Healthcare Improvement Scotland | DCRS Death Certification Review Service

Death Certification Review Service

Annual Report 2024 – 2025

NHS SCOTLAND

Published 2025

www.healthcareimprovementscotland.scot

Contents

Overview by Senior Medical Reviewer **3**

A decade of improvement (2015 – 2025) ..... Error! Bookmark not defined.

In the last year (2024 – 2025) ..... Error! Bookmark not defined.

Death Certification Review Service (DCRS) Medical Reviews **6**

Case Overview **7**

Enquiry Line **7**

Improving the Quality and Accuracy of Medical Certificates of Cause of Death (MCCD) **8**

Review outcomes **8**

Administrative Improvements **10**

Reports to the Procurator Fiscal **10**

Educational Learning – Pleural plaques **10**

Educational conversations **11**

Educational Learning **11**

Review of MCCD completed by certifying doctor for 87 year-old **11**

Clinical Governance **12**

Advance Registration **12**

Non-randomised reviews **13**

Interested person, registrar referrals, 'for cause' reviews **13**

Deaths outwith Scotland (repatriations) **14**

Service Performance **15**

A decade of improvement **15**

Service Level Agreements **16**

Stakeholder engagement **17**

Quote from certifying doctor **17**

MCCD Process Improvements **18**

Remote registration **18**

eMCCD into secondary care **18**

Complaints and Freedom of information requests **19**

Complaints **19**

Freedom of Information.....19
Next we will aim to… 20
Call for action 20
Death Certification Review Service Management Board 21
Acknowledgements 21
Your Feedback.....21
Our Board members 22
Appendix 1: Service data..... 23
Appendix 2: Glossary of terms..... 28

Overview by Senior Medical Reviewer

Dr George Fernie
Senior Medical Reviewer

Ten years ago, on the 13th of May 2015, we successfully launched the Death Certification Review Service (DCRS)[1] as the first of the four home nations to reform the way in which we scrutinise Medical Certificates of Cause of Death (MCCDs) where the need for change had first been identified a decade previously.

In Scotland, although the motivation for the introduction of DCRS may partly have been failings identified with certification of death by the Vale of Leven Inquiry[2] it cannot have been unconnected to the events in England where the delay in establishing the criminality of the serial killer Harold Shipman resulted in one of the recommendations made by Dame Janet Smith[3] that MCCDs, for burials and cremations alike, would be subject to scrutiny by an independent 'medical examiner' albeit this arrangement did not materialise in our neighbouring jurisdiction until 2024.

The death certification medical reviewer system was launched throughout Scotland simultaneously, on time and under budget notwithstanding a brand-new IT system linking two governmental departments, the NHS and National Records for Scotland. The fact that we flicked a switch, and the service went 'live' without problem, albeit with a degree of apprehension, was testament to the thorough preparation by the programme team at Healthcare Improvement Scotland[4].

We opted for a random, proportionate review system with the stated intent of improving the quality and accuracy of MCCDs, deriving better public health data (which became especially important during the Covid-19 pandemic) and enhancing clinical governance. These three primary drivers remain the same at our 10th anniversary and have delivered the promised improvement without causing delay to funeral arrangements for families.

[1] Death Certification Review Service (DCRS) – Healthcare Improvement Scotland
[2] vale-of-leven-hospital-inquiry-report.pdf
[3] 856302_Shipman_Vol3_TXT
[4] Healthcare Improvement Scotland

Scottish Government decided the service should be free at the point of delivery for relatives of the deceased and the service should be independently based in our national quality improvement organisation. Both these choices turned out to be enlightened and allowed the service to reduce a not-in-order rate for certificates from over 50% in the first quarter of 2015, when we implemented the system, to 18.5% by the end of March 2025.

As well as our main function of reviewing MCCDs that have not been reported to the Procurator Fiscal, the service authorises burial or cremation for those who die outwith Scotland. This secondary more minor role is incredibly important to support those who have elected to return here at the end of their lives and typically involves even more tragic deaths due to their often traumatic nature. The approach of the service has been one of compassion and very much focussed on the wishes of those who have suffered a bereavement, in order to support them through this process without adding to their grief.

A major other benefit for certifying doctors has been the introduction of our enquiry line where we typically help around 2,500 callers each year as part of our supportive and educational commitment. The goodwill engendered from this has been instrumental in gaining the co-operation of certifying doctors in the circa 6,000 certificates reviewed annually.

The electronic case management system (eCMS) has evolved out of all recognition with continuous learning being factored into the process. The eMCCD has been a particular accomplishment with the vast majority of reviews being completed pre-registration before the family are even aware of selection[5].

An enormous thanks to all at Healthcare Improvement Scotland, our stakeholders including public partners and our sponsors who have helped the service achieve an impressive result such that we could not have predicted.

[5] MCCDs are randomly selected for review by National Records of Scotland within seconds of the MCCD being entered onto the death registration system.

Service Highlights

Over the last 10 years the service, through the review of MCCDs and informed improvements to processes and systems, the service has supported improvement in the quality and accuracy of MCCDs, whilst reducing the impact MCCD reviews have on families. Fuller details are contained within the report.

A decade of improvement (2015 – 2025)

67,452 MCCD reviews completed — 67,452

59.4% overall improvement in the quality of MCCDs — 59.4%

In the last year (2024 – 2025)

Public Assurance	6250 MCCD reviews completed	6250
Sustained Improvement	82.2% of certificates reviewed were 'In Order'	82.2%
Impact on families	Standard reviews completed in under 6 hours	<6 hours
Advance Registrations	81.2% completed within an hour, all under 2 hours	<2 hour
Repatriations to Scotland	Requests for repatriation approved within 1.5 days	<1.5 days

Death Certification Review Service (DCRS) Medical Reviews

The Death Certification Review Service operates within the Certification of Death (Scotland) Act 2011[6] legislative framework and the role of the service[7] is to improve:

- quality and accuracy of Medical Certificates of Cause of Death (MCCD)s, 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 areas most needed.
- clinical governance[8], helping to improve standards in Scottish healthcare.

In Scotland last year, doctors certified over **60,000** deaths of which **12%** were randomly selected[9] for a medical review by National Records of Scotland (NRS).

Our medical reviewers look at these MCCDs and speak with the certifying doctor about the circumstances of the death to ensure the information on the certificate is accurate.

If the certificate is **'not in order'** the medical reviewer will request the certificate is amended.

The local authority will complete death registration which then allows families to finalise funeral arrangements.

