'not in order'. Of those, 728 (72%) of MCCDs 'not in order' had at least **one clinical closure category** recorded with 48% being classified as 'Cause of Death too Vague'.

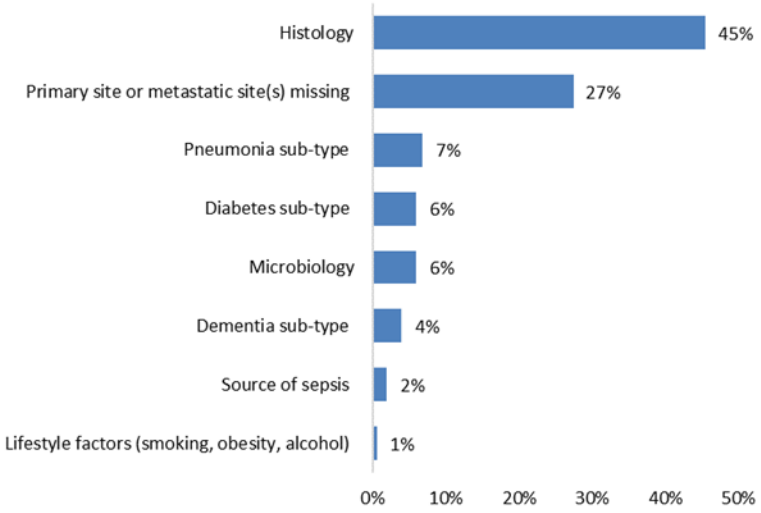
Breakdown of closure category as a percentage of clinical categories



[7] MCCDs are randomly selected for review by National Records of Scotland using an algorithm that selects approx 10% of MCCDs for Level 1 review and 2% at Level 2. In certain circumstances, a review can be escalated from Level 1 to Level 2. https://www.healthcareimprovementscotland.org/our_work/governance_and_assurance/death_certification/questions_and_answers.aspx

Analysis of reviews closed with 'Cause of Death too Vague' recorded shows that 45% are due to Histology, and 27% due to primary site or metastatic site(s) missing[8].

Breakdown of 'Cause of death too vague' closure as a percentage of total number

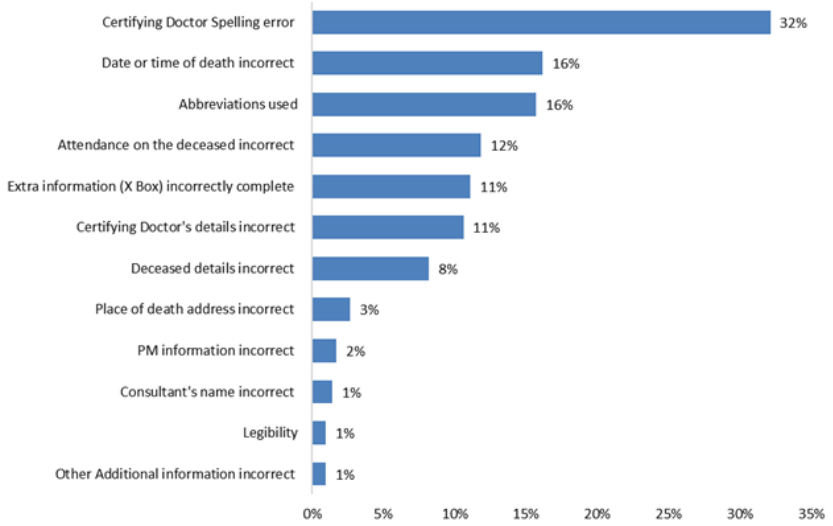


Note: *MCCDs can be closed with more than one closure category.*

Administrative Improvements

Administrative errors are spelling mistakes, use of abbreviations and failing to sign the certificate. In 2021/22, 41% of MCCDs 'not in order' had an administrative closure category recorded. Certifying doctor spelling error being recorded against 133 MCCDs (32%).

Breakdown of 'Administrative errors' category as a percentage of total number



*The **Improved Histology***

MCCD reported cause of death as: *Oesophageal cancer*

Improved MCCD to: *Squamous cell carcinoma of oesophagus*

Medical Reviewer

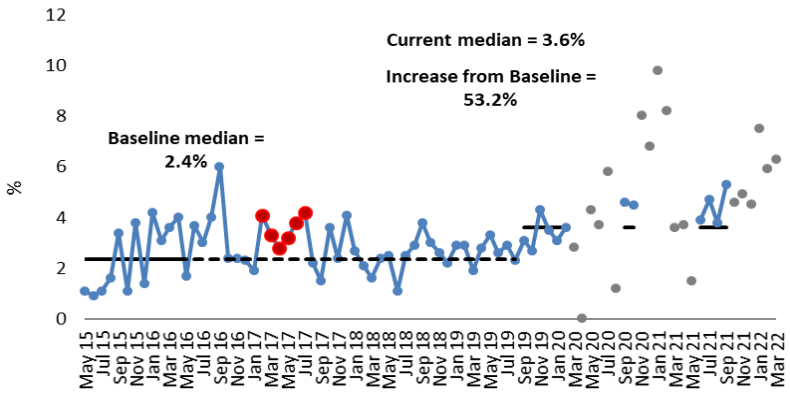
[8] See Appendix for full breakdown of reasons for 'not in order'

Reports to the Procurator Fiscal

Sudden, suspicious, accidental and unexplained deaths including deaths which may give rise to public anxiety are required to be reported to the Procurator Fiscal[9].

