Healthcare Improvement Scotland | DCRS Death Certification Review Service

Death Certification Review Service

Annual Report 2022 - 2023

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Senior Medical Reviewer Overview 2022/23

Dr George Fernie
Senior Medical Reviewer

On writing the overview to last year's annual report, it was with cautious optimism as we were starting to exit the pandemic and moving gently to what would be the 'new normal'. I reported that the Death Certification Review Service returned successfully to business as usual on 7 March 2022.

However, we had learned a number of lessons from dealing with COVID-19 disease and by the autumn of 2022 it became apparent that pressures were building. There were continuing cases of coronavirus in the community in conjunction with the predicted upsurge of Influenza A and at the same time there were a number of norovirus cases in care homes. Taking into account the experience from the past two years, we recommended that it would be appropriate to modify the random sampling rate of medical certificates of cause of death (MCCDs[1]) to take pressure off general practice and secondary care. We did this successfully, re-adopting hybrid reviews and varying the percentage of reviews selected between January and March 2023 in response to these exceptional circumstances across Scotland. An important factor was the need for public reassurance with the period for reduction being as short as possible and the rate increasing as quickly as practicable. Business as usual reviews were re-introduced on 20th March 2023.

The service has been progressing direct access to NHS clinical portals (patient medical notes) across Scotland to facilitate the more detailed level 2 review. This year we successfully connected to clinical viewer in the East of Scotland. This reduces the administrative burden within boards and improves the focus of reviews. At the time of writing, connection to the remainder of Scottish boards had been achieved.

Looking ahead, the service will continue to work closely with NHS boards to reduce the number of clinical and administrative errors on MCCDs and continue to educate on appropriate reporting of deaths to the Procurator Fiscal.

We will continue to collaborate with National Services Scotland (NSS), which provides services and advice to the NHS and wider public sector, and the Scottish Government to roll out eMCCD into secondary care. The first phase of the NHS Lothian Pilot was successful and we await some IT system change to support the second component of testing.

[1] MCCD is a paper certificate. eMCCD is an electronic certificate.

As indicated last year, we participate in the MCCD educational advisory group hosted by NHS Education Scotland to support accurate completion of MCCDs across Scotland. Part of this work consisted of reviewing the DCRS website and updating training materials to ensure consistency with the revised Chief Medical Officer (CMO) guidance.

We will again work with this group to develop new materials including our 'be kind' poster which highlights some of the most common errors made when completing an MCCD and getting it 'right' at the 'right' time, which seems a good note upon which to end this foreword.

Dr George Fernie
Senior Medical Reviewer

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

Death Certification Review Service

The Certification of Death (Scotland) Act 2011[2] is the legislative framework within which the Death Certification Review Service operates. The role of the service[3] is to improve:

- quality and accuracy of MCCDs, giving the public assurance 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[4], helping to improve standards in Scottish healthcare.

The service's 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'[5].

MCCDs are randomly selected for either a Level 1 or Level 2 review by National Records of Scotland (NRS) Forward Electronic Registration (FER) system.

During the Covid-19 pandemic the service worked closely with key stakeholders and introduced a 'Hybrid' review process that continued to provide the assurance the public expected, whilst adjusting the review selection rates to allow front line services to focus on delivery of care and death registrations to continue without delay.

During the winter 2022/23, the service re-introduced Hybrid reviews in response to increasing demands within health boards.

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

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

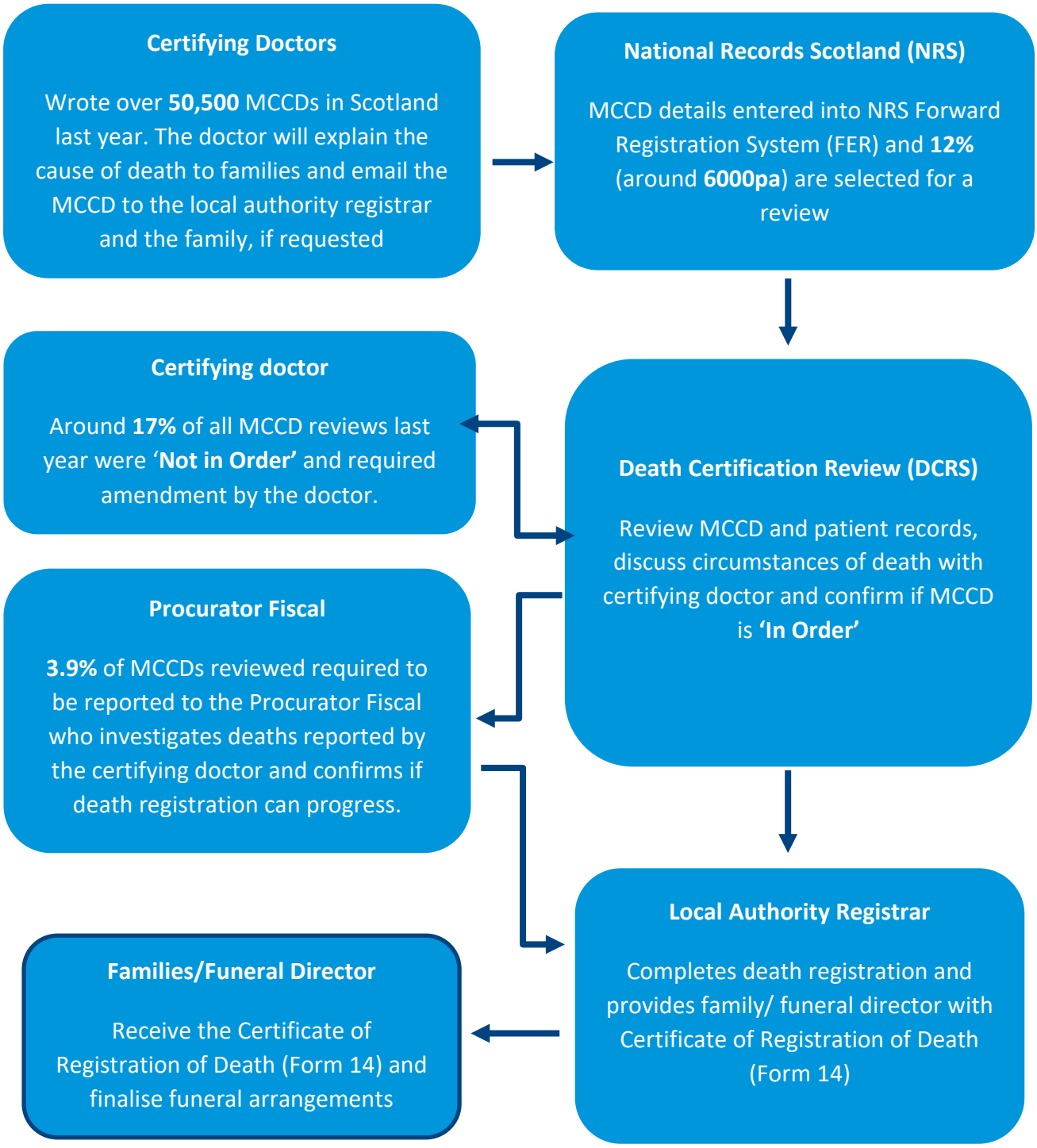
[4] The framework through which healthcare organisations are accountable for continuously improving the quality of their services and safeguarding high quality of care.

