Healthcare Improvement Scotland | DCRS Death Certification Review Service

Death Certification Review Service

Annual Report 2025–2026

NHS SCOTLAND

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Overview by Senior Medical Reviewer

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Senior Medical Reviewer

This marks the eleventh occasion on which I have introduced the annual report for the Death Certification Review Service (DCRS). Last year, we reflected on and consolidated the achievements of our first decade.

Our three core drivers remain unchanged: improving the quality and accuracy of Medical Certificates of Cause of Death (MCCDs), deriving better public health data, and enhancing clinical governance. While these ambitions are critical, we remain acutely aware that each certificate represents an individual life lost, and that families and loved ones are often experiencing profound grief. With this in mind, we continue to place strong emphasis on a trauma-informed, bereavement-centred approach. Despite ongoing pressures across the public sector, we remain committed to avoiding unnecessary delays to funeral arrangements.

We are equally mindful of the demands on colleagues across the NHS, in both primary and secondary care, whose priority must be the care of the living. My aim has always been to place patients and families at the heart of our work, delivering improvements in a supportive and educational way.

While early progress in improving MCCD content has naturally plateaued, we are optimistic about further gains. The successful trial of electronically completed MCCDs (eMCCDs) in NHS Lothian is expected to enable full integration with the Forward Electronic Register (FER) at National Records of Scotland in the near future—what I have previously described as the “final piece of the jigsaw”. Alongside our structured annual reviews with each health board, this provides a realistic opportunity to further reduce the ‘not-in-order’ rate, which is the metric that we use. The roll out of eMCCDs into NHS Lothian is anticipated to be the first step towards a national rollout in the coming years.

Being able to access the clinical portal in all boards was, indeed, a ‘gamechanger’ for DCRS and although the more difficult information governance requirements had been negotiated some time earlier, the technical firewall difficulties allowing us to do this were finally overcome. A minor consequence is that the need to physically obtain and scan medical records has reduced significantly, leading to less familiarity with this process when it is required.

In previous reports, I highlighted the importance of enabling interested person reviews, even where an initial assessment of the MCCD had already taken place. DCRS has now influenced legislative change in this area, culminating in amendments to primary legislation. One of the high spots was providing evidence to the Health, Social Care and Sport Committee in December 2025. Although I have had experience of giving evidence at a variety of courts and tribunals, interrogation by this committee, gentle and civilised as it was, made me grateful that I had prepared thoroughly for the process and appreciated the wider organisational support along with that from colleagues in the Scottish Government to realise this improvement.

These legislative changes not only widen access to interested person reviews but also reinforce the principle of respecting death certification arrangements across the UK. This is particularly important in supporting families who wish funerals to take place in Scotland.

Our service level agreements remain focused on delivering reviews efficiently and compassionately, without placing additional burden on families or staff. Currently, Level 1 reviews are completed on average within 5 hours, and Level 2 reviews within 7.5 hours. Once again, we have been able to approve 100% of advance registrations within 2 hours which has been greatly valued by minority faith groups and also those with cultural requirements for burial within 3 days which remains the expectation in some remote and rural parts of Scotland.

Finally, I would like to extend my sincere thanks to colleagues across Healthcare Improvement Scotland, our stakeholders, public partners, and sponsors. Their continued support has enabled the service to achieve results that exceed expectations.

Service highlights

Over the past 11 years, the service has improved the quality and accuracy of MCCDs through reviews and process improvements, while reducing the impact of reviews on families. Fuller details are contained within the report.

In the last year (2025 – 2026)

Public Assurance	6118 MCCD reviews completed	
Sustained Improvement	79.4% of certificates reviewed were 'In Order'	
Impact on families	On average, standard reviews were completed in under 7.5 hours	
Advance Registrations	93.4% completed within an hour, all under 2 hours	
Repatriations to Scotland	On average, requests for repatriation were approved within 2 days	

Death Certification Review Service (DCRS)

The Death Certification Review Service operates within the Certification of Death (Scotland) Act 2011[1] legislative framework and the role of the service[2] 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[3], helping to improve standards in Scottish healthcare

In Scotland last year, doctors certified over **60,000** deaths of which **12%** were randomly selected[4] 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.

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

2 https://www.healthcareimprovementscotland.scot/inspections-reviews-and-regulation/death-certification-review-service-dcrs