Our medical review team found 258 (4.7%) of all certificates reviewed by the service during the past year should actually have been reported to the Procurator Fiscal. The run chart shows a sustained increase of 53.2%, from 2.4% to 3.6% since Sept 2019.

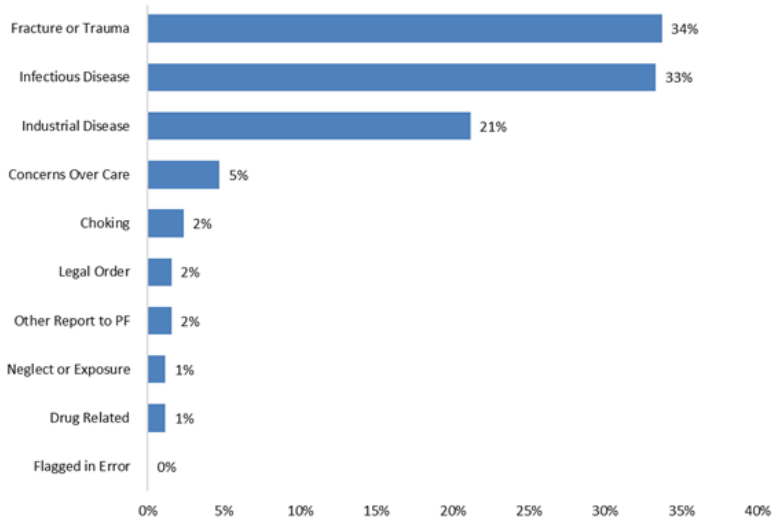
Run chart of monthly percentage reviews to Procurator Fiscal



Note: *Run chart analysis includes periods when the service is operating as 'business as usual' (blue dots). Analysis pertaining to hybrid reviews (grey dots) can be found in the 'Hybrid Review' section.*

The most common reasons for failing to report to the Procurator Fiscal are detailed below[10]:

Reasons for reporting to the Procurator Fiscal



*The **Procurator Fiscal Guidance***

MCCD reported other significant conditions (part ii) as: *Self neglect*
Reason to report to Procurator Fiscal: *patient had 'Self Neglect' recorded against previous hospital admissions, however declined offer of support. Consideration by Procurator Fiscal necessary to establish if non-compliance/lack of engagement with services were factors in hastening the death.* ***Medical Reviewer***

[9] Details of cases required to be reported to the Procurator Fiscal can be found on the Crown Office and Procurator Fiscal office website: https://www.copfs.gov.uk/for-professionals/reporting-deaths/reporting-deaths/

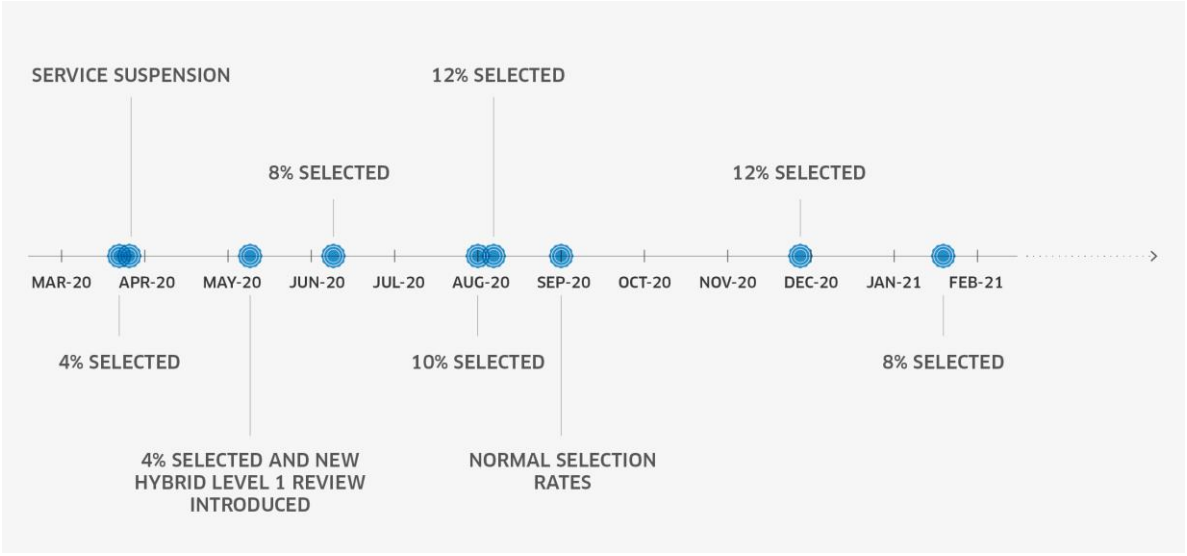
[10] See Appendix for full breakdown of main reasons for reporting to the Procurator Fiscal