Families can ask for an MCCD to be reviewed either before or after death registration if they feel the certificate does not accurately reflect the cause of death.

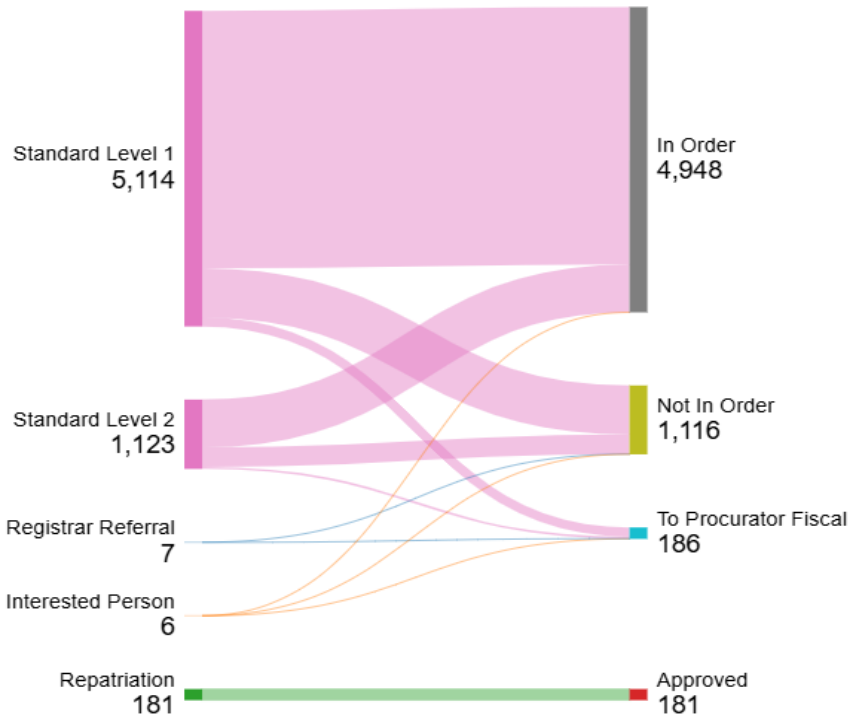
The service is also responsible for approval of burial or cremation to Scotland for persons who have died abroad. Registration of deaths abroad occur in accordance with the local regulations where the person died.

[6] https://www.legislation.gov.uk/asp/2011/11/pdfs/asp_20110011_en.pdf
[7] https://www.healthcareimprovementscotland.scot/inspections-reviews-and-regulation/death-certification-review-service-dcrs
[8] The framework through which healthcare organisations are accountable for continuously improving the quality of their services and safeguarding high quality of care.
[9] During death registration, National Records of Scotland randomly select MCCDs for medical review and forward to DCRS.

Case Overview

The service reviewed a total of **6,431** cases in 2024/25, of which 6,237 **(97%)** were standard reviews[10] and 194 **(3%)** non-standard[11] reviews. The diagram [12] 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 2024/25[13]



Enquiry Line

The service dealt with 2,394[14] enquiries last year. The majority of calls **(88%)** were from doctors seeking clinical advice on how to most accurately represent a death on a MCCD.

- GP clinical advice 1,739 **(72.6%)**
- Hospital clinical advice 321 **(13.4%)**
- Hospice clinical advice 46 **(1.9%)**

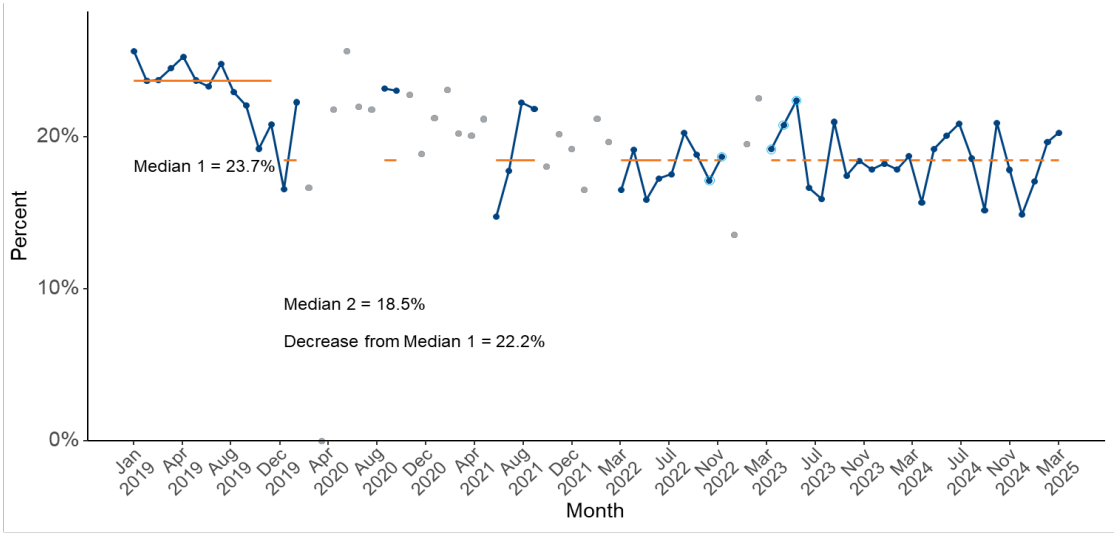
We also provided advice on 288 **(12%)** other calls; to registrars, families and the Procurator Fiscal.

[10] Standard Reviews (Level 1, Level 2). 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.
[11] Non-standard Reviews (Interested Person reviews, Registrar referrals and Repatriations to Scotland)
[12] 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.
[13] See Appendix 1 for full breakdown of cases and enquiries over last 3 years.
[14] See Appendix 1 for full breakdown of enquiries over last 3 years.