[5] 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.

Journey of a Medical Certificate of Cause of Death (MCCD)

Depending on the cause and circumstances of a death an MCCD can travel in a number of directions and can stop at a number of places on the way, each stop adding delays to families being able to complete funeral arrangements.

The flowchart below shows the journey of the MCCD.



Highlights

Public Assurance

6,071 MCCDs reviews completed

Clinical Support

98% of doctors surveyed found the enquiry line to be very helpful

Continuous Improvement

78.7% of MCCD's reviewed were 'in order'

Stakeholder feedback

"I have used this service many times and have had a positive experience on every occasion. It's a very good and helpful service and has definitely improved the quality of the death certificates I complete."

Certifying doctor

Impact for families

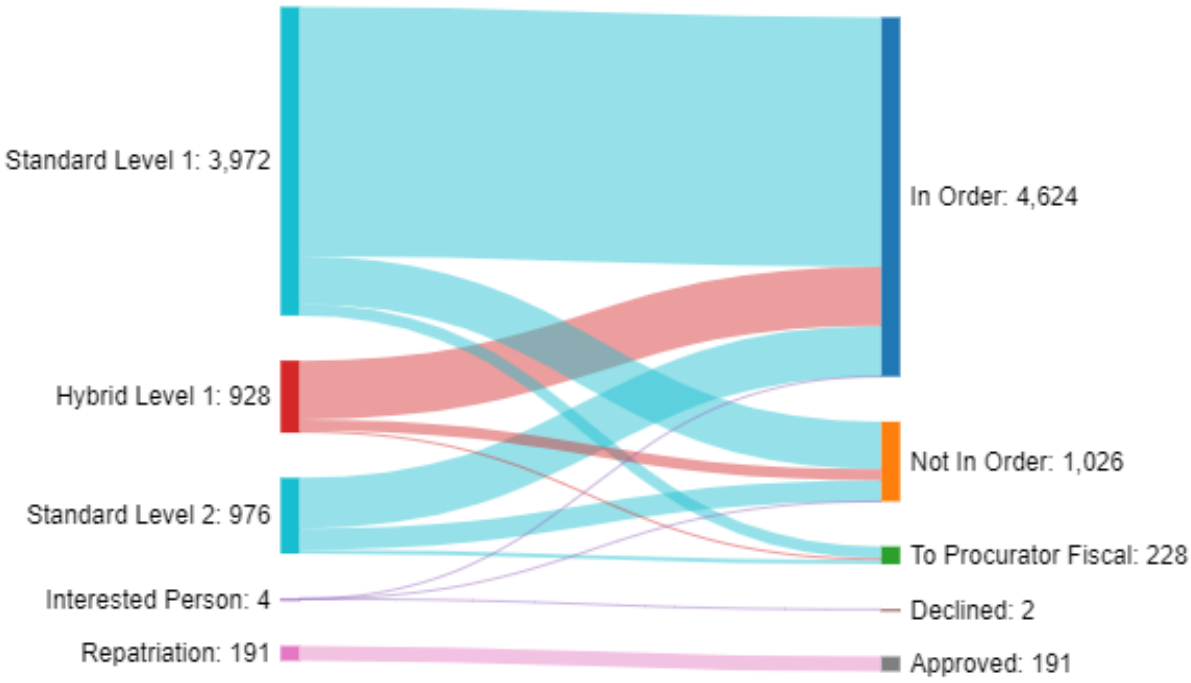
Average review time

Level 1 - less than **4 hours**
Level 2 - just over **8 hours**

Case Overview

The service reviewed a total of **6,071** cases in 2022/23, of which 5876 were standard reviews[6] and 195 non-standard[7] reviews. The diagram [8] below shows a breakdown by case type and the outcome for cases reviewed.

Sankey diagram of number of cases and breakdown of case type and outcome in 2022/23[9]



Enquiry Line

The service dealt with 2,546 enquiries last year. A return to around 200 per month following a sharp increase during the height of the Covid-19 pandemic.

The majority of calls (83.9%), were from doctors seeking clinical advice on how to best represent a death on a MCCD.

- GP clinical advice 1,716 (67.4%)
- Hospital clinical advice 384 (15.1%)

[6] Standard Reviews (Level 1, Level 2, Hybrid). 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. Hybrid reviews are Level 1 reviews, used in conjunction with reduced MCCD selection rates and allows the medical reviewers to amend minor errors, allowing certifying doctors to focus on patient care and allow bereaved families to register the death.

[7] Non Standard Reviews (Interested Person, Repatriations and For Cause)

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

[9] See Appendix 1 for full breakdown of cases and enquiries over last 3 years.