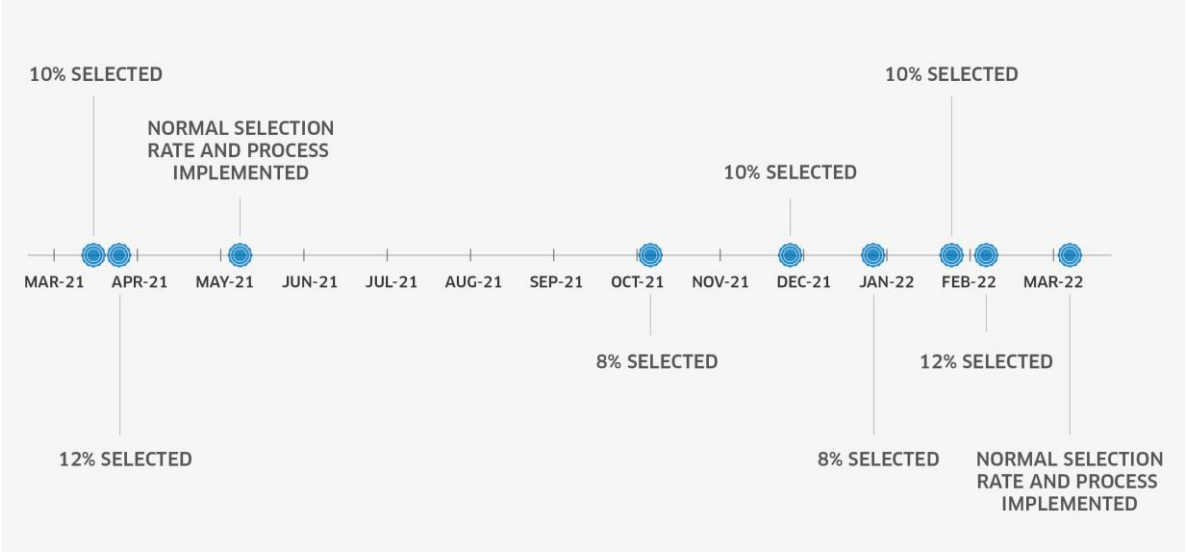
Public health information

Hybrid Review

The service introduced 'Hybrid'[11] reviews in response to the Covid-19 pandemic and worked closely with Scottish Government, monitoring and adjusting the proportion of MCCDs selected for review. This varied from 4% at the peak of the pandemic, to 12% when the number of deaths being reported had reduced significantly. The timeline below shows the changes implemented over the last 2 years.

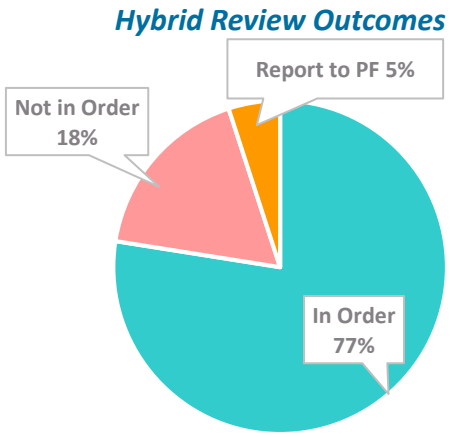
Timeline of changes to selection rates





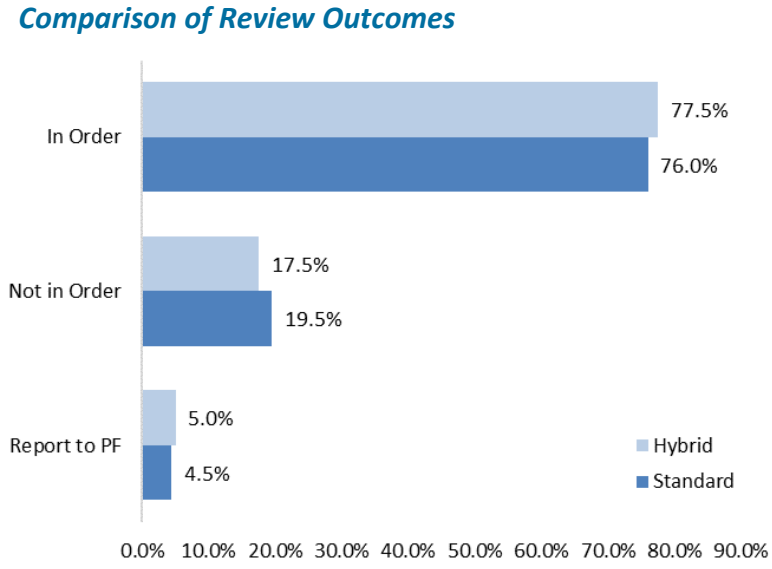
[11] Hybrid reviews are Level 1 reviews, used when the service MCCD selection rate is not 'business as usual' and allows the service medical reviewers to amend minor errors, such as spelling mistakes, allowing certifying doctors to focus on patient care and bereaved families to register the death without unnecessary delays.

In **2021/22**, the service reviewed **2,557** MCCDs using Hybrid Level 1 process. The breakdown below shows the outcome Hybrid reviews [12].



Standard v Hybrid Review Outcome

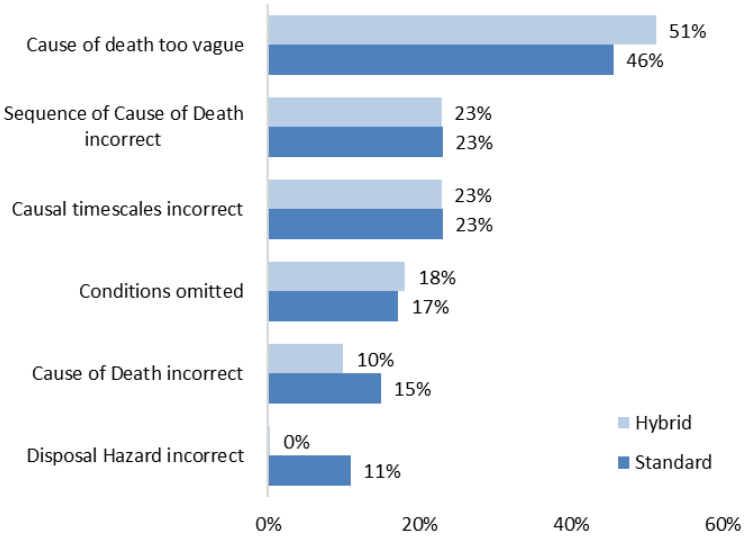
The service carried out comparative analysis of the outcomes of reviews using standard and hybrid review processes. The graph below shows the percentages of MCCDs 'not in order' were similar for both review types.