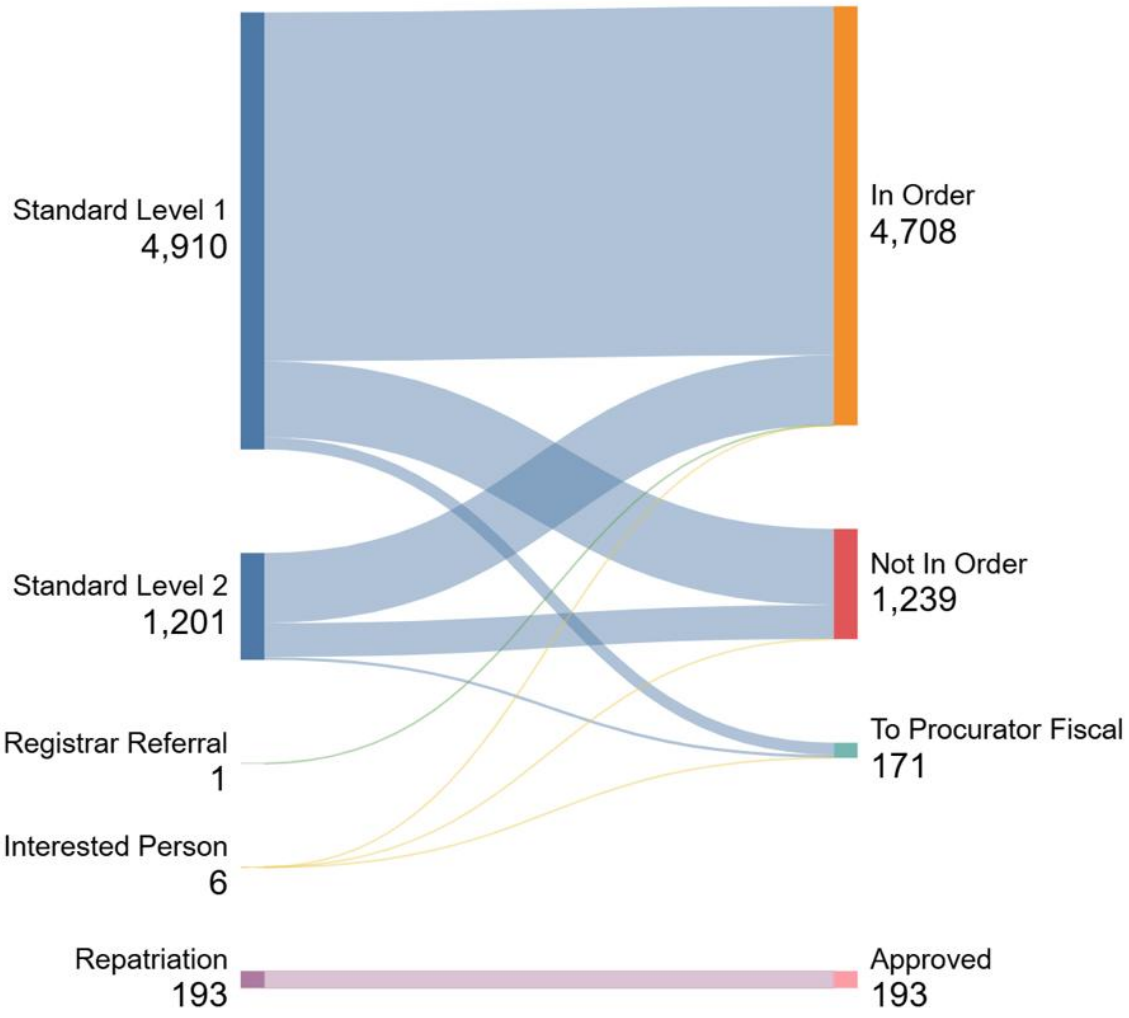
3 The framework through which healthcare organisations are accountable for continuously improving the quality of their services and safeguarding high quality of care.

4 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 **6311** cases in 2025/26, of which 6,111 **(97%)** were standard reviews[5] and 200 **(3%)** non-standard[6] reviews. The diagram [7] 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 2025/26[8]



[5] 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.

[6] Non-standard Reviews (Interested Person reviews, Registrar referrals and Repatriations to Scotland)

[7] 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.

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

Enquiry line

The service dealt with 2,370[9] enquiries last year. The majority of calls **(90.3%)** were from doctors seeking clinical advice on how to best represent a death on a MCCD:

- GP clinical advice 1,802 **(76.0%)**
- hospital clinical advice 279 **(11.8%)**
- hospice clinical advice 58 **(2.4%)**

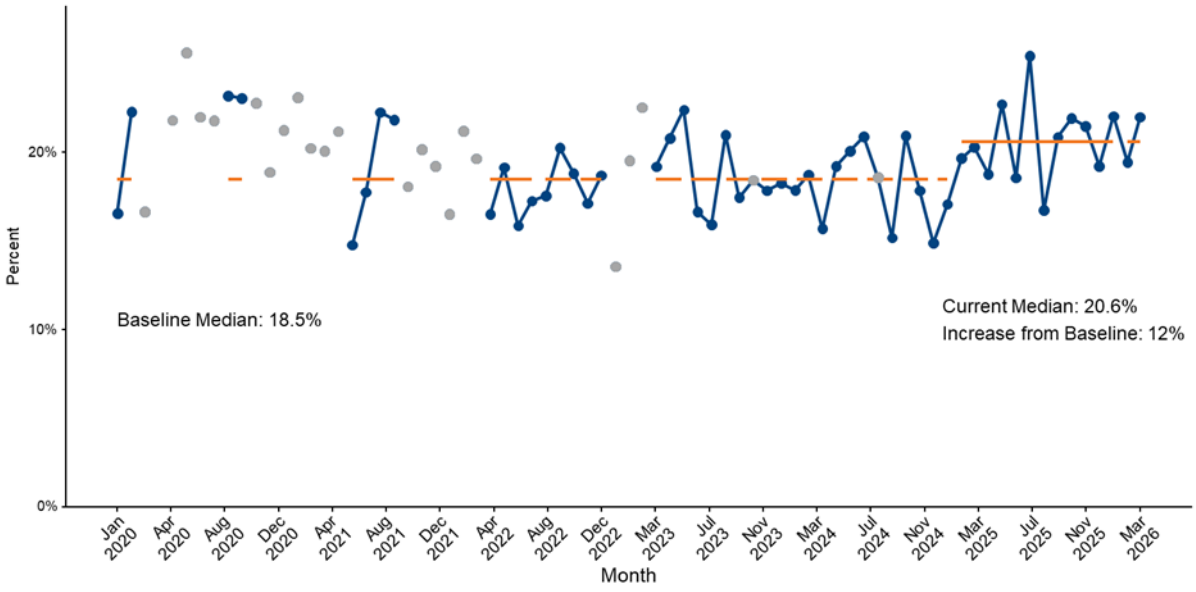
We also provided advice on 231 **(9.7%)** other calls: to registrars, families and the Procurator Fiscal.