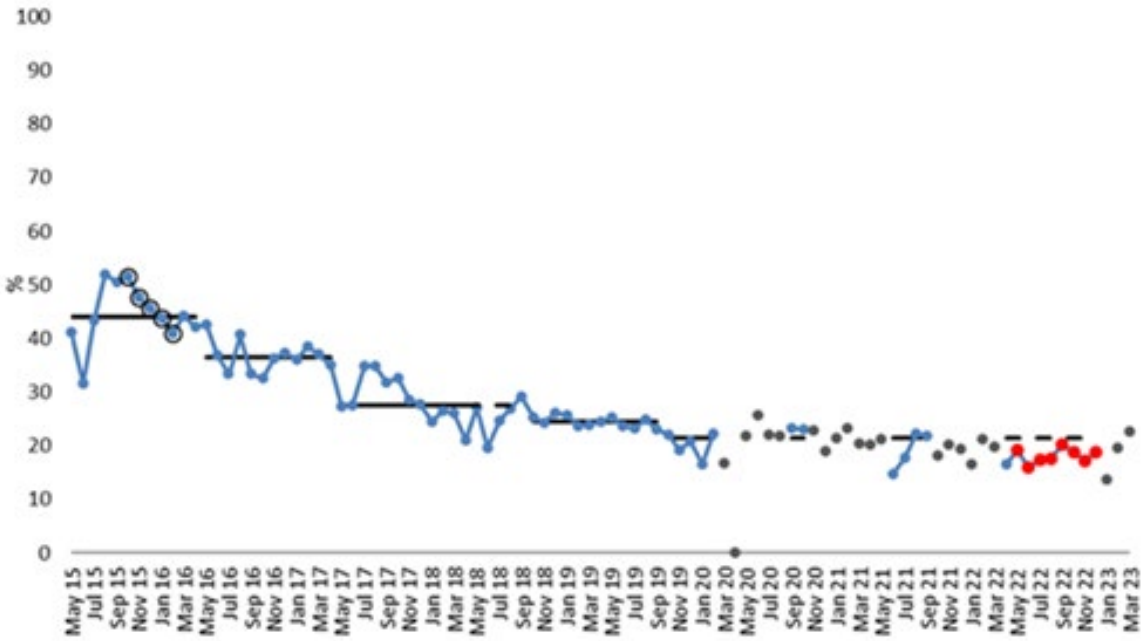
- Hospice clinical advice 36 (1.4%)

Review outcomes

Standard Reviews

The monthly percentage of MCCDs found to be 'not in order' has seen a sustained improvement to a current median of 21.4%, an **improvement of 51.5%** from the baseline level of 44.0%. There are signs of a further decrease below the current median, however run chart analysis was paused between January and March 2023 due to a return to Hybrid reviews and varied levels of case selection rates in response to pressures highlighted within Health Boards over the winter.

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), hybrid reviews (grey dots), signal of improvement (red dots)*

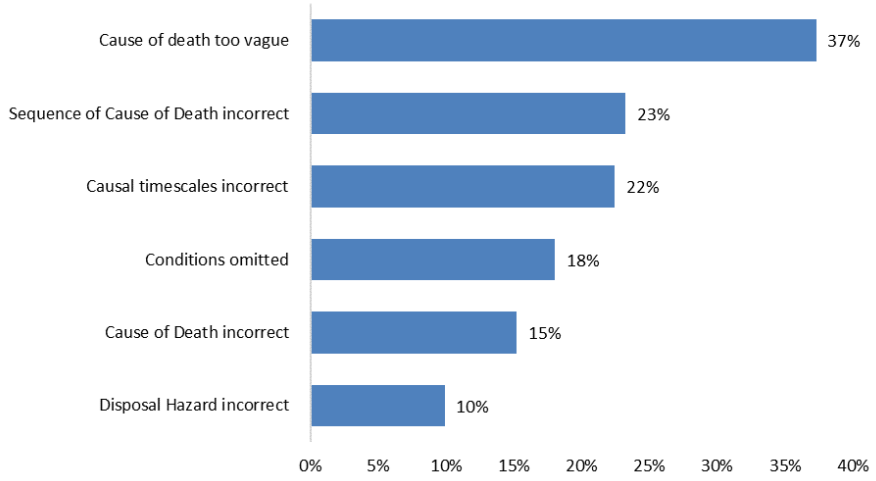
Clinical Improvements

In 2022/23,

- **1,025 (17.4%)** of MCCDs reviewed were found to be **'not in order'**
- **748 (73%)** of those 'not in order' recorded at least **one clinical closure category**[10]
- **37%** of the clinical closure category was classified as 'Cause of Death too Vague'.

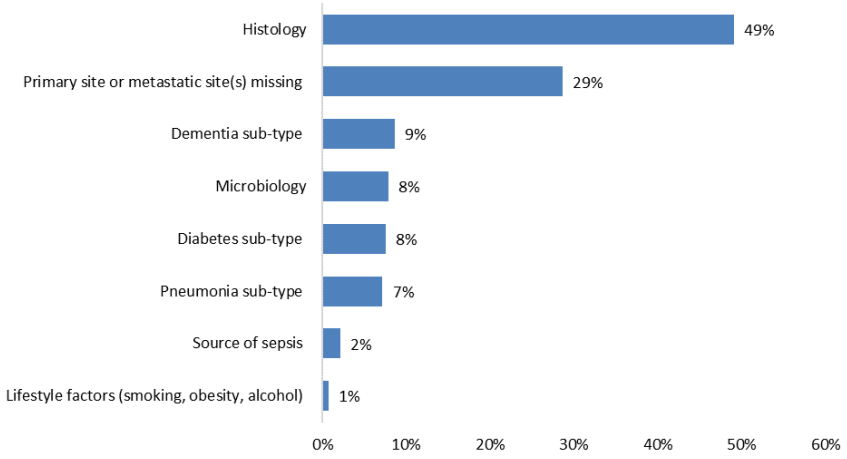
MCCDs can be closed with more than one closure category and the graph below shows the most common errors and omissions on MCCDs reviewed.

Breakdown of closure category as a percentage of clinical categories



Analysis of reviews deemed to have 'Cause of Death too Vague' shows **49%** are due to Histology and **29%** due to primary site or metastatic site(s) missing[11].

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



[10]The cause(s) of death detailed on the MCCD must represent a reasonable conclusion as to the likely cause(s) of death, and the other information contained in the certificate is correct. Where changes are required to the cause of death, these are categorised by clinical category, for changes to the information on the certificate this is categorised as administrative errors.