[12] See Appendix for full breakdown of Hybrid review outcomes

The comparison revealed 'Cause of death too vague' remains the most common reason attributed to inaccurate completion of an MCCD, with this occurring slightly more often during the period of hybrid reviews[13].

Comparison of closure category as a percentage of clinical categories



*The **Collaboration***

I'd like to record my thanks to everyone who has been involved in this work over the last two years. It's appeared seamless but I know that's because of the hard work that's gone on in the background.

Member of Burial and Cremation Team Scottish Government

[13] See Appendix for full breakdown of Hybrid review outcomes

Non randomised reviews

Interested person, registrar referrals and 'for cause' reviews

Members of the public can request an Interested Person review[14] and registrars can refer an MCCD to the service for review if they feel the certificate is not accurate.

The service will carry out a Level 2 review, if the death has not previously been reviewed by us, or the death has not already been reported to the Procurator Fiscal. Review numbers remain low. Last year

- 11 interested persons' reviews, of which one was declined as the death had been considered by the procurator fiscal previously
- two registrar referrals[15].
- No 'for cause' reviews[16].

Below is a breakdown of the outcome of these reviews[17].

Outcomes of non randomised review

Deaths outwith Scotland (repatriations)

The service is responsible for approving burial or cremation in Scotland, of people who have died abroad and want to be repatriated to Scotland.

In 2021/22, the service received 84 repatriation requests. All were approved, with 57 (67.9%) approved for cremation, and 27 (32.1%) for burial. One family requested a post mortem which was approved.

[14] http://www.healthcareimprovementscotland.org/our_work/governance_and_assurance/death_certification/review_service_information/interested_person_review.aspx

[15] Registrar referrals: If a registrar considers an MCCD to be incorrect they can make a request to the service to carry out a review of the certificate.

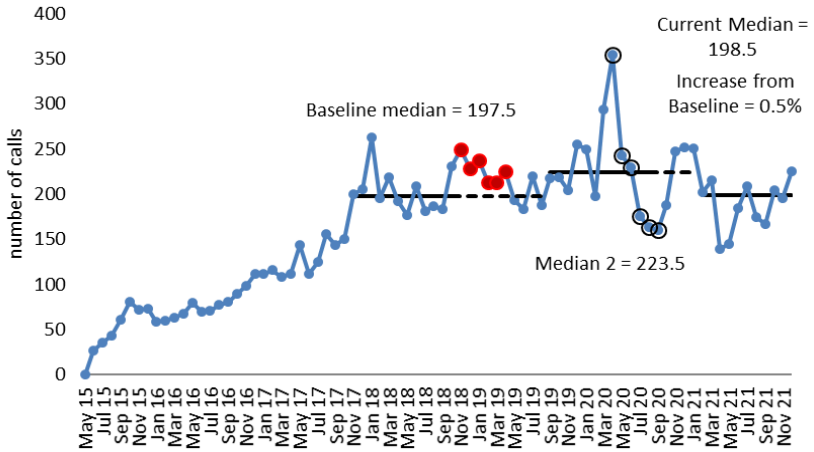
[16] For cause reviews: A review of a series of certificates written by the same doctor to support improvement. This can be for a specified number of certificates or an agreed length of time which is agreed by the doctor's supervisor.

[17] See Appendix for full breakdown of non-randomised reviews

Enquiry Line

The service dealt with 2,279 calls last year. The run chart below shows calls to the service have returned to around 200 per month following a sharp increase during the height of the Covid-19 pandemic.

Number of calls to the enquiry line by month



The majority of calls (81.8%)[18], were from doctors seeking clinical advice on how to represent a death on a MCCD.

- GP clinical advice 1,489 (65.3%)
- Hospital clinical advice 337 (14.8%)
- Hospice clinical advice 39 (1.7%)

Sudden and unexpected death audit

Medical Reviewer, Dr Sonya McCullough carried out an audit of 100 enquiry calls to establish the 'efficacy of our advice line in supporting doctors issue an MCCD following a sudden or unexpected death.

The majority (91%) of sudden/unexplained deaths in the audit were deaths in the community, with most patients being aged 60 years and over (92%).