[9] 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'[10] from January 2020 to March 2026 indicates that the percentage 'not in order' has increased to a current median of **20.6%** in 2025; an overall increase of **12% from** the baseline of **18.5**%.

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)*

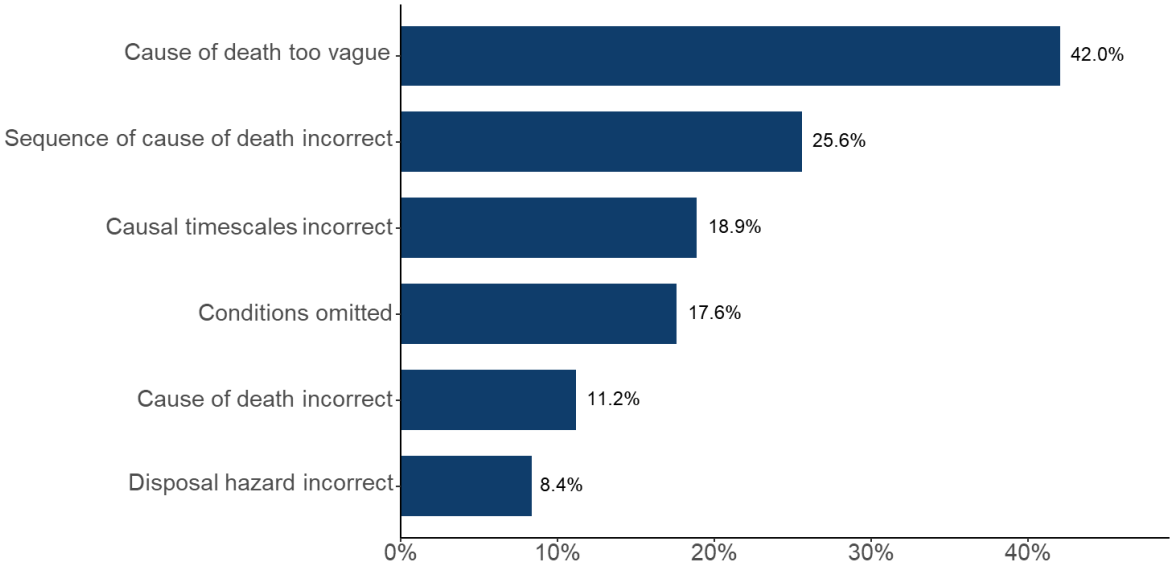
Review outcomes

In 2025/26, 6,111 medical reviews were carried out, of which 1,236 **(20.2%)** were found to be **'not in order'.** Of these, 778 **(62.9%)** had at least **one clinical closure category** error recorded, of which **42.0%** were 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.

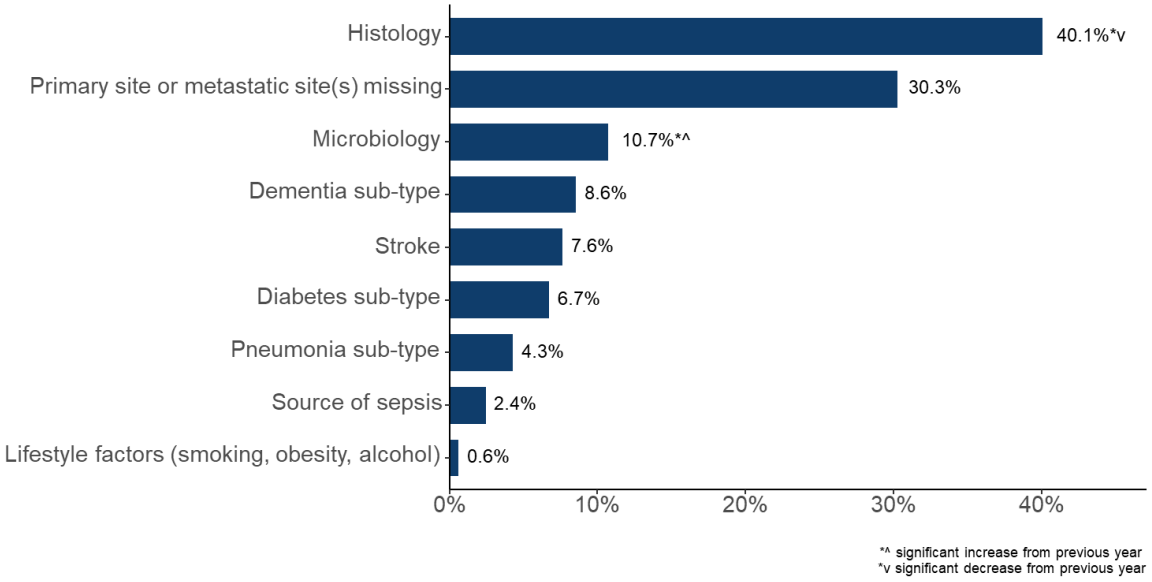
[10] The Certification of Death (Scotland) Act 2011, s8 (4) explains 'not in order' as "where a medical reviewer is not satisfied, on the basis of the evidence available to the medical reviewer, that the certificate represents a reasonable conclusion as to the likely cause (causes) of death, and the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

Breakdown of clinical closure categories as a percentage of MCCDs with clinical category errors[11]



Analysis of reviews deemed to have 'cause of death too vague' shows **40.1%** are due to histology, which was a significant decrease from **50.7%** the previous year. **30.3%** due to primary site or metastatic site(s) missing[12]. Microbiology saw a significant increase from 5.9% to 10.7%.