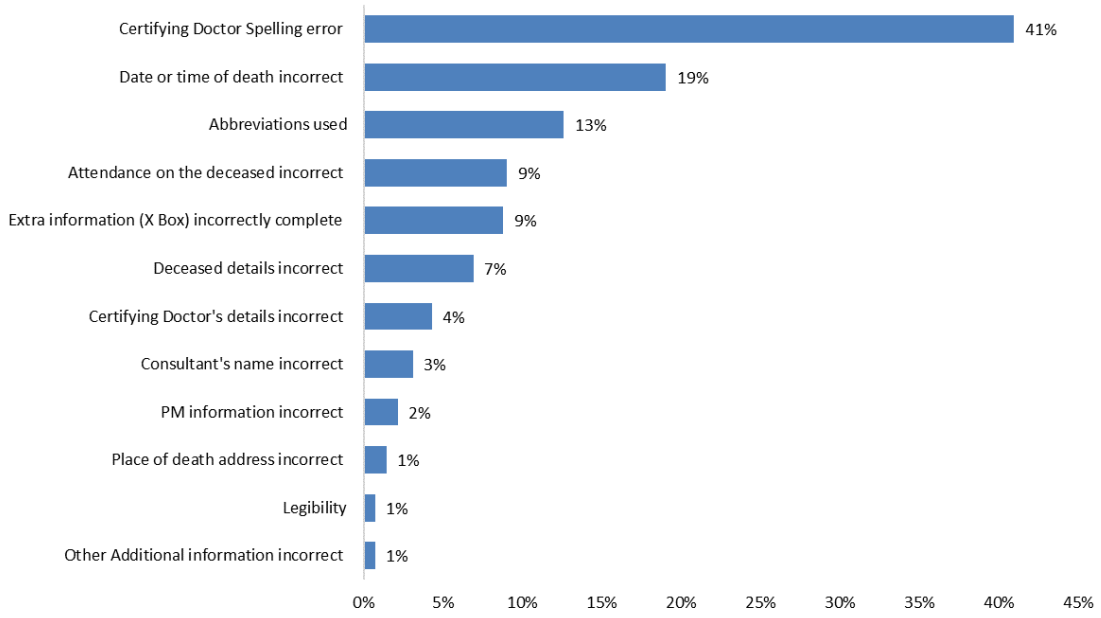
[11] See Appendix 1 for full breakdown of reasons for 'not in order'.

MCCD Review Educational learning
Level 1 review: Underlying cause of death was a ‘malignant neoplasm of duodenum’. A more accurate cause of death would be ‘adenocarcinoma of the duodenum’. This provides better public health information around underlying causes of death.

Administrative Improvements

Administrative errors are spelling mistakes, use of abbreviations and failing to sign the certificate. Last year, 41% of MCCDs 'not in order' had an administrative closure category recorded. Certifying doctor spelling error was recorded against 172 (41%) of MCCDs reviewed.

Breakdown of ‘Administrative errors’ category as a percentage of total number[12]



MCCD Review Educational learning
In conjunction with NHS Greater Glasgow & Clyde, the service developed a one page MCCD poster detailing what information should be included on an MCCD. The resource aims to ‘Be kind to families’, is a great A4 tool that can be displayed on walls to help doctors reduce administrative errors and ‘Get it right first time’. A copy of the ‘Be kind to families’ poster can be viewed at Appendix 2 or you can download your own copy and access our other educational resources on how to accurately complete an MCCD.

[12] Table 3 and 4 within Appendix 1 provides full details of clinical and administrative errors recorded over the last 3 years.

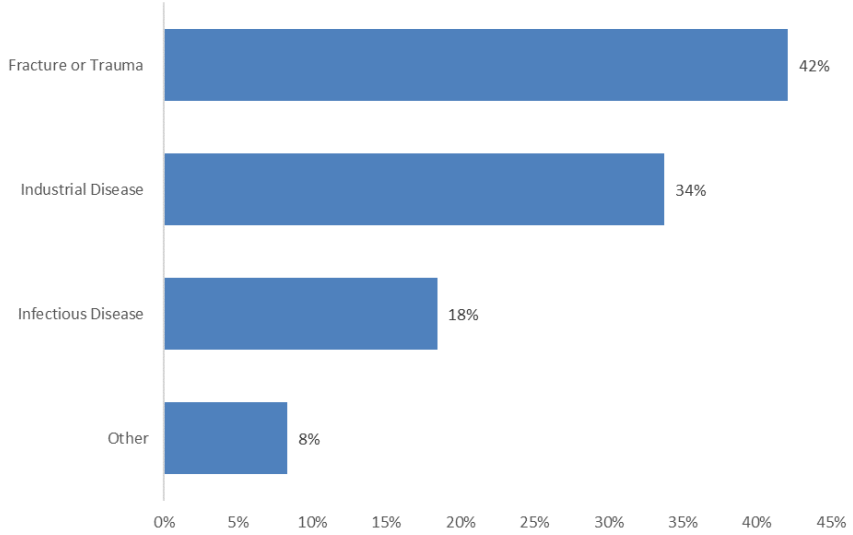
Reports to the Procurator Fiscal

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

Our medical review team found 228 (3.9%) of all certificates reviewed by the service during the past year should actually have been reported to the Procurator Fiscal.

The most common reasons for failing to report to Procurator Fiscal were for fracture or trauma (42%) and Industrial disease (34%) where they caused or contributed to the death. Other common categories include infectious disease (18%), concerns over care (2%) and choking (2%)[13]

Reasons for reporting to the Procurator Fiscal



Note: *Reports can be made for more than one reason*

MCCD review educational learning
Death of 89-year-old man. Certifying doctor confirmed cause of death as Subdural Haematoma. It was noted during the review discussion this had followed a fall. The deceased also had a pacemaker present which had not been noted in the hazards box. A replacement MCCD was required following consideration of the death by the Procurator Fiscal under Para 3 Unnatural Accidental deaths (including those resulting from falls).

[13] See Appendix 1 for full breakdown of main reasons for reporting to the Procurator Fiscal

Below is an overview of deaths that require to be reported to the Procurator Fiscal. For full details please refer to the current COPFS guidance[14].