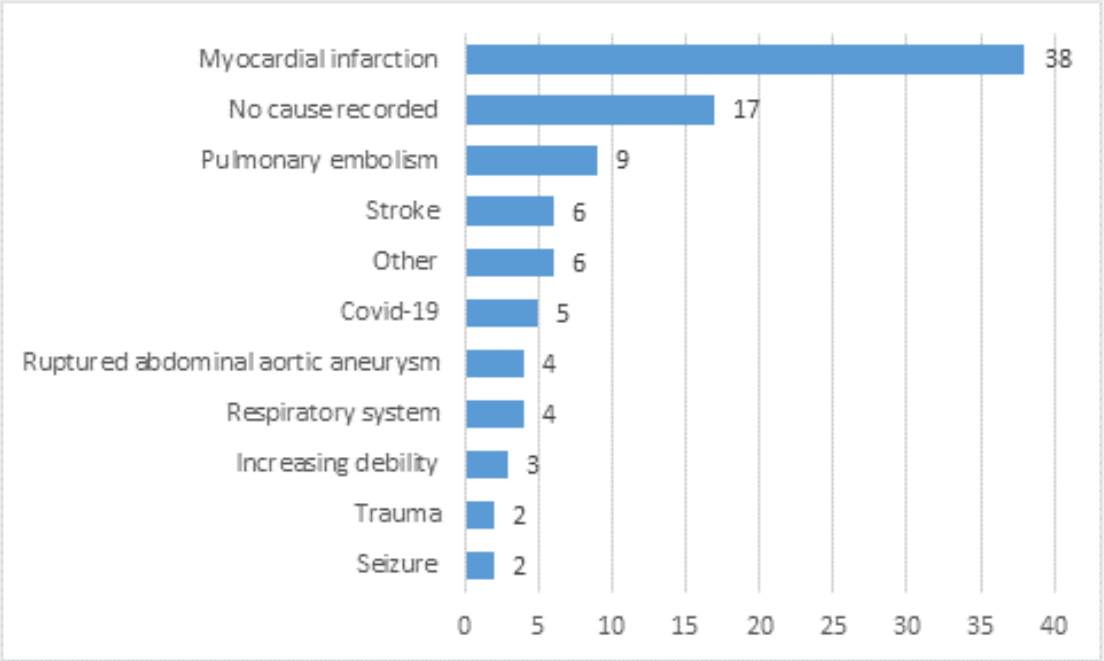
Following conversation with our medical review team, 58% of certifying doctors issued an MCCD, indicating the value of the service to GPs.

The Procurator Fiscal was involved in 17 deaths as 'no cause of death' was established, indicating appropriate signposting to the Crown Office and Procurator Fiscal Service.

[18] See Appendix for full breakdown of enquiry call over last 3 years

The graph below details the direct cause of death established during the call.

Enquiry call direct cause of death outcome



*The **Enquiry Line***

***GP call to DCRS:** 85 year old care home resident. History of Alzheimer's Disease (5 years) with increasingly frailty. Contracted COVID-19 disease in the care home which resulted in death 9 days later.*

***Outcome:** The discussion assisted the GP to formulate a sequence of cause of death of: COVID-19 disease with Alzheimer's Disease as a secondary cause. The service reminded the doctor deaths from COVID-19 disease contracted in a care home must be reported to the Procurator Fiscal.*

Medical Reviewer

Service Performance

The service operates under agreed service level agreements set by the Scottish Government. The table below shows the service continues to complete reviews well within the required timescales.

Service Level Agreements

Review Type	Service Level Agreement timescale	Average Review time per working hour
Level 1	1 working day	**Less than 4 hours**
Level 2	3 working days	**Just over one day**
Advance registration	2 hours	**Less than one hour**
Senior medical review	1 working day	**No cases**
Interested person	3 to 14 days	**Under 3 days**
Repatriation	5 working days	**Under 2 days**

Advance Registration

Families who have suffered a bereavement may need the funeral to go ahead promptly and the service aims to support this through our advance registration process.

The number of advanced registration applications remains low with 61 in 2021/22. Of these requests 45 (73.8%) were approved and of the 16 (26.2%) not approved, 68.8% were declined as the review was either complete or nearing completion. The service failed to make a decision on 2 requests within the 2 hour time frame.

Certifying doctor feedback

The service carried out a smart survey in June 2021 seeking feedback from doctors selected for review. Overall, responses from the **166 respondents** was very positive.

We asked if…	Response
DCRS staff were friendly and courteous	99% agree
The Medical reviewer explained the review process clearly	90% agree
The medical reviewer understood the case	99% agree
The review was educationally focused	88%
Length of review call was just right	98%
Experience of the review process has highlighted the importance of getting the MCCD accurate	91%

Key themes from the feedback, which we continue to progress, included consistency with advice around Reporting of Covid-19 deaths to the Procurator Fiscal, education and impact of review process on delivery of front line services.

Gathering views

Due to government restrictions around the pandemic, the service has been unable to seek views on the death registration process directly from bereaved families.

Instead we formed a 'Registrars' focus group and collated anecdotal feedback on the death registration process, which included;