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

Run chart analysis of monthly percentage 'not in order'[15] from January 2019 to March 2025 indicates that the percentage 'not in order' improved to a current median of **18.5%** in 2020; an overall reduction of **22.2%** from the baseline of **23.7%.**

Run chart of monthly percentage case MCCDs 'Not in Order' in Scotland



Note: *Run chart analysis includes periods when the service is operating as 'business as usual' (blue dots). Hybrid reviews implemented during the pandemic are not included in the analysis (grey dots)*

Review outcomes

In 2024/25, 6,237 medical reviews were carried out, of which

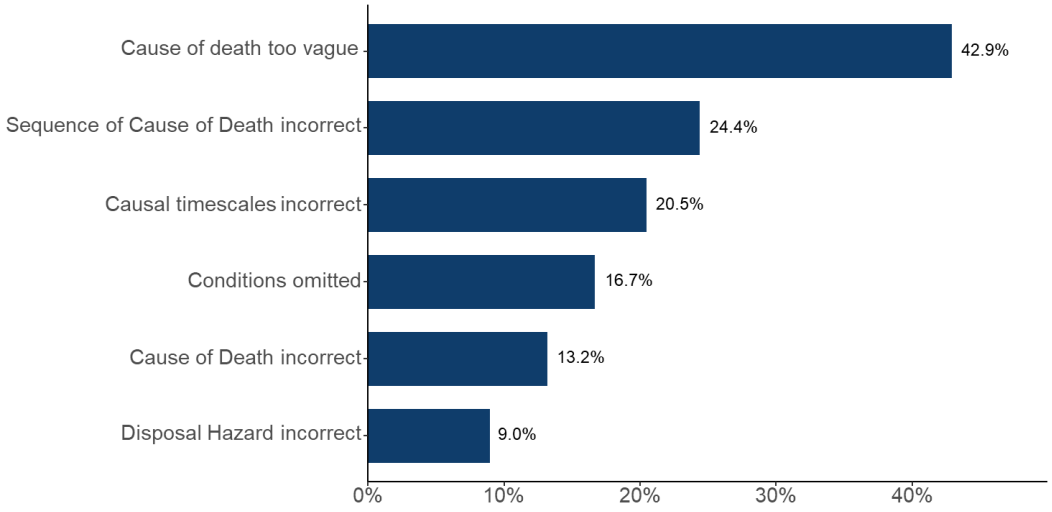
- 1,110 **(17.8%)** were found to be **'not in order'.** Of these,
  - 713 **(64.2%)** had at least **one clinical closure category** error recorded[16], of which
  - **42.9%** were classified as '**Cause of Death too Vague'.**

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

[16] 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.

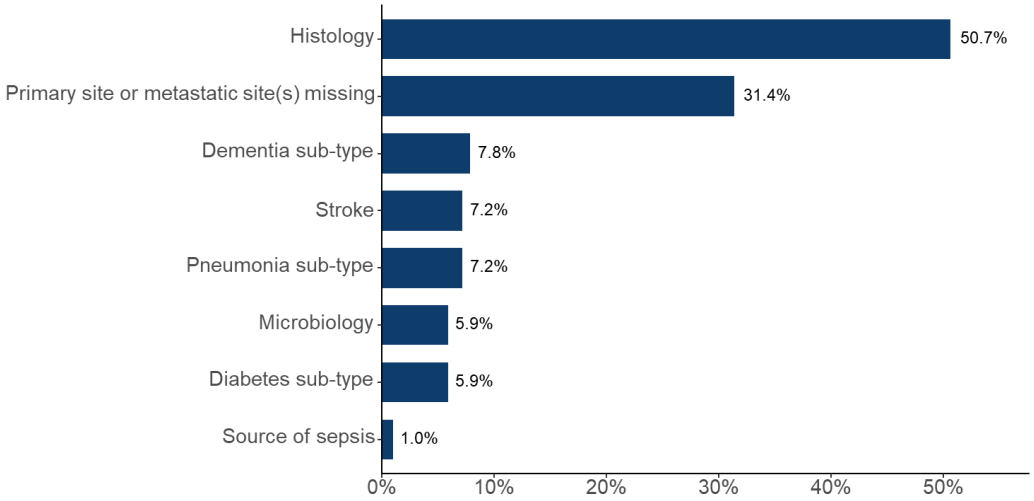
MCCDs can be closed with more than one closure category and the graph below shows the most common errors and omissions on MCCDs reviewed.

Breakdown of clinical closure categories as a percentage of MCCDs with clinical category errors[17]



Analysis of reviews deemed to have 'Cause of Death too Vague' shows **50.7%** are due to histology[18] and **31.4%** due to primary site or metastatic site(s) missing[19].

Breakdown of 'Cause of death too vague' closure as a percentage of MCCDs with a clinical category error of 'cause of death too vague'

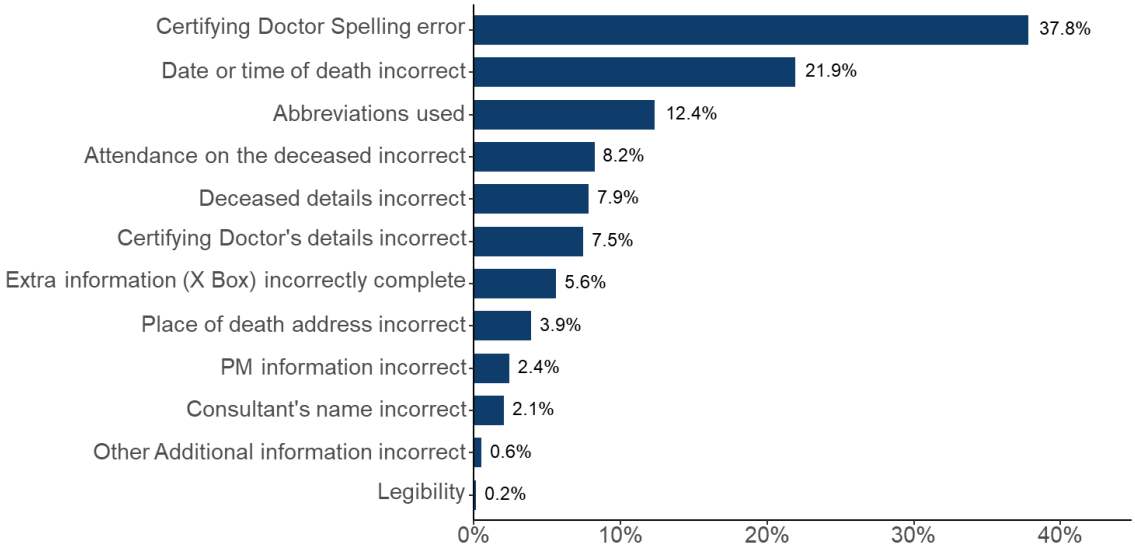


[17] Table 3 within Appendix 1 provides full details of clinical and administrative errors recorded over the last 3 years
[18] The examination of tissue and cell samples under a microscope to diagnose any abnormalities or changes.
[19] See Appendix 1 for full breakdown of reasons for 'not in order'.