Unnatural cause of death	Natural cause of death
Suspicious deaths – i.e. where homicide cannot be ruled out	Any death due to natural causes where the cause of death cannot be identified by a medical practitioner to the best of his or her knowledge and belief
Drug related deaths - including deaths due to adverse drug reactions reportable under the Medicines and Healthcare Products Regulatory Agency (MHRA) (Yellow Card Scheme)	Deaths as a result of neglect/fault
Accidental deaths (including those resulting from falls)	Deaths of children which are sudden or unexpected and unexplained perinatal deaths Any death of a child or young person under the age of eighteen years who is 'looked after' by a local authority
Deaths resulting from an accident in the course of employment	Deaths from notifiable industrial/ infectious diseases
Deaths of children from overlaying or suffocation	Deaths under medical or dental care where there has been a concern raised about the treatment or suggestion that there has been fault or negligence on the part of the medical/paramedical staff (See section 9 of COPFS guidance)
Deaths where the circumstances indicate the possibility of suicide	Deaths while subject to compulsory treatment under mental health legislation or whilst subject to legal custody
	Any death not falling into any of the foregoing categories where the circumstances surrounding the death may cause public anxiety.

[14] Details of cases required to be reported to the Procurator Fiscal can be found on the Crown Office and Procurator Fiscal office website: Reporting deaths | COPFS

In January 2023, the service consulted with the Chief Medical Officer for Scotland and the Crown Office to agree a derogation [15]of reporting of seasonal influenza.

Non randomised reviews

Interested person, registrar referrals and 'for cause' reviews

The service can carry out reviews requested by members of the public (Interested Person review)[16] and Local Authority registrars (Registrar Referral)[17] if they feel the certificate is not accurate.

These type of requests remain low. Last year, 4 interested persons' requests were received, of which two were declined as the death had been previously considered by the procurator fiscal. One MCCD was found to be 'Not in Order'.

Deaths outwith Scotland (repatriations)

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

In 2022/23, the service received **191** repatriation requests, of which,

- **130** (68.1%) were males, 61 females
- **120** (62.8%) were individuals 60 years or older
- **55** people (28.8%) died in Spain.

The table below provides some additional demographics including age and the top 5 countries people have been repatriated from.

Age	No of deaths
0 - 19	7
20 - 39	19
40 - 59	45
60 - 79	97
80+	23

Repatriated from	No of deaths
Spain	55
Turkey	20
USA/Canada	15
Greece	11
Cyprus	10

Male	Female
130	61

[15] Relaxing of the legal requirement to report Influenza deaths to COPFS.
[16] http://www.healthcareimprovementscotland.org/our_work/governance_and_assurance/death_certification/review_service_information/interested_person_review.aspx
[17] Death certification in Scotland: The Death Certfication Review Service (healthcareimprovementscotland.org)

All repatriation applications were approved, with 132 (69.1%) approved for cremation, and 59 (30.9%) for burial. Two post mortem applications were approved.

Service Performance

Service Level Agreements

The service operates under agreed service level agreements set by the Scottish Government. The table below explains the timescales and how we performed.

Type	Service Level Agreement timescale	Average Review time
Level 1	1 working day	Less than 4 hours
Level 2	3 working days	Just over one day
Advance registration	2 hours	Under 30 minutes
Senior medical review	1 working day	No cases
Interested person	3 to 14 days	Just over 3 days
Repatriation	5 working days	Under 2 days

It has been a challenging year for the National Health Service. However, despite this reviews continue to be completed 96% of the time well within the agreed timescales.

Of the 232(3.8%) of cases that breached[18] the timescales, 196 (84.5%) were due to the certifying doctor being unavailable. Of these, 154 (79%) were in secondary care. One reason for this could be the use of paper MCCDs in secondary care resulting in a delay between the death occurring and death registration taking place.

[18] See Appendix for full breakdown of breached cases.

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 advance registration applications remains low with 73 (1.2%) in 2022/23. Of these requests,

- **63** (86.3%) were approved
- **10** (13.7%) were not approved, of which **60%** were declined as the review was already complete or nearing completion.
- all received a decision on their application **within 2 hours**.

Of the 63 advance registrations that were approved, 11 (17.5%) were subsequently found to be 'not in order' and one (1.59%) was reported to PF when additional information became available.

Feedback and Complaints

The service is very mindful of the impact our work can have on families and therefore consistency with our processes and accuracy of information in a timely manner are two service priorities.

Last year we carried out a review with funeral directors across Scotland on our management of repatriations. We also conducted a smart survey with doctors who had contacted our enquiry line for advice on how best to represent a cause of death on an MCCD, or whether there was a requirement to report the death to the Procurator Fiscal.

Certifying doctors

The service carried out a smart survey in March 2023 seeking feedback from doctors on their experience of the service. Below are what **58 respondents** told us;

- 96% agreeing it was easy to get through to the service
- 98% agreeing the advice received was helpful
- 79% confirming they had used the enquiry line before

> *I have used this service many times and have had a positive experience on every occasion. It's a very good and helpful service and has definitely improved the quality of the death certificates I complete.*
>
> ***Certifying doctor***

Funeral directors

During the pandemic DCRS relocated and upgraded their ICT systems and introduced a number of changes on how we process repatriations to Scotland. The aim of the review was to make the experience of repatriation for funeral directors and families easy and supportive. We,

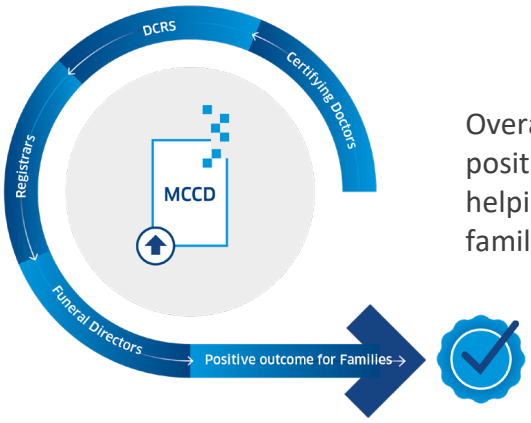
- reviewed and updated our standard operating procedures, letter templates and information on our website
- carried out an internal review of our initial telephone conversations between our medical review assistants and funeral directors for consistency and to ensure we provided the 'right' information at the 'right' time
- created a step by step 'how to guide' for funeral directors
- asked **27** funeral directors from across Scotland how we were doing