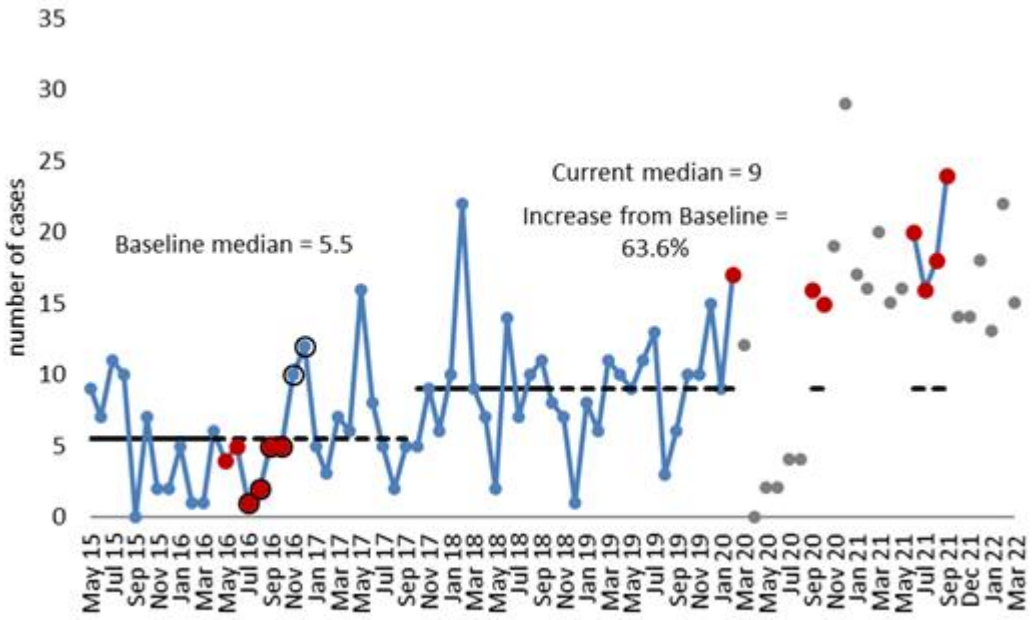
- Electronic MCCD registration was arguably more 'public friendly'
- Delays with registration if death required reporting to the Procurator Fiscal, which was understandable given the significant increase in reportable deaths,
- Remote registration was better for families as they could do this from the comfort of their own home with family support.

Breached Cases

It has been a challenging year for the health service which has resulted in delays in completing reviews within the agreed timescales (breached cases).

In 2021/22, we had 217 breached cases[19] during 'business as usual' periods, with 187 (86.2%) due to the certifying doctor being unavailable. The run chart below shows since January 2020, the service is taking longer to conclude our reviews.

Number of SLA breaches by month



[19] See Appendix for full breakdown of breached cases

Feedback and Complaints

In 2021/22 we dealt with 4 complaints, 2 were upheld, one partially upheld and one not upheld[20].

As part of service improvement, learning from all concerns have been addressed through updated processes and full staff training.

Service Developments

In response to longer review times and feedback from Health Board staff on the challenges of being able to positively support MCCD reviews whilst providing direct clinical care, the service has been working with Health Boards to establish direct access to patient clinical portals. We currently have access to West of Scotland (WofS) portals and continue to progress access with other boards.

Training and education

The service continues to work with NHS Education for Scotland and have produced a range of educational resources to support doctors, healthcare professionals, funeral directors, registrars and members of the public through the review process. All our resources, including a new animation which talks you through how to complete a paper MCCD accurately can be found at:

https://www.sad.scot.nhs.uk/atafter-death/death-certification or

https://www.healthcareimprovementscotland.org/our_work/governance_and_assurance/death_certification/educational_support.aspx

*The **Clinical Portal***

MCCD reported cause of death as:
Part: 1a) *Bowel perforation, 1b) Ischaemic bowel, 1c) Atrial fibrillation*
Part 2: *Ischaemic heart disease, Peripheral vascular disease, immunoglobulin A nephropathy.*

Outcome: *The medical reviewer accessed the clinical portal which had copies of the Immediate Discharge Summary and a letter from a Nephrology out-patient appointment which confirmed the conditions and the sequence of fatal events. The service were able to carry out a focused review with the doctor who had written an excellent MCCD.*

Medical Reviewer

[20] https://www.healthcareimprovementscotland.org/our_work/governance_and_assurance/death_certification/complaints_and_feedback.aspx

What we will do in 2022–2023

We will…

- Continue to work with NHS boards to reduce the number of clinical and administrative errors on MCCDs and failing to report deaths to the Procurator Fiscal
- Work with health boards to roll out eMCCD into secondary care
- Progress direct access to Health Board clinical portals to reduce administrative resource requirements within boards
- Participate in the MCCD educational advisory group to support accurate completion of MCCDs across Scotland

Acknowledgements

Thank you to colleagues at Healthcare Improvement Scotland, National Services Scotland, National Records of Scotland and our own team. Your excellent collaborations have helped us to assure accurate death certification over the last year. Special thanks to Rod Burns, Jennifer Morris, Sandra McDougall and Debbie Redgate who have taken up new opportunities. And to our data analyst Keir Robertson, thank you for your support in developing our new data reports.

Death Certification Review Service Management Board

The service is funded by the Scottish Government and supported by the Death Certification Review Service Management Board. We hope you have enjoyed reading about our work. If you have any comments please get in touch at his.dcrsadmin@nhs.scot.

Name	Designation	Organisation
Maggie Buettner Young	IT Programme Manager & Engagement Lead	National Services Scotland (Digital and Security)
Gillian Aitken	Head of Process	National Records of Scotland
Cathy Dunlop	Senior Registrar, East Ayrshire	Association of Registrars of Scotland
Dr George Fernie	Senior Medical Reviewer	Healthcare Improvement Scotland (DCRS)
Angela Hay	Operations Team Manager	Healthcare Improvement Scotland (DCRS)
Alexandra Jones	Public Partner	Healthcare Improvement Scotland
Clare Dunn	Public Partner	Healthcare Improvement Scotland
Lynsey Cleland	Director of Quality Assurance	Healthcare Improvement Scotland
Ann Gray	Principal Procurator Fiscal Depute	Scottish Fatalities Investigation Unit
Burial & Cremation, Anatomy and Death Certification team		Scottish Government
Tim Norwood	Data & Measurement Advisor	Healthcare Improvement Scotland
Dr Ruth Stephenson	Deputy Senior Medical Reviewer	Healthcare Improvement Scotland (DCRS)
Maria Stirling	Specialty Trainee	Scottish Academy of Trainee Doctors
Andrea Telford	Service Manager	Healthcare Improvement Scotland (DCRS)
Janice Turner	Principal Educator, Medical Education	NHS Education for Scotland

Healthcare Improvement Scotland

The service is part of Healthcare Improvement Scotland, an organisation with one purpose – better quality health and social care for everyone in Scotland.