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



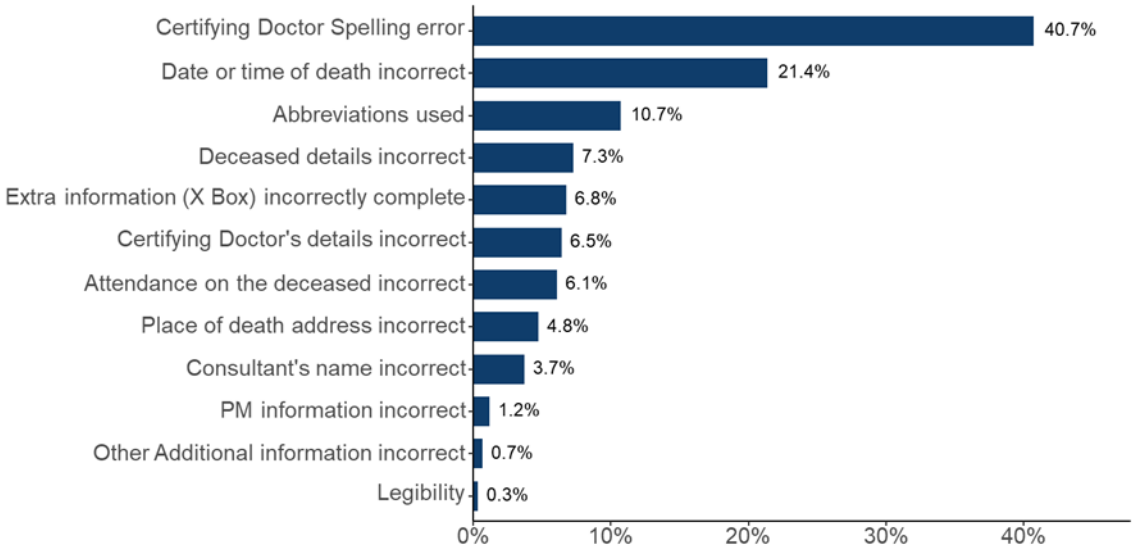
[11] Table 3 within Appendix 1 provides full details of clinical and administrative errors recorded over the last 3 years

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

Administrative improvements

Administrative errors include spelling mistakes, use of abbreviations and failing to sign the certificate. Last year**, 47.7%** of MCCDs 'not in order' had an administrative closure category[13] recorded. Certifying doctor spelling error was recorded against 240 **(40.7%)** of MCCDs with at least one administrative error.

Breakdown of administrative errors as a percentage of MCCDs with administrative errors



[13] Changes to fields other than the 'cause of death' on the MCCD are categorised as 'administrative' errors.

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[14].

Our medical review team found 169 **(2.8%)** of all certificates reviewed last year had not been reported to the Procurator Fiscal by the certifying doctor when this should have taken place. The most common oversight in reporting was where there was fracture or trauma **(60.4%)** or a known industrial disease **(17.2%)** that caused or contributed to the death. Causes due to a known industrial disease however had reduced significantly from **27.4%** in 2024/25.

Educational Learning – Pleural plaques case study

Crown Office and Procurator Fiscal Service (COPFS) advised last year 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. Although there has been occasional confusion with this different approach, the revised position has generally worked well over this period.

Educational conversation with the certifying doctor via enquiry line

The doctor called to seek advice about whether the death should be reported to the Procurator Fiscal in view of the presence of pleural plaques.

A retired manual worker died from cancer of the pancreas with liver metastases and progressive liver failure. He had an incidental finding of pleural plaques on chest X ray and CT of his chest. There was no asbestosis seen on CT. The pancreatic cancer was not known to be associated with asbestos exposure.

The proposed sequence of cause of death was:

1a – liver failure 1 week

1b – metastases to the liver 3 months

1c – carcinoma of the head of pancreas 3 months

The medical reviewer advised that the death was NOT reportable according to current Chief Medical Officer (CMO) and COPFS guidance.

Learning points:

- A death does not require to be reported to the Procurator Fiscal if pleural plaques feature and the doctor is satisfied that they played no part in the person's death.
- Deaths where asbestosis or mesothelioma were present should be reported to the Procurator Fiscal unless compensation has already been paid.

[14] reporting-deaths-information-for-medical-practitioners.docx (live.com)

Educational conversations

Medical reviews are 'educational conversations' and whilst some MCCDs require an amendment, many are deemed 'in order' **(77%)**. Of those deemed to be "in order", **44%** were given educational support. Of the cases with education offered, **40.8%** were offered to primary care doctors, and **59.2%** were offered to secondary care doctors. Of the total cases where education was offered, the most common education types offered were 'add sub-type or make more specific' **(33.9%)**, and 'Intervals' **(23.3%)**. 'Intervals', 'Extra Information (X box)', and 'PM information' each saw significant increases from the previous year.