We asked …	You told us…	
How was your contact with DCRS?	Helpful, informative and efficient	96%
How would you rate the accuracy of information provided by DCRS staff?	Extremely accurate/accurate	100%
How helpful would you rate the documentation provided by DCRS?	Extremely/very helpful	100%
DCRS timescales for progressing repatriations is 5 days. How did we do?	Better than/as expected	100%
How satisfied were you with the service provided by DCRS?	Very satisfied	100%

> *At a time where there seems to be cut backs in every sector that we work with to try and support the bereaved it is reassuring to know that you continue to provide a prompt and efficient service which puts the bereaved at the heart of all you do.*
> *Thank you.*
>
> ***Funeral Director***

Complaints

In 2022/23, we dealt with two complaints, both from doctors who felt they had undergone a high number of reviews. DCRS do not select MCCDs for review, this process is carried out randomly by NRS Forward Electronic Register (FER). Both complaints were 'not upheld'.[19]



Overall feedback on our service remains very positive and we thank all our stakeholders for helping us to achieve positive outcomes for families.

Clinical Governance

As part of the MCCD review process, medical reviewers will discuss clinical governance issues or concerns raised by families with the certifying doctor. In 2022/23, no significant clinical governance concerns were identified.

Service Developments

Clinical portals

The service has established direct access to NHS Health Board clinical portals (patient medical notes) across most of Scotland to support Level 2 reviews. The benefits are

- reduced administration within boards as DCRS can directly review the information required to complete the review
- reduced administration for DCRS as staff do not need to rely on hospital medical record departments emailing the information
- quicker review times for families allowing them to progress funeral arrangements

In the West of Scotland, where direct access to clinical portals has been in place for 12 months, the average time to completion of a Level 2 review has reduced by around two hours.

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

eMCCD

Roll out of electronic MCCDs to secondary care is progressing with NHS Lothian successfully completing phase 1 testing. Phase 2 testing will progress in 2023.

MCCD educational advisory group

The service continues to work with NHS Education for Scotland (NES) and the MCCD educational advisory group to develop a suite of educational resources to support accurate completion of MCCDs[20].

Deaths abroad working group

Victim Support Scotland have received Scottish Government funding to establish a specialist service offering financial and emotional support to families resident in Scotland affected by an overseas murder or culpable homicide. DCRS continues to work in partnership with other stakeholders to ensure families receive the 'right' support and information at the 'right' time.

What we will do in 2023–2024

We will…

- work with health boards to roll out eMCCD into secondary care
- continue to work with NHS boards to reduce the number of clinical and administrative errors on MCCDs and educate on appropriate reporting of deaths to the Procurator Fiscal
- finalise direct access to Health Board clinical portals to reduce administrative resource requirements within boards

[20] After Death | At Death | Support Around Death (scot.nhs.uk)

Death Certification Review Service Management Board

The service is funded by the Scottish Government and supported by the DCRS 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)
Louise Budge	Acting Head of Registration	National Records of Scotland
Cathy Dunlop	Registration Services Manager, 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
Lynsey Cleland	Director of Quality Assurance	Healthcare Improvement Scotland
Ann Gray	Principal Procurator Fiscal Depute	Scottish Fatalities Investigation Unit
Katrina McNeill	Senior Policy Manager	Scottish Government Burial, Cremation, Anatomy and Death Certification team
Lucy Aitken	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 Nicholson	Principal Educator, Medical Education	NHS Education for 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 Clare Dunn, HIS Public Partner who has retired from the DCRS management board. Also our data analysts Tim Norwood, Keir Robertson and Lucy Aitken, thank you for your support in developing our data reports.

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

	Year 6		Year 7		Year 8	
Case type	01 Apr 2020 - 31 Mar 2021		01 Apr 2021 - 31 Mar 2022		01 Apr 2022 - 31 Mar 2023	
Standard Level 1 and Level 2	4364	(98.6%)	5444	(98.2%)	5876	(96.8%)
Repatriation	55	(1.2%)	84	(1.5%)	191	(3.1%)
Interested Person	6	(0.1%)	11	(0.2%)	4	(0.1%)
Registrar Referral	2	(0%)	2	(0%)	0	(0%)
MR For Cause Referral	0	(0%)	0	(0%)	0	(0%)
Total	*4427*		*5541*		*6071*	

Note: case numbers in the 3 years above reflect variation in review selection rates in response to the pandemic and post pandemic pressures on the NHS.

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

	Year 6		Year 7		Year 8	
Outcome	01 Apr 2020 - 31 Mar 2021		01 Apr 2021 - 31 Mar 2022		01 Apr 2022 - 31 Mar 2023	
Email amendments	810	(89.6%)	892	(88.4%)	869	(84.8%)
Replacement MCCD	94	(10.4%)	117	(11.6%)	156	(15.2%)
Total	*904*		*1009*		*1025*	

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

	Year 6		Year 7		Year 8	
Closure Category	01 Apr 2020 - 31 Mar 2021		01 Apr 2021 - 31 Mar 2022		01 Apr 2022 - 31 Mar 2023	
Cause of Death too vague	347	(55.1%)	351	(48.2%)	279	(37.3%)
Cause of Death incorrect	75	(11.9%)	92	(12.6%)	114	(15.2%)
Sequence of Cause of Death incorrect	135	(21.4%)	167	(22.9%)	174	(23.3%)
Causal timescales incorrect	122	(19.4%)	167	(22.9%)	168	(22.5%)
Conditions omitted	98	(15.6%)	129	(17.7%)	135	(18%)
Disposal Hazard incorrect	38	(6%)	45	(6.2%)	74	(9.9%)
Total	*815*		*951*		*944*	