For more information visit http://www.healthcareimprovementscotland.org/

Appendix 1: Service data

The tables below provide a more detailed breakdown of the service data over the last 3 years[21].

Table 1: Cases reviewed by type

Case type	Year 5 01 Apr 2019 - 31 Mar 2020	Year 6 01 Apr 2020 - 31 Mar 2021	Year 7 01 Apr 2021 - 31 Mar 2022
Standard Level 1 and Level 2	5635 (93.4%)	4322 (97.6%)	5382 (97.1%)
Advance Registration	175 (2.9%)	42 (0.9%)	61 (1.1%)
Repatriation	212 (3.5%)	55 (1.2%)	84 (1.5%)
Interested Person	6 (0.1%)	6 (0.1%)	11 (0.199%)
Registrar Referral	3 (0%)	2 (0%)	2 (0.04%)
MR For Cause Referral	0 (0%)	0 (0%)	0 (0%)
Total	*6031*	*4427*	*5540*

Table 2: Number and percentage of 'not in order' cases by outcome

Outcome	Year 5 01 Apr 2019 - 31 Mar 2020	Year 6 01 Apr 2020 - 31 Mar 2021	Year 7 01 Apr 2021 - 31 Mar 2022
Email amendments	1131 (92%)	810 (89.6%)	892 (88.4%)
Replacement MCCD	99 (8%)	94 (10.4%)	117 (11.6%)
Total	*1230*	*904*	*1009*

Table 3: Number and percentage of clinical closure categories for MCCDs with errors

Closure Category	Year 5 01 Apr 2019 - 31 Mar 2020	Year 6 01 Apr 2020 - 31 Mar 2021	Year 7 01 Apr 2021 - 31 Mar 2022
Cause of Death too vague	494 (53.3%)	347 (55.1%)	351 (48.2%)
Cause of Death incorrect	129 (13.9%)	75 (11.9%)	92 (12.6%)
Sequence of Cause of Death incorrect	242 (26.1%)	135 (21.4%)	167 (22.9%)
Causal timescales incorrect	184 (19.9%)	122 (19.4%)	167 (22.9%)
Conditions omitted	192 (20.7%)	98 (15.6%)	129 (17.7%)
Disposal Hazard incorrect	25 (2.7%)	38 (6%)	45 (6.2%)
Total	*1266*	*815*	*951*

Note: there can be more than one closure category error in each case

Table 4: Number and percentage of cases with closure category 'administrative error'

Administraive Error	Year 5 01 Apr 2019 - 31 Mar 2020	Year 6 01 Apr 2020 - 31 Mar 2021	Year 7 01 Apr 2021 - 31 Mar 2022
Attendance on the deceased incorrect	0 (0%)	0 (0%)	49 (11.8%)
Abbreviations used	80 (20.5%)	59 (15.6%)	65 (15.7%)
Certifying Doctor's details incorrect	48 (12.3%)	39 (10.3%)	44 (10.6%)
Certifying Doctor Spelling error	123 (31.5%)	112 (29.6%)	133 (32.1%)
Consultant's name incorrect	0 (0%)	0 (0%)	6 (1.4%)
Date or time of death incorrect	0 (0%)	0 (0%)	67 (16.2%)
Deceased details incorrect	104 (26.7%)	126 (33.3%)	34 (8.2%)
Extra information (X Box) incorrectly comp	46 (11.8%)	45 (11.9%)	46 (11.1%)
Legibility	2 (0.5%)	2 (0.5%)	4 (1%)
PM information incorrect	0 (0%)	0 (0%)	7 (1.7%)
Place of death address incorrect	0 (0%)	0 (0%)	11 (2.7%)
Other Additional information incorrect	34 (8.7%)	26 (6.9%)	4 (1%)
Total	*437*	*409*	*470*

Note: there can be more than one administrative error in each case

[21] Data source: Death Certification Review Service eCMS and National Records of Scotland.

Table 5: Cases reported to procurator fiscal by type

Case type	Year 5 01 Apr 2019 - 31 Mar 2020	Year 6 01 Apr 2020 - 31 Mar 2021	Year 7 01 Apr 2021 - 31 Mar 2022
Standard Level 1 and Level 2	174 (95.1%)	248 (98.8%)	254 (98.4%)
Advance Registration	8 (4.4%)	2 (0.8%)	1 (0.4%)
Interested Person	0 (0%)	0 (0%)	3 (1.2%)
MR For Cause Referral	0 (0%)	0 (0%)	0 (0%)
Registrar Referral	1 (0.5%)	1 (0.4%)	0 (0%)
Total	*183*	*251*	*258*
% cases reported to PF	3.1%	5.7%	4.7%