Educational Learning – Review Case study

Review of MCCD completed by certifying doctor for 86 year-old

Part I Disease of the condition directly leading to death and antecedent causes

1a Chronic Lymphocytic Leukaemia

Part II Other significant conditions

2a Malignant Neoplasm of Colon

Medical reviewer observations of certificate and review of patient medical records

Cause of death too vague.

Adenocarcinoma of Caecum.

Educational conversation with the certifying doctor

The certifying doctor agreed to amend the certificate to correct above to add specific site and histology.

Death registered as

Part I Disease of the condition directly leading to death and antecedent causes

1a Chronic Lymphocytic Leukaemia

Part II Other significant conditions

2a Adenocarcinoma of caecum

Below are the **three** 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.

Educational delivery

Educational events

During 2025/26, the Medical Reviewers (MRs) and Medical Reviewer Assistants (MRAs) delivered a wide range of educational sessions to medical students, trainee doctors, doctors and registrars across Scotland. More than **350** participants attended these sessions over the year, with feedback consistently rated as excellent.

"I learned about how to properly fill in a death certificate and how it is important to mention hazards especially for those who handle the body. I also learnt about the role of DCRS. It was very interesting, and the cases were helpful to get a better understanding."

Educational resources

A new eLearning module, *Improving the quality of Medical Certificates of Cause of Death: Avoiding errors*, was launched on TURAS in June 2025. The module addresses frequently occurring errors on MCCDs in Scotland through nine scenarios set in primary and secondary care, with content applicable to all clinical settings. Since its launch **229** professionals have completed the module with another **89** in progress.

During the year, the **Common admin errors** and ***Top tips for certifying doctors*** resources were also updated and published on the DCRS website.

Health Board Annual Review Meetings

Annual review meetings took place with all Health Boards during November 2025 and January 2026.

Individual meetings were carried out with all Boards to discuss the outcomes for Medical Certificate of Cause of Deaths written within their board and reviewed by our service.

The meetings concentrated on quality improvement and control with the purpose of strengthening how we:

- support quality improvement through constructive professional dialogue
- promote a learning system by sharing and spreading any innovative and effective practice that we identify
- use the range of information available to us to assist in identifying and recommending areas for improvement and providing practical support where possible

Example Board improvement action	The board will liaise with their local improvement advisors (within their Improvement Academy) to help devise appropriate quality improvement methodology to encourage CDs to lower the 'not in order' rate, thereby avoiding administrative errors, such as spelling mistakes, incorrect dates and times, and also when to report cases to Scottish Fatalities Investigation Unit (SFIU).
DCRS learning point - CMO Guidance	Reminder to all Boards that CMO guidance states that the MCCD should not be given directly to the family but rather sent to the registration office.

Clinical governance

As part of the MCCD review process, medical reviewers review a patient's prescriptions on the Emergency Care Summary (ECS) and if necessary, 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 2025/26, there were **61** requests, of which **all (100%)** were approved. This was a significant increase from **91.7%** approved in 2024/25.

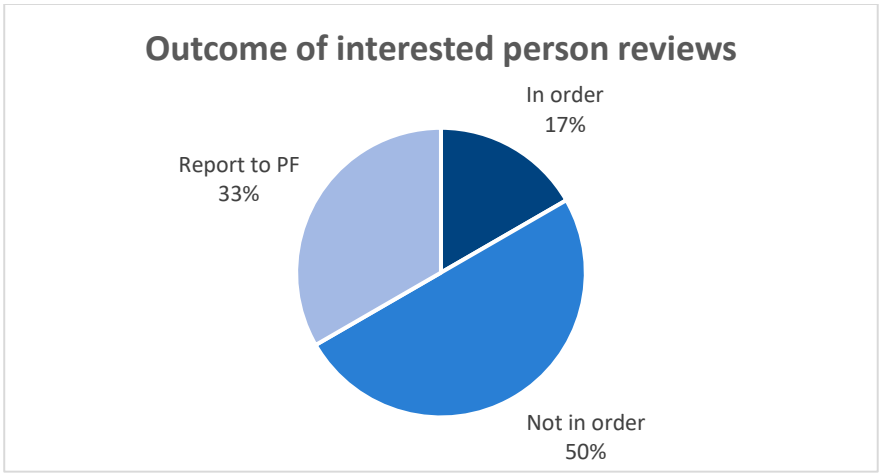
The service continues to successfully meet its aim of completing all advance registration requests within two hours, indeed 57 **(93.4%)** of requests considered this year received a decision within one hour.

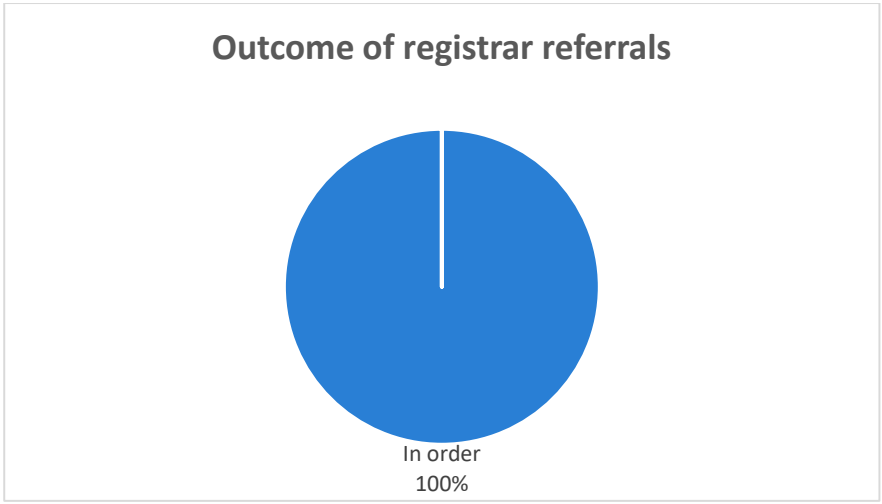
Non-randomised reviews

Interested person, registrar referrals, 'for cause' reviews

The service reviews MCCDs at the request of members of the public (Interested Person review)[15] and local authority registrars (Registrar Referral) if they feel the certificate is not accurate.