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

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

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

Administrative Error	Year 6 01 Apr 2020 - 31 Mar 2021		Year 7 01 Apr 2021 - 31 Mar 2022		Year 8 01 Apr 2022 - 31 Mar 2023	
Attendance on the deceased incorrect	0	(0%)	49	(11.8%)	38	(9%)
Abbreviations used	59	(15.6%)	65	(15.7%)	53	(12.6%)
Certifying Doctor's details incorrect	39	(10.3%)	44	(10.6%)	18	(4.3%)
Certifying Doctor Spelling error	112	(29.6%)	133	(32.1%)	172	(41%)
Consultant's name incorrect	0	(0%)	6	(1.4%)	13	(3.1%)
Date or time of death incorrect	0	(0%)	67	(16.2%)	80	(19%)
Deceased details incorrect	126	(33.3%)	34	(8.2%)	29	(6.9%)
Extra information (X Box) incorrectly complete	45	(11.9%)	46	(11.1%)	37	(8.8%)
Legibility	2	(0.5%)	4	(1%)	3	(0.7%)
PM information incorrect	0	(0%)	7	(1.7%)	9	(2.1%)
Place of death address incorrect	0	(0%)	11	(2.7%)	6	(1.4%)
Other Additional information incorrect	26	(6.9%)	4	(1%)	3	(0.7%)
Total	*409*		*470*		*461*	

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

Table 5: Cases reported to procurator fiscal by type

Case type	Year 6 01 Apr 2020 - 31 Mar 2021		Year 7 01 Apr 2021 - 31 Mar 2022		Year 8 01 Apr 2022 - 31 Mar 2023	
Standard Level 1 and Level 2	250	(99.6%)	255	(98.8%)	228	(100%)
Interested Person	0	(0%)	3	(1.2%)	0	(0%)
MR For Cause Referral	0	(0%)	0	(0%)	0	(0%)
Registrar Referral	1	(0.4%)	0	(0%)	0	(0%)
Total	*251*		*258*		*228*	
% cases reported to PF	5.7%		4.7%		3.9%	

Table 6: Reasons Cases reported to procurator fiscal

Reason for reporting to PF	Year 7 01 Apr 2021 - 31 Mar 2022		Year 8 01 Apr 2022 - 31 Mar 2023	
Choking	6	(2.3%)	5	(2.1%)
Concerns Over Care	12	(4.7%)	5	(2.1%)
Drug Related	3	(1.2%)	2	(0.9%)
Flagged in Error	0	(0%)	0	(0%)
Fracture or Trauma	86	(33.5%)	96	(41%)
Industrial Disease	54	(21%)	77	(32.9%)
Infectious Disease	85	(33.1%)	42	(17.9%)
Legal Order	4	(1.6%)	3	(1.3%)
Neglect or Exposure	3	(1.2%)	3	(1.3%)
Stroke	0	(0%)	0	(0%)
Other Report to PF	4	(1.6%)	1	(0.4%)
Total	*257*		*234*	

Note: there can be more than one reason in each case

Table 7: Hybrid case data

	Year 6		Year 7		Year 8	
Review Outcome	01 Apr 2020 - 31 Mar 2021		01 Apr 2021 - 31 Mar 2022		01 Apr 2022 - 31 Mar 2023	
In order	2188	(75.4%)	1999	(77.6%)	759	(81.8%)
Not in order	542	(18.7%)	449	(17.4%)	143	(15.4%)
CD report to PF	173	(6%)	128	(5%)	26	(2.8%)
Total	*2903*		*2576*		*928*	

Table 8: Number of calls received by the enquiry line

	Year 6		Year 7		Year 8	
	01 Apr 2020 - 31 Mar 2021		01 Apr 2021 - 31 Mar 2022		01 Apr 2022 - 31 Mar 2023	
eMCCD issue	13	(0.5%)	0	(0%)	0	(0%)
Funeral Director	16	(0.6%)	11	(0.5%)	16	(0.6%)
GP Clinical Advice	1802	(67.3%)	1511	(66.3%)	1716	(67.4%)
GP Process Advice	161	(6%)	154	(6.8%)	157	(6.2%)
Hospice Clinical Advice	78	(2.9%)	40	(1.8%)	36	(1.4%)
Hospice Process Advice	10	(0.4%)	6	(0.3%)	10	(0.4%)
Hospital Clinical Advice	362	(13.5%)	346	(15.2%)	384	(15.1%)
Hospital Process Advice	30	(1.1%)	44	(1.9%)	48	(1.9%)
Informant/family	28	(1%)	52	(2.3%)	34	(1.3%)
Interested Person	0	(0%)	6	(0.3%)	3	(0.1%)
Other	52	(1.9%)	27	(1.2%)	42	(1.6%)
Procurator Fiscal	14	(0.5%)	6	(0.3%)	8	(0.3%)
Registrar	0	(0%)	23	(1%)	45	(1.8%)
Registrar Case Not Selected for Review	42	(1.6%)	0	(0%)	0	(0%)
Registrar Case Selected for Review	14	(0.5%)	0	(0%)	0	(0%)
Repatriation	2	(0.1%)	1	(0%)	3	(0.1%)
Signposted	53	(2%)	40	(1.8%)	44	(1.7%)
DCRS Protocol issue	0	(0%)	0	(0%)	0	(0%)
No advice type recorded	0	(0%)	12	(0.5%)	0	(0%)
Total	*2677*		*2279*		*2546*	

Table 9: Advance registration requests with outcomes

	Year 6		Year 7		Year 8	
Request outcome	01 Apr 2020 - 31 Mar 2021		01 Apr 2021 - 31 Mar 2022		01 Apr 2022 - 31 Mar 2023	
Approved	29	(69%)	45	(73.8%)	63	(86.3%)
Not approved	13	(31%)	16	(26.2%)	10	(13.7%)
Review outcome						
In order	35	(83.3%)	52	(85.2%)	56	(76.71%)
not in order	5	(11.9%)	8	(13.1%)	13	(17.81%)
PF	2	(4.8%)	1	(1.6%)	4	(5.48%)
Total	*42*		*61*		*73*	