Table 6: Hybrid data

Review Outcome	Year 6 01 Apr 2020 - 31 Mar 2021	Year 7 01 Apr 2021 - 31 Mar 2022
In order	2166 (75.3%)	1981 (77.5%)
Not in order	539 (18.7%)	448 (17.5%)
CD report to PF	172 (6%)	128 (5%)
Total	*2877*	*2557*

Table 7: Number of calls received by the enquiry line

	Year 5 01 Apr 2019 - 31 Mar 2020	Year 6 01 Apr 2020 - 31 Mar 2021	Year 7 01 Apr 2021 - 31 Mar 2022
eMCCD issue	15 (0.6%)	13 (0.5%)	0 (0%)
Funeral Director	26 (1%)	16 (0.6%)	10 (0.4%)
GP Clinical Advice	1637 (62%)	1802 (67.3%)	1489 (65.3%)
GP Process Advice	185 (7%)	161 (6%)	152 (6.7%)
Hospice Clinical Advice	80 (3%)	78 (2.9%)	39 (1.7%)
Hospice Process Advice	9 (0.3%)	10 (0.4%)	6 (0.3%)
Hospital Clinical Advice	438 (16.6%)	362 (13.5%)	337 (14.8%)
Hospital Process Advice	37 (1.4%)	30 (1.1%)	44 (1.9%)
Informant/family	17 (0.6%)	28 (1%)	52 (2.3%)
Interested Person	0 (0%)	0 (0%)	6 (0.3%)
Other	57 (2.2%)	52 (1.9%)	27 (1.2%)
Procurator Fiscal	9 (0.3%)	14 (0.5%)	6 (0.3%)
Registrar	0 (0%)	0 (0%)	23 (1%)
Registrar Case Not Selectec	41 (1.6%)	42 (1.6%)	0 (0%)
Registrar Case Selected for	6 (0.2%)	14 (0.5%)	0 (0%)
Repatriation	5 (0.2%)	2 (0.1%)	1 (0%)
Signposted	69 (2.6%)	53 (2%)	38 (1.7%)
DCRS Protocol issue	10 (0.4%)	0 (0%)	0 (0%)
No advice type recorded	0 (0%)	0 (0%)	49 (2.2%)
Total	*2641*	*2677*	*2279*

Table8: Advance registration requests with outcomes

Request outcome	Year 5 01 Apr 2019 - 31 Mar 2020	Year 6 01 Apr 2020 - 31 Mar 2021	Year 7 01 Apr 2021 - 31 Mar 2022
Approved	117 (66.9%)	29 (69%)	45 (73.8%)
Not approved	58 (33.1%)	13 (31%)	16 (26.2%)
Review outcome			
In order	135 (77.1%)	35 (83.3%)	52 (85.25%)
not in order	32 (18.3%)	5 (11.9%)	8 (13.11%)
PF	8 (4.6%)	2 (4.8%)	1 (1.64%)
Total	*175*	*42*	*61*

Table 9: Number (and percentage) of Breached Cases

Reason for breach	Year 5 01 Apr 2019 - 31 Mar 2020	Year 6 01 Apr 2020 - 31 Mar 2021	Year 7 01 Apr 2021 - 31 Mar 2022
Certifying doctor unavailable	111 (86.7%)	131 (84%)	187 (86.2%)
MR unavailable	3 (2.3%)	4 (2.6%)	6 (2.8%)
Other*	12 (9.4%)	15 (9.6%)	22 (10.1%)
Paper record cannot be delivei	1 (0.8%)	0 (0%)	1 (0.5%)
Paper record is lost	0 (0%)	0 (0%)	0 (0%)
System error breach	1 (0.8%)	0 (0%)	0 (0%)
System unavailable	0 (0%)	6 (3.8%)	1 (0.5%)
Total	*128*	*156*	*217*

Table 10: Number and percentage of interested person reviews

Request outcome	Year 5 01 Apr 2019 - 31 Mar 2020	Year 6 01 Apr 2020 - 31 Mar 2021	Year 7 01 Apr 2021 - 31 Mar 2022
Not Approved	1 (16.7%)	2 (33.3%)	1 (9.1%)
Approved	5 (83.3%)	4 (66.7%)	10 (90.9%)
Total Requests	*6*	*6*	*11*

Table 11: Number and percentage of registrar referral reviews

Review outcome	Year 5 01 Apr 2019 - 31 Mar 2020	Year 6 01 Apr 2020 - 31 Mar 2021	Year 7 01 Apr 2021 - 31 Mar 2022
In order	0 (0%)	1 (50%)	0 (0%)
Not in order	2 (66.7%)	0 (0%)	2 (100%)
Escalated to PF	1 (33.3%)	1 (50%)	0 (0%)
Total	*3*	*2*	*2*

Table 12: Number and percentage of repatriation reviews

Request outcome	Year 5 01 Apr 2019 - 31 Mar 2020	Year 6 01 Apr 2020 - 31 Mar 2021	Year 7 01 Apr 2021 - 31 Mar 2022
Approved	212 (100%)	55 (100%)	84 (100%)
Not approved	0 (0%)	0 (0%)	0 (0%)
Total	*212*	*55*	*84*

You can read and download this document from our website.
We are happy to consider requests for other languages or formats.
Please contact our Equality and Diversity Advisor on 0141 225 6999
or email his.contactpublicinvolvement@nhs.scot

Death Certification Review Service
Healthcare Improvement Scotland

Gyle Square
1 South Gyle
Edinburgh
EH12 9EB

0300 123 1898
his.dcrs@nhs.scot
www.healthcareimprovementscotland.org