Administrative Improvements

Administrative errors include spelling mistakes, use of abbreviations and incorrect patient details, such as accurate date/time of death. Last year, **48.1%** of MCCDs 'not in order' had an administrative closure category[20] recorded. Certifying doctor spelling error was recorded against 202 **(37.8%)** of MCCDs with at least one administrative error.

Breakdown of administrative errors as a percentage of MCCDs with administrative errors [21]



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[22].

Our medical review team found 180 **(2.9%)** of all certificates reviewed last year had not been reported to the Procurator Fiscal by the certifying doctor. The most common oversight in reporting was where there was fracture or trauma **(54.4%)** or a known industrial disease **(27.8%)** that caused or contributed to the death.[23]

Educational Learning – Pleural plaques

Crown Office and Procurator Fiscal Service (COPFS) advised that the incidental finding of pleural plaques, which is a marker of exposure to asbestos, no longer requires to be reported if it did not contribute to the death of that person

[20] Changes to fields other than the 'cause of death' on the MCCD are categorised as 'administrative' errors.
[21] See Appendix 1 for full details of clinical and administrative errors recorded over the last 3 years.
[22] reporting-deaths-information-for-medical-practitioners.docx (live.com)
[23] See Appendix 1 for full breakdown of main reasons for reporting to the Procurator Fiscal

Educational conversations

Medical reviews are 'educational conversations' and whilst some MCCDs require an amendment, many are deemed 'in order' **(57.2%)** or 'in order with educational support' **(42.8%).** Below is an example of an MCCD review which required an MCCD amendment.

Educational Learning **Review of MCCD completed by certifying doctor for 87 year-old**
Part I Disease of the condition directly leading to death and antecedent causes 1a Frailty 1b Probable Bowel Cancer **Part II Other significant conditions** 2a Breast Cancer 2b COPD
Medical reviewer observations of certificate and review of patient medical records
Histology: Breast cancer appears to be intraductal cancer in situ of right breast **Abbreviations used:** COPD needs expanded
Educational conversation with the certifying doctor
The certifying doctor agreed to amend the certificate by add histology to the cancer and spelling COPD in full.
Death registered as
Part I Disease of the condition directly leading to death and antecedent causes 1a Frailty 1b Probable Bowel Cancer **Part II Other significant conditions** 2a Intraductal Carcinoma in situ of Right Breast 2b Chronic Obstructive Pulmonary Disease

Below are the **3** most common areas where medical reviewers provide education to certifying doctors to support improvement in the quality of death certification.

Cause of death sub-type should be more specific	The MCCD should be specific, e.g. if the cause of death is Dementia, the MCCD should, if known, include the sub-type, such as Alzheimer's Vascular, Lewy Body etc. Similarly, adding histology, the organism in deaths from infection, type of diabetes, type of stroke are important.
Intervals inaccurate	Duration of illness should be recorded, but is not necessary with old age, frailty of old age or conditions since birth.
Time of death incorrect or ward details missing	Time of death should be time of 'last breath' or if not witnessed, best estimate from available information. Ward information/number must be included.

Clinical Governance

As part of the MCCD review process, medical reviewers review a patient's prescriptions on the Emergency Care Summary (ECS) and discuss these with the certifying doctor during the review conversation. This ensures clinical governance around prescribing. However, once adequate detail for the purpose of the review has been obtained, in keeping with the Caldicott principles, no further examination of the deceased person's records is performed.

Advance Registration

Families may for religious observance or compassionate reasons require a funeral to go ahead promptly. The service aims to support this through our advance registration process, which allows funerals to proceed before the MCCD review is complete.

The number of advance registration applications remains low. In 2024/25, there were,

- 48 **(0.7%)** requests, of which
- 44 **(91.7%)** were approved
- 4 **(8.3%)** were declined as the medical reviewer felt the certificate may require an amendment. Of these, **2** required a replacement MCCD.

The service continues to successfully met its aim of completing all advance registration requests within 2 hours, indeed 39 **(81.2%)** of requests considered this year received a decision within one hour.

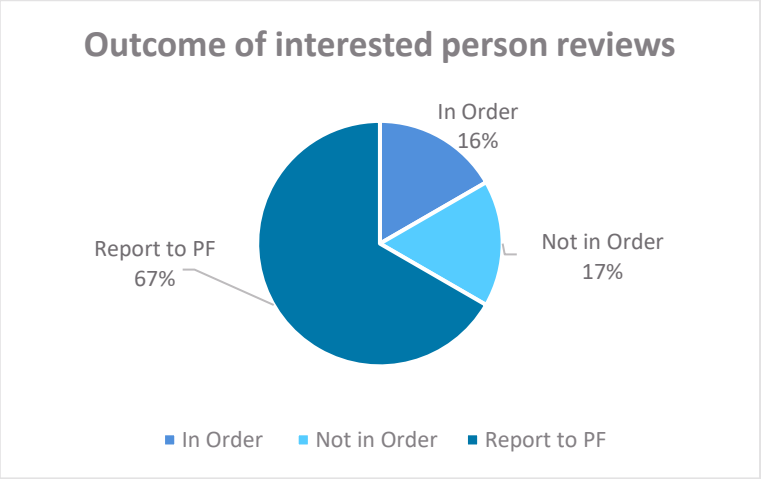
Non-randomised reviews

Interested person, registrar referrals, 'for cause' reviews

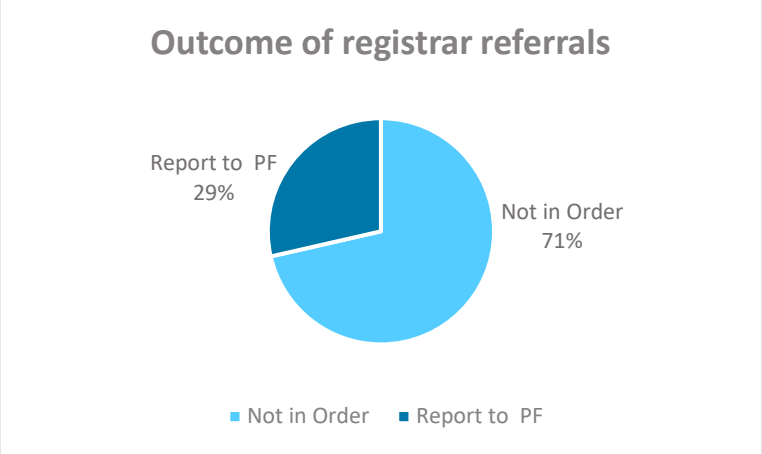
The service reviews MCCDs at the request of members of the public (Interested Person review)[24] or local authority registrars (Registrar Referral) if they feel the certificate is not sufficiently accurate.