Table 10: Number (and percentage) of Breached Cases

Reason for breach	Year 6 01 Apr 2020 - 31 Mar 2021		Year 7 01 Apr 2021 - 31 Mar 2022		Year 8 01 Apr 2022 - 31 Mar 2023	
Certifying doctor unavailable	135	(86.5%)	193	(88.9%)	196	(84.5%)
DCRS delay	0	(0%)	0	(0%)	10	(4.3%)
Delay in obtaining/receiving required information*	0	(0%)	0	(0%)	26	(11.2%)
Other	21	(13.5%)	24	(11.1%)	0	(0%)
Total	*156*		*217*		*232*	

**Includes delay in obtaining additional information, receiving medical notes, or receiving email amendment/replacement*

Note: In 2022, the service reviewed and updated the closure categories for breached reasons to support better reporting. Historical data around reasons for breached SLA times can be found in previous DCRS annual reports previous DCRS Annual Reports

Table 11: Number and percentage of interested person reviews

Request outcome	Year 6 01 Apr 2020 - 31 Mar 2021		Year 7 01 Apr 2021 - 31 Mar 2022		Year 8 01 Apr 2022 - 31 Mar 2023	
Not Approved	2	(33.3%)	1	(9.1%)	2	(50%)
Approved	4	(66.7%)	10	(90.9%)	2	(50%)
Total Requests	*6*		*11*		*4*	
Review outcome approved						
In order	3	(75%)	3	(30%)	1	(50%)
Not in order	1	(25%)	4	(40%)	1	(50%)
Reported to PF	0	(0%)	3	(30%)	0	(0%)

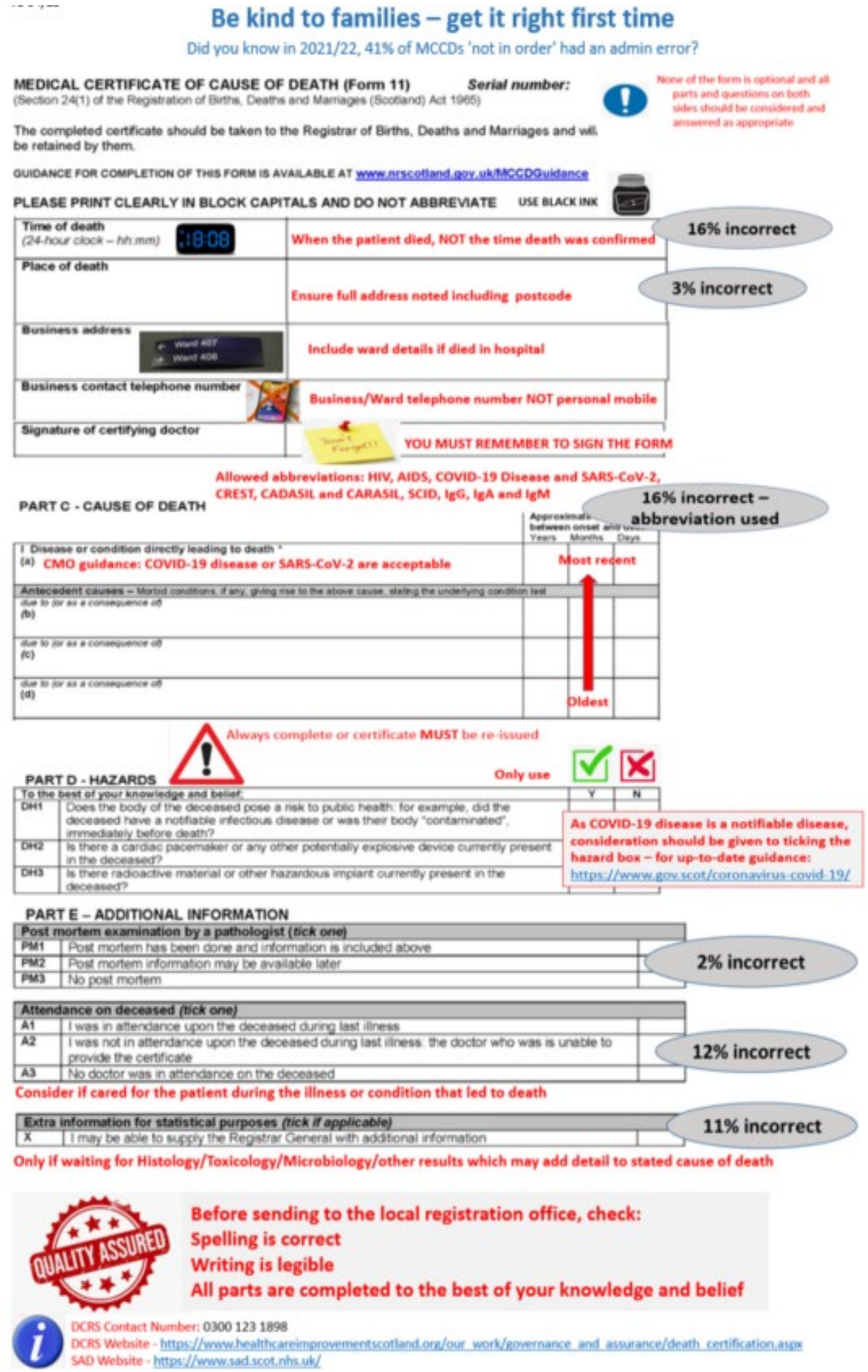
Table 12: Number and percentage of registrar referral reviews

Review outcome	Year 6 01 Apr 2020 - 31 Mar 2021		Year 7 01 Apr 2021 - 31 Mar 2022		Year 8 01 Apr 2022 - 31 Mar 2023	
In order	1	(50%)	0	(0%)	0	(0%)
Not in order	0	(0%)	2	(100%)	0	(0%)
Escalated to PF	1	(50%)	0	(0%)	0	(0%)
Total	*2*		*2*		*0*	

Table 13: Number and percentage of repatriation reviews

Request outcome	Year 6 01 Apr 2020 - 31 Mar 2021		Year 7 01 Apr 2021 - 31 Mar 2022		Year 8 01 Apr 2022 - 31 Mar 2023	
Approved	55	(100%)	84	(100%)	191	(100%)
Not approved	0	(0%)	0	(0%)	0	(0%)
Total	*55*		*84*		*191*	

Appendix 2: Be kind to families poster



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Healthcare Improvement Scotland

The Death Certification Review 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/

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