The volume of these types of requests remains low[16]. Last year, the service received **six** Interested Person requests, and **one** Registrar referral. The two charts below provide an overview of the outcomes from these reviews.





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

[16] 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[17]. In 2025/26, the service received **193** repatriation requests, of which:

- **138** (71.5%) were male, **55** (28.5%) were female
- **121** (62.7%) were individuals aged 60 years or older
- **61** people (31.6%) died in Spain
- **61** cases (31.6%) were reported to the Procurator Fiscal (PF)
- **4** requests for a postmortem examination were made and approved.

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

Age	No of deaths
0 - 19	5
20 - 39	21
40 - 59	46
60 - 79	97
80+	24

Repatriated from	No of deaths
Spain	61
Turkey	14
UAE	11
France	8
Portugal	8
Republic of Ireland	8

Funeral type	No of deaths
Burial	62
Cremation	131

Causes of death*
Cardiovascular
Not stated**
Infective
Traumatic
Respiratory

**top 5 in order of greatest frequency*

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

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

Service performance

Service Level Agreements

The service aims to complete reviews without any negative impact on families, and staff work relentlessly to complete reviews as quickly as possible.

Standard level 1 reviews are now completed on average within **5** hours and level 2 reviews within **7.5** hours. The table below details our average performance against service level agreement timeframes set by the Scottish Government. These times are monitored for changes and where issues are identified we modify processes accordingly.

Around **413** (6.5%) of case reviews breached SLA timescales, of which:

- **250** (60.5%) were due to the certifying doctor being unavailable
- **73** (17.7%) were due to a dual delay[18]
- **302** (73.1%) were in secondary care

Identification of delays due to internal processes have been identified and improvement plans have been put in place.

[18] The dual delay category was brought in in March 2025 to allow capture of delays across the review process. It identifies where delays are attributable to both DCRS and the availability of the certifying doctor.

Stakeholder engagement

In January 2025, the service sought feedback from registrars across Scotland to better understand their experience of the advance registration service. The advance registration (AR) process is offered to help avoid unnecessary delays for families by enabling funeral arrangements to proceed while a review is underway. This is carried out through local authority registrars.

A total of **77 registrars from 23 Scottish local authorities** participated.

Awareness of the advanced registration process

Overall awareness of Advance Registration eligibility criteria was high, indicating that national guidance is reaching registrars effectively.

Awareness was high across all AR categories:

- religious/cultural: 94.8%
- compassionate: 89.5%
- practical/administrative: 90.9%

Use of the advance registration process

Almost half of respondents (47%) reported having used the AR process, with most indicating experience of using it between one and ten times. The process is most commonly used for practical reasons, such as travel arrangements, but is also applied in religious, cultural and compassionate circumstances.

Feedback suggests that the AR process is generally perceived as efficient, clear and well-supported by staff. However, respondents identified opportunities for improvement, particularly in relation to **administrative burden**, **digital functionality** and **inconsistency in certain operational scenarios**. Given the low-volume but highly sensitive nature of AR cases, clarity and confidence in the process remain essential.

Overall conclusion

The AR process is performing well, with **excellent processing times, strong staff performance**, and **high registrar awareness**.

Modernisation—particularly **increased digitisation and improved system integration**—represents the most significant opportunity to enhance efficiency and further reduce administrative burden for both registrars and families.

As part of the improvement work the need to submit an additional supplementary details form has been removed. This has reduced paperwork giving registrar process efficiencies.

"I always call DCRS to let them know I am sending AR request over and I have never had any issues, seems like a streamlined process"

MCCD Process improvements

eMCCD roll out into secondary care

Electronic MCCD in the hospital setting 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 now been established, and it is anticipated that eMCCDs will be fully rolled out across NHS Lothian in Summer 2026.

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 someone who raised concerns over the review taking longer to complete than was informed. The complaint was not upheld as the Level 2 review had been completed within the SLA timescales.

Freedom of Information

The service also responded to **three** Freedom of Information (FOI) requests.

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 waiting to register a death
- in partnership with Public Services Delivery Scotland (PSD Scotland) review and update our existing e-learning resources and develop new resources around neonatal death certification.

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 since the service began have helped us to assure and improve the quality of death certification across Scotland.