The volume of these types of requests remains low[25]. Last year, the service received **6** Interested Person requests, and **7** Registrar referrals. The two charts below provide an overview of the outcomes from these reviews.

Outcome of interested person reviews 24/25



Outcome of registrar referrals reviews 24/25



[24] https://www.healthcareimprovementscotland.scot/inspections-reviews-and-regulation/death-certification-review-service-dcrs/death-certification-review-service-interested-person-review/

[25] See Appendix 1 for full breakdown of Interested person and Registrar referral reviews

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[26].

In 2024/25, the service received **181** repatriation requests, of which,

- 120 **(66.3%)** were male, 61 **(33.7%)** were female
- 109 **(60.2%)** were individuals aged 60 years or older
- 57 people **(31.5%)** died in Spain
- 1 request for a post-mortem examination was made and approved.

The tables below provides some additional demographics including age, top **5** countries people have been repatriated from, funeral type and the most common causes of death.

Age	No of deaths
0 - 19	4
20 - 39	15
40 - 59	53
60 - 79	84
80+	25

Repatriated from	No of deaths
Spain	57
Turkey	17
France	10
Greece	9
USA	9

Funeral type	No of deaths
Burial	58
Cremation	123

Causes of death	No of deaths
Cardiovascular	55
Not stated*	35
Respiratory	15

**For privacy reasons, some countries do not provide the actual cause of death on the medical certificate*

[26] Death Certification Review Service: deaths abroad – Healthcare Improvement Scotland

Service Performance

A decade of improvement

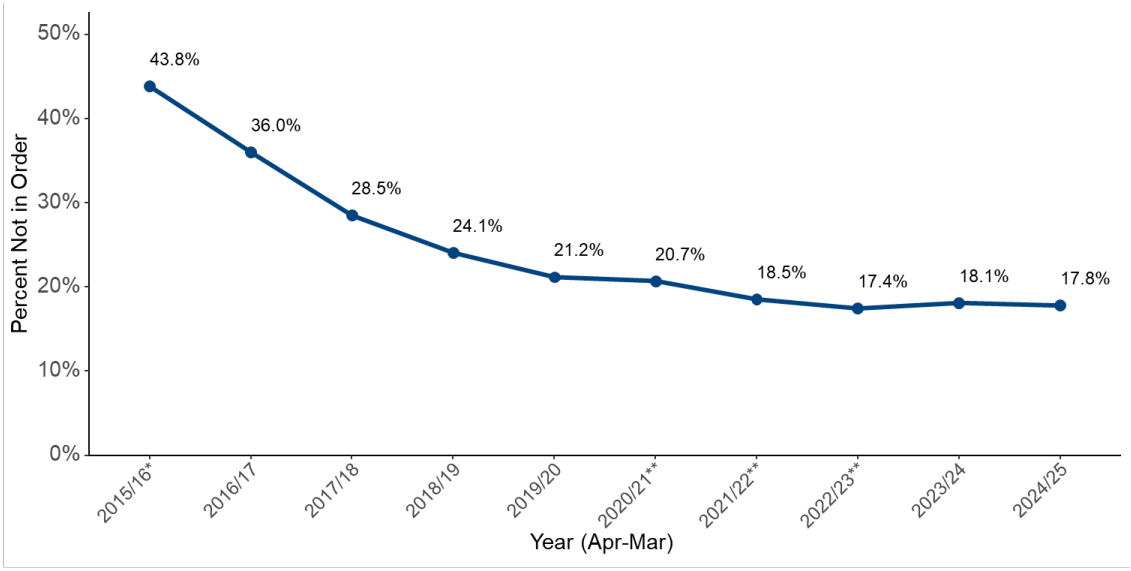
Since launching the service in May 2015, DCRS has reviewed a total **67,452**[27] cases, **83.4%** of which were standard case reviews.

The quality of certificates reviewed over this period has significantly improved. In the first year **43.8%** of cases were found to be 'not in order'. By March 2025, this figure had reduced to **17.8%,** equating to **59.4%** reduction in errors on MCCDs over time.

During the COVID-19 pandemic, the service introduced 'hybrid' reviews to ensure scrutiny of death certification continued. Hybrid reviews allowed the medical reviewer to scrutinise the Key Information Summary (KIS) freeing up hospital and general practice clinical and administrative staff resource to respond to the clinical needs of patients across the country, whilst giving the much sought after public assurance around death certification at that time. This valuable facility was retained subsequently allowing more focused reviews.

Whilst much of the overall reduction was made in the earlier years, the educational work of the service, as can be seen in the graph below, has helped support sustained improvement during the pandemic in 2020 and beyond.

Annual percentages of standard case MCCDs 'Not in Order'



**Partial Year*
***Includes hybrid reviews*

[27] See Appendix 1 for full breakdown of case reviews over the last 3 years

Service Level Agreements

The service aims to complete reviews without negatively impacting on families, and staff work relentlessly to complete reviews as quickly as possible.

Standard level 1 reviews are now completed on average, within **4** hours and level 2 reviews within **6** hours. The table below details our average performance against service level agreement timeframes set by the Scottish Government.

Around **217** (3.4%) of case reviews breached[28] SLA timescales, of which

- **195** (89.9%) were due to the certifying doctor being unavailable
- **161** (74.2%) were in secondary care

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

Stakeholder engagement

In September 2024, the service sought feedback from 159 certifying doctors on their experience of the service. Below is a summary of the **114 (72%)** responses received.

We asked doctors…	% who agreed
Was the medical reviewer friendly and courteous?	**99%**
Did the medical reviewer clearly describe the death certification review process?	**85%**
Did the medical reviewer understand the patient's case?	**98%**
Was the conversation with the medical reviewer educationally focussed?	**83%**
Was the duration of the conversation about right?	**99%**
My experience of the review process has highlighted the importance of MCCD accuracy?	**91%**
Was your experience of the review service positive?	**92%**

Feedback from doctors	
MCCD selection does not always feel random. I have completed around 60 reviews.	National Records of Scotland (NRS) are responsible for selecting MCCDs for review and use a one-in-eight chance-based algorithm which can result in certificates being selected one after another.
Review calls come in during busy morning clinical periods. Can review calls be made in the morning?	The service has one day in which to complete most of their reviews. Contact with doctors is instigated once initial review checks have been carried out. Forefront of our call management is ensuring reviews do not cause any impact on families who are trying to progress with funeral arrangements.