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

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
Chioma Agoucha	Public Partner	Healthcare Improvement Scotland
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)
Katrina McNeill	Scottish Government Senior Policy Manager	Burial, Cremation, Anatomy and Death Certification team
Dr Janice Nicolson	Principal Educator, Medical Education	Public Services Delivery Scotland
Carolyn Nickels	Head of Registration	National Records of Scotland
Sarah Patterson	ICM Representative for SARDG	Scottish Academy Resident Doctors Group
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)
Andrea Telford	Service Manager	Healthcare Improvement Scotland (DCRS)
Camilla Young	Programme 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[19]. 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 9		Year 10		Year 11	
Case Type	01 Apr 2023 - 31 Mar 2024		01 Apr 2024 - 31 Mar 2025		01 Apr 2025 - 31 Mar 2026	
Standard Level 1, Level 1 hybrid and Level 2	6,174	97.2%	6,237	97.0%	6,111	96.8%
Repatriation	178	2.8%	181	2.8%	193	3.1%
Interested Person	1	0.0%	6	0.1%	6	0.1%
Registrar Referral	1	0.0%	7	0.1%*	1	0.0%*
MR For Cause Referral	0	0.0%	0	0.0%	0	0.0%
Total	*6,354*		*6,431*		*6,311*	

**Significant change from previous year*

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

	Year 9		Year 10		Year 11	
Case Type	01 Apr 2023 - 31 Mar 2024		01 Apr 2024 - 31 Mar 2025		01 Apr 2025 - 31 Mar 2026	
Email amendments	985	88.1%	980	88.3%	1,060	85.8%
Replacement MCCD	133	11.9%	130	11.7%	176	14.2%
Total	*1,118*		*1,110*		*1,236*	

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

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

Case Type	Year 9 01 Apr 2023 - 31 Mar 2024		Year 10 01 Apr 2024 - 31 Mar 2025		Year 11 01 Apr 2025 - 31 Mar 2026	
Cause of Death too vague	316	40.6%	306	42.9%	327	42.0%
Cause of Death incorrect	121	15.6%	94	13.2%*	87	11.2%
Sequence of Cause of Death incorrect	213	27.4%	174	24.4%	199	25.6%
Causal timescales incorrect	158	20.3%	146	20.5%	147	18.9%
Conditions omitted	140	18.0%	119	16.7%	137	17.6%
Disposal Hazard incorrect	59	7.6%	64	9.0%	65	8.4%
Total	*1,007*		*903*		*962*	

**Significant change from previous year*

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'

Case Type	Year 9 01 Apr 2023 - 31 Mar 2024		Year 10 01 Apr 2024 - 31 Mar 2025		Year 11 01 Apr 2025 - 31 Mar 2026	
Attendance on the deceased incorrect	44	9.4%	44	8.2%	36	6.1%
Abbreviations used	63	13.5%	66	12.4%	63	10.7%
Certifying Doctor's details incorrect	24	5.2%	40	7.5%	38	6.5%
Certifying Doctor Spelling error	179	38.4%	202	37.8%	240	40.7%
Consultant's name incorrect	7	1.5%	11	2.1%	22	3.7%
Date or time of death incorrect	102	21.9%	117	21.9%	126	21.4%
Deceased details incorrect	39	8.4%	42	7.9%	43	7.3%
Extra information (X Box) incorrectly complete	36	7.7%	30	5.6%	40	6.8%
Legibility	0	0.0%	1	0.2%	2	0.3%
PM information incorrect	8	1.7%	13	2.4%	7	1.2%
Place of death address incorrect	13	2.8%	21	3.9%	28	4.8%
Other Additional information incorrect	2	0.4%	3	0.6%	4	0.7%
Total	*517*		*590*		*649*	

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

Table 5: Cases reported to procurator fiscal by type

Case Type	Year 9 01 Apr 2023 - 31 Mar 2024		Year 10 01 Apr 2024 - 31 Mar 2025		Year 11 01 Apr 2025 - 31 Mar 2026	
Standard Level 1, Level 1 hybrid and Level 2	199	99.5%	180	96.8%	169	98.8%
Interested Person	1	0.5%	4	2.2%	2	1.2%
Registrar Referral	0	0.0%	0	0.0%	0	0.0%
MR For Cause Referral	0	0.0%	2	1.1%	0	0.0%
Total	*200*		*186*		*171*	
% cases reported to PF	3.2%		2.9%		2.8%	

Table 6: Reasons Cases reported to procurator fiscal

Case Type	Year 9 01 Apr 2023 - 31 Mar 2024		Year 10 01 Apr 2024 - 31 Mar 2025		Year 11 01 Apr 2025 - 31 Mar 2026	
Choking	3	1.5%	3	1.6%	5	2.9%
Concerns Over Care	9	4.5%	13	7.0%	19	11.1%
Drug Related	6	3.0%	10	5.4%	8	4.7%
Flagged in Error	0	0.0%	0	0.0%	0	0.0%
Fracture or Trauma	103	51.5%	98	52.7%	102	59.6%
Industrial Disease	68	34.0%	51	27.4%	29	17.0%*
Infectious Disease	2	1.0%	5	2.7%	4	2.3%
Legal Order	4	2.0%	4	2.2%	2	1.2%
Neglect or Exposure	7	3.5%	8	4.3%	8	4.7%
Stroke	0	0.0%	0	0.0%	0	0.0%
Other Report to PF	2	1.0%	2	1.1%	5	2.9%
Total Cases	*200*		*186*		*171*	