Quote from certifying doctor

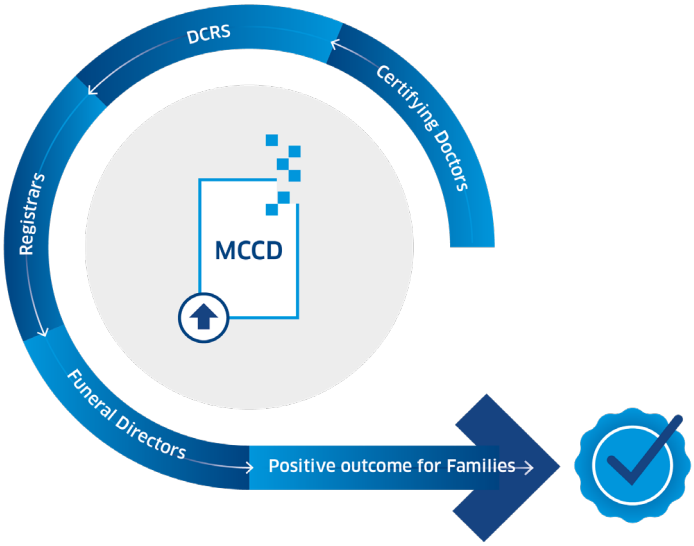
> *Such a useful service for advice regarding death certification and support in reaching decision in complex or unusual cases. A very helpful resource, especially if no other colleagues around to discuss cases with.*

MCCD Process Improvements

Remote registration

The service continues to work with key stakeholders to ensure positive outcomes for families. During 2024/25, in partnership with National Records of Scotland (NRS), Association of Registrars of Scotland (ARoS), Crown Office and Procurator Fiscal Service (COPFS), NHS Education for Scotland (NES) and Scottish Government, a review of the new death certification remote registration was carried out. This resulted in

- Chief Medical Officer (CMO) guidance being updated to ensure consistency with new remote registration process.
- NHS Education for Scotland developing a frequently asked questions for non-medical staff learning resource.
- COPFS developing guidance for their website on reporting deaths to the Procurator Fiscal.
- ARoS agreeing registrars can correct minor spelling errors agreed by doctors over the telephone.
- NRS updating their website detailing the new legislative remote registration process.



eMCCD into secondary care

Electronic MCCD has been developed by NHS Lothian and has been successfully piloted with doctors using the system to generate eMCCDs. Connectivity with Sci-Gateway and NRS has yet to be established, but it is anticipated this will be completed during 2025/26. Scottish Government are leading on the roll-out across Scotland and have established an NHS Board implementation group to support this.

Complaints and Freedom of information requests

Complaints

The service received **one** complaint this year from a certifying doctor who felt the selection process for MCCD reviews was not random. The complaint was not upheld, however in response to this, the service collaborated with National Records of Scotland to produce a leaflet detailing the death registration process in Scotland as shown in the flowchart below.

Certifying Doctors

Certifying doctors should

- consider if the death requires reporting to the Procurator Fiscal
- certify the death by completing a MCCD (form 11)
- explain the cause of death to families
- send the MCCD to the registration office requested by the family.

National Records of Scotland (NRS)

National Records of Scotland (NRS) will randomly select 12% of MCCDs for medical review.

Death Certification Review Service

Death Certification Review Service must review

- MCCD (form 11)
- Patient records
- Speak to the certifying doctor, or other relevant person
- agree any changes required.

Families

Families have a legal duty to register a death within 8 days.

Local Authority Registrars

Local Authority Registrars wil register the death and issue a Certificate of Registration of Death (form 14).

Freedom of Information

The service also responded to **one** Freedom of Information (FOI) request.

Next we will aim to…

- Sustain the improvement in the quality of MCCDs written in Scotland by developing our educational approach with doctors and Health Boards.
- Support implementation of eMCCD into secondary care with key stakeholders.
- Continue to work with NHS boards to reduce the number of clinical and administrative errors on MCCDs and educate on early and appropriate reporting of deaths to the Procurator Fiscal to reduce impact on families awaiting to register a death.
- Develop our Health Board annual review process and encourage local quality assurance checks to support improved quality in the completion of MCCDs.
- Regularly engage with stakeholders to ensure our medical reviews do not negatively impact on families.
- In partnership with National Education Scotland (NES) review and update our existing e-learning resources and develop new resources around neonatal death certification.

Call for action

An Interested person review is a level 2 review, however under the current Certification of Death (Scotland) Act 2011, if a level 1 review has already been carried out by the service or the death had been reported to the Procurator Fiscal, no further review can be undertaken. This seemed intrinsically unfair and not what the drafters of the legislation would have anticipated but is a consequence of being able to adopt a digital system which has delivered much more timely reviews than was achievable in the two pilots.

The service calls for a change in the s4. of the Certification of Death (Scotland) Act 2011, to allow Interested Person level 2 reviews to be undertaken even if the death has been reported to the Procurator Fiscal or underwent a level 1 review.

Death Certification Review Service Management Board

The service is funded by the Scottish Government and supported by the DCRS Management Board.

Acknowledgements

The management board would like to thank the medical review service staff and colleagues within Healthcare Improvement Scotland, National Records of Scotland and families. Your contributions over the last 10 years have helped us to assure and improve the quality of death certification across Scotland.

Special thanks to our data analysts and advisors, Keir Robertson, Alexandra Dunn, Lucy Aitken and Tim Norwood, for all your support in developing our data reports.

To management board members who sadly left this year, Lynsey Cleland, Maggie Buettner-Young and Alex Jones. Thank you, your support shaping the work of the service has been invaluable.

Also, to NHS Lothian, who led the development of IT systems to support eMCCD in secondary care. A significant step in achieving a fully integrated electronic MCCD system in Scotland.

Your Feedback

We hope you have found the report on our work informative and reassuring. If you have any comments, please get in touch.

Our Board members

Name	Designation	Organisation
Lucy Aitken	Data & Measurement Advisor	Healthcare Improvement Scotland
Eddie Docherty	Director of Quality Assurance	Healthcare Improvement Scotland
Cathy Dunlop	Registration 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)
Chioma Agoucha	Public Partner	Healthcare Improvement Scotland
Katrina McNeill	Scottish Government Senior Policy Manager	Burial, Cremation, Anatomy and Death Certification team
Dr Janice Nicolson	Principal Educator, Medical Education	NHS Education for Scotland
Carolyn Nickels	Head of Registration	National Records of Scotland
Rosemary Pengelly	Public Partner	Healthcare Improvement Scotland
Elainne Sibbald	Principal Procurator Fiscal Depute	Scottish Fatalities Investigation Unit
Dr Ruth Stephenson	Deputy Senior Medical Reviewer	Healthcare Improvement Scotland (DCRS)
Roberta Garau	Doctor	Scottish Academy of Trainee Doctors
Andrea Telford	Service Manager	Healthcare Improvement Scotland (DCRS)

Appendix 1: Service data

The tables below provide a more detailed breakdown of the service data over the last 3 years[29]. Percentages have been rounded to 1 decimal place. This means they do not always add up to 100%.

Table 1: Cases reviewed by type

	Year 8		Year 9		Year 10	
Case Type	01 Apr 2022 - 31 Mar 2023		01 Apr 2023 - 31 Mar 2024		01 Apr 2024 - 31 Mar 2025	
Standard Level 1, Level 1 hybrid and Level 2	5,875	96.8%	6,174	97.2%	6,237	97.0%
Repatriation	191	3.1%	178	2.8%	181	2.8%
Interested Person	4	0.1%	1	0.0%	6	0.1%
Registrar Referral	0	0.0%	1	0.0%	7	0.1%
MR For Cause Referral	0	0.0%	0	0.0%	0	0.0%
Total	*6,070*		*6,354*		*6,431*	

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

	Year 8		Year 9		Year 10	
Case Type	01 Apr 2022 - 31 Mar 2023		01 Apr 2023 - 31 Mar 2024		01 Apr 2024 - 31 Mar 2025	
Email amendments	869	84.8%	985	88.1%	980	88.3%
Replacement MCCD	156	15.2%	133	11.9%	130	11.7%
Total	*1,025*		*1,118*		*1,110*	

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

	Year 8		Year 9		Year 10	
Case Type	01 Apr 2022 - 31 Mar 2023		01 Apr 2023 - 31 Mar 2024		01 Apr 2024 - 31 Mar 2025	
Cause of Death too vague	279	37.3%	316	40.6%	306	42.9%
Cause of Death incorrect	114	15.2%	121	15.6%	94	13.2%
Sequence of Cause of Death incorrect	174	23.3%	213	27.4%	174	24.4%
Causal timescales incorrect	168	22.5%	158	20.3%	146	20.5%
Conditions omitted	135	18.0%	140	18.0%	119	16.7%
Disposal Hazard incorrect	74	9.9%	59	7.6%	64	9.0%
Total	*944*		*1,007*		*903*	

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

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

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

Case Type	Year 8 01 Apr 2022 - 31 Mar 2023		Year 9 01 Apr 2023 - 31 Mar 2024		Year 10 01 Apr 2024 - 31 Mar 2025	
Attendance on the deceased incorrect	38	9.0%	44	9.4%	44	8.2%
Abbreviations used	53	12.6%	63	13.5%	66	12.4%
Certifying Doctor's details incorrect	18	4.3%	24	5.2%	40	7.5%
Certifying Doctor Spelling error	172	41.0%	179	38.4%	202	37.8%
Consultant's name incorrect	13	3.1%	7	1.5%	11	2.1%
Date or time of death incorrect	80	19.0%	102	21.9%	116	21.7%
Deceased details incorrect	29	6.9%	39	8.4%	47	8.8%
Extra information (X Box) incorrectly complete	37	8.8%	36	7.7%	30	5.6%
Legibility	3	0.7%	0	0.0%	1	0.2%
PM information incorrect	9	2.1%	8	1.7%	13	2.4%
Place of death address incorrect	6	1.4%	13	2.8%	17	3.2%
Other Additional information incorrect	3	0.7%	2	0.4%	3	0.6%
Total	*461*		*517*		*590*	

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

Table 5: Cases reported to procurator fiscal by type

Case Type	Year 8 01 Apr 2022 - 31 Mar 2023		Year 9 01 Apr 2023 - 31 Mar 2024		Year 10 01 Apr 2024 - 31 Mar 2025	
Standard Level 1, Level 1 hybrid and Level 2	228	100.0%	199	99.5%	180	96.8%
Interested Person	0	0.0%	1	0.5%	4	2.2%
Registrar Referral	0	0.0%	0	0.0%	0	0.0%
MR For Cause Referral	0	0.0%	0	0.0%	2	1.1%
Total	*228*		*200*		*186*	
% cases reported to PF	3.9%		3.2%		2.9%	

Table 6: Reasons Cases reported to procurator fiscal

Case Type	Year 8 01 Apr 2022 - 31 Mar 2023		Year 9 01 Apr 2023 - 31 Mar 2024		Year 10 01 Apr 2024 - 31 Mar 2025	
Choking	5	2.2%	3	1.5%	3	1.7%
Concerns Over Care	5	2.2%	9	4.5%	7	3.9%
Drug Related	2	0.9%	6	3.0%	8	4.4%
Flagged in Error	0	0.0%	0	0.0%	0	0.0%
Fracture or Trauma	96	42.1%	103	51.8%	98	54.4%
Industrial Disease	77	33.8%	68	34.2%	50	27.8%
Infectious Disease	42	18.4%	2	1.0%	5	2.8%
Legal Order	3	1.3%	4	2.0%	4	2.2%
Neglect or Exposure	3	1.3%	7	3.5%	8	4.4%
Stroke	0	0.0%	0	0.0%	0	0.0%
Other Report to PF	1	0.4%	1	1.0%	2	1.1%
Total Cases	*228*		*199*		*180*	

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

Table 7: Number of calls received by the enquiry line

	Year 8 01 Apr 2022 - 31 Mar 2023		Year 9 01 Apr 2023 - 31 Mar 2024		Year 10 01 Apr 2024 - 31 Mar 2025	
Funeral Director	16	0.6%	23	1.0%	24	1.0%
GP Clinical advice	1,716	67.4%	1,637	67.8%	1,739	72.6%
GP Process advice	157	6.2%	130	5.4%	74	3.1%
Hospice Clinical advice	36	1.4%	63	2.6%	46	1.9%
Hospice Process advice	10	0.4%	5	0.2%	6	0.3%
Hospital Clinical advice	384	15.1%	349	14.5%	321	13.4%
Hospital Process advice	48	1.9%	39	1.6%	33	1.4%
Informant or family	34	1.3%	40	1.7%	26	1.1%
Interested Person	3	0.1%	2	0.1%	4	0.2%
Other	42	1.6%	26	1.1%	27	1.1%
Police Scotland	0	0.0%	0	0.0%	2	0.1%
Procurator Fiscal	8	0.3%	11	0.5%	4	0.2%
Registrar	45	1.8%	38	1.6%	38	1.6%
Repatriation	3	0.1%	5	0.2%	3	0.1%
Signposted	44	1.7%	47	1.9%	47	2.0%
No advice type recorded	0	0.0%	0	0.0%	0	0.0%
Total	*2,546*		*2,415*		*2,394*	

Table 8: Advance registration requests with outcomes

	Year 8		Year 9		Year 10	
Request Outcome	01 Apr 2022 - 31 Mar 2023		01 Apr 2023 - 31 Mar 2024		01 Apr 2024 - 31 Mar 2025	
Approved	63	86.3%	49	75.4%	44	91.7%
Not Approved	10	13.7%	16	24.6%	4	8.3%
Review Outcome						
In Order	56	76.7%	54	83.1%	37	77.1%
Not in Order	13	17.8%	8	12.3%	11	22.9%
PF	4	5.5%	3	4.6%	0	0.0%
Total	*73*		*65*		*48*	

Table 9: Number (and percentage) of Breached Cases

	Year 8		Year 9		Year 10	
Reason for Breach	01 Apr 2022 - 31 Mar 2023		01 Apr 2023 - 31 Mar 2024		01 Apr 2024 - 31 Mar 2025	
Certifying doctor unavailable	196	84.5%	141	83.9%	195	89.9%
DCRS delay	10	4.3%	6	3.6%	1	0.5%
Delay in obtaining/receiving required information*	25	10.8%	20	11.9%	18	8.3%
Other	1	0.4%	1	0.6%	3	1.4%
Total	232		168		217	

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

Table 10: Number and percentage of interested person reviews

	Year 8		Year 9		Year 10	
Request Outcome	01 Apr 2022 - 31 Mar 2023		01 Apr 2023 - 31 Mar 2024		01 Apr 2024 - 31 Mar 2025	
Approved	2	50.0%	1	100.0%	6	100.0%
Not Approved	2	50.0%	0	0.0%	0	0.0%
Total Requests	*4*		*1*		*6*	
Review outcome						
In Order	1	50.0%	0	0.0%	1	16.7%
Not in Order	1	50.0%	0	0.0%	1	16.7%
Reported to PF	0	0.0%	1	100.0%	4	66.7%

Table 11: Number and percentage of registrar referral reviews

	Year 8		Year 9		Year 10	
Review Outcome	01 Apr 2022 - 31 Mar 2023		01 Apr 2023 - 31 Mar 2024		01 Apr 2024 - 31 Mar 2025	
In Order	0	0.0%	0	0.0%	0	0.0%
Not in Order	0	0.0%	1	100.0%	5	71.4%
Escalated to PF	0	0.0%	0	0.0%	2	28.6%
Total	*0*		*1*		*7*	

Table 12: Number and percentage of repatriation reviews

	Year 8		Year 9		Year 10	
Request Outcome	01 Apr 2022 - 31 Mar 2023		01 Apr 2023 - 31 Mar 2024		01 Apr 2024 - 31 Mar 2025	
Approved	191	100.0%	178	100.0%	181	100.0%
Not Approved	0	0.0%	0	0.0%	0	0.0%
Total	*191*		*178*		*181*	

Table 13: Cases reviewed by DCRS between 01 May 2015 – 31 March 2025

Case Type	Number Cases	Percent Total
Standard	56,243	83.4%
Enquiry	9,475	14.0%
Repatriation	1,583	2.3%
Registrar Referral	84	0.1%
Interested Person	54	0.1%
For Cause	13	0.0%
Total	*67,452*	

Appendix 2: Glossary of terms

COPFS	Crown Office and Procurator Fiscal Service
DCRS	Death Certification Review Service
eCMS	Electronic Case Management System used by the service to manage reviews.
eMCCD	Electronic Medical Certificate of Cause of Death
FOI	Freedom of Information requests
For Cause Reviews	The DCRS medical reviewer can, if concerned, request a series of MCCDs written by a specific doctor are reviewed for a specific period of time.
HIS	Healthcare Improvement Scotland
In Order	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 them, the certificate represents a reasonable conclusion as to the likely cause (causes) of death, and the other information contained in the certificate is correct."
Interested Person Review	A request by a family member, healthcare professional involved in the deceased's care, funeral director or person in charge of burial/cremation can request a review of an MCCD if the death has not already been considered by the Procurator Fiscal or reviewed by the service already.
Level 1 Review	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.
Level 2 Review	Level 2 reviews consist of a review of the MCCD and the patient medical records and a discussion with the certifying doctors.
Not In Order	The Certification of Death (Scotland) Act 2011, s8 (4) explains 'not in order' as "where a medical reviewer is not satisfied, on the basis of the evidence available to them, that the certificate represents a reasonable conclusion as to the likely cause (causes) of death, and the other information contained in the certificate is correct."
MCCD	Medical Certificate of Cause of Death

Non Standard Review	Non-standard Reviews are; Interested Person reviews, Registrar referrals and Repatriations to Scotland
NRS	National Records of Scotland
PF	Procurator Fiscal. Criteria for reporting to the PF: reporting-deaths-information-for-medical-practitioners.docx (live.com)
Registrar referral	A local authority registrar can request a review of an MCCD if the death has not already been reported to PF or reviewed by the service already.
Repatriation	Burial or cremation of a person who has died abroad in Scotland
Sankey Diagram	Sankey diagram should be read from left to right. The diagram 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.
SLA	Service Level Agreements are the agreed timescales within which the service will complete reviews.
Standard Review	Standard Reviews are Level 1 and Level 2 reviews.
The 'Act'	Certification of Death (Scotland) Act 2011 https://www.legislation.gov.uk/asp/2011/11/pdfs/asp_20110011_en.pdf

Published | Month 2025

Need information in a different format? Contact our Equality, Inclusion and Human Rights Team to discuss your needs. Email his.equality@nhs.scot or call 0141 225 6999. We will consider your request and respond within 20 days.

Healthcare Improvement Scotland

Death Certification Review Service
0300 123 1898
his.dcrs@nhs.scot

For more information visit:
http://www.healthcareimprovementscotland.scot/ or
Death Certification Review Service