**Significant change from previous year*

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

Table 7: Number of calls received by the enquiry line

	Year 9		Year 10		Year 11	
	01 Apr 2023 - 31 Mar 2024		01 Apr 2024 - 31 Mar 2025		01 Apr 2025 - 31 Mar 2026	
Funeral Director	23	1.0%	24	1.0%	11	0.5%*
GP Clinical advice	1,637	67.8%	1,739	72.6%*	1,802	76.0%*
GP Process advice	130	5.4%	74	3.1%*	88	3.7%
Hospice Clinical advice	63	2.6%	46	1.9%	58	2.4%
Hospice Process advice	5	0.2%	6	0.3%	9	0.4%
Hospital Clinical advice	349	14.5%	321	13.4%	279	11.8%
Hospital Process advice	39	1.6%	33	1.4%	34	1.4%
Informant or family	40	1.7%	26	1.1%	20	0.8%
Interested Person	2	0.1%	4	0.2%	8	0.3%
Other	26	1.1%	27	1.1%	27	1.1%
Police Scotland	0	0.0%	2	0.1%	2	0.1%
Procurator Fiscal	11	0.5%	4	0.2%	6	0.3%
Registrar	38	1.6%	38	1.6%	19	0.8%*
Repatriation	5	0.2%	3	0.1%	6	0.3%
Signposted	47	1.9%	47	2.0%	1	0.0%*
No advice type recorded	0	0.0%	0	0.0%	0	0.0%
Total	*2,415*		*2,394*		*2,370*	

**Significant change from previous year*

Table 8: In order cases with education offered

Education Offered	Year 9 01 Apr 2023 - 31 Mar 2024		Year 10 01 Apr 2024 - 31 Mar 2025		Year 11 01 Apr 2025 - 31 Mar 2026	
PM information	6	0.3%	3	0.1%	13	0.6%*
Did a condition need to be there	55	2.4%	35	1.7%	33	1.6%
Part B Details of Certifying Doctor	75	3.3%	114	5.4%*	125	6.1%
Unnecessary narrative or symbols	76	3.3%	51	2.4%	62	3.0%
Part D Hazards	71	3.1%	41	1.9%*	43	2.1%
Extra information (X Box)	85	3.7%	98	4.6%*	155	7.5%*
Lifestyle factors (alcohol, smoking or weight)	95	4.2%	106	5.0%	101	4.9%
Attendance on deceased	139	6.1%	121	5.7%	148	7.2%
Sequence	158	6.9%	115	5.4%*	109	5.3%
Part A Details of Deceased including ward details	196	8.6%	291	13.8%*	292	14.2%
Intervals	366	16.1%	406	19.2%*	479	23.3%*
Add sub type or make more specific	846	37.2%	706	33.4%*	695	33.9%
Total	*2,168*		*2,087*		*2,255*	

**Significant change from previous year*

Table 9: Advance registration requests with outcomes

Request Outcome	Year 9 01 Apr 2023 - 31 Mar 2024		Year 10 01 Apr 2024 - 31 Mar 2025		Year 11 01 Apr 2025 - 31 Mar 2026	
Approved	49	75.4%	44	91.7%*	61	100.0%*
Not Approved	16	24.6%	4	8.3%*	0	0.0%*
Request Outcome						
In Order	54	83.1%	37	77.1%	52	85.2%
Not in Order	8	12.3%	11	22.9%	9	14.8%
PF	3	4.6%	0	0.0%	0	0.0%
Total	*65*		*48*		*61*	

**Significant change from previous year*

Table 10: Number (and percentage) of Breached Cases

Reason for Breach	Year 9 01 Apr 2023 - 31 Mar 2024		Year 10 01 Apr 2024 - 31 Mar 2025		Year 11 01 Apr 2025 - 31 Mar 2026	
Certifying doctor unavailable	141	83.9%	195	89.9%	250	60.5%*
DCRS delay	6	3.6%	1	0.5%*	47	11.4%*
Delay in obtaining/receiving required information**	20	11.9%	18	8.3%	40	9.7%
Dual delay	0	0.0%	0	0.0%	73	17.7%*
Other	1	0.6%	3	1.4%	3	0.7%
Total	168		217		413	

**Significant change from previous year*

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

Table 11: Number and percentage of interested person reviews

Request Outcome	Year 9 01 Apr 2023 - 31 Mar 2024		Year 10 01 Apr 2024 - 31 Mar 2025		Year 11 01 Apr 2025 - 31 Mar 2026	
Approved	1	100.0%	6	100.0%	6	100.0%
Not Approved	0	0.0%	0	0.0%	0	0.0%
Total Requests	*1*		*6*		*6*	
Review outcome approved						
In Order	0	0.0%	1	16.7%	1	16.7%
Not in Order	0	0.0%	1	16.7%	3	50.0%
Reported to PF	1	100.0%	4	66.7%	2	33.3%

Table 12: Number and percentage of registrar referral reviews

Review Outcome	Year 9 01 Apr 2023 - 31 Mar 2024		Year 10 01 Apr 2024 - 31 Mar 2025		Year 11 01 Apr 2025 - 31 Mar 2026	
In Order	0	0.0%	0	0.0%	1	100.0%
Not in Order	1	100.0%	5	71.4%	0	0.0%
Escalated to PF	0	0.0%	2	28.6%	0	0.0%
Total	*1*		*7*		*1*	

Table 13: Number and percentage of repatriation reviews

	Year 9		Year 10		Year 11	
Request Outcome	01 Apr 2023 - 31 Mar 2024		01 Apr 2024 - 31 Mar 2025		01 Apr 2025 - 31 Mar 2026	
Approved	178	100.0%	181	100.0%	193	100.0%
Not Approved	0	0.0%	0	0.0%	0	0.0%
Total	*178*		*181*		*193*	

Appendix 2: Glossary of terms

AR	Advance Registration
CMO	Chief Medical Officer
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 Review	Level 2 reviews consist of a review of the MCCD and the patient medical records and a discussion with the certifying doctors. Level 2 reviews also require a review of patient medical records.
MCCD	Medical Certificate of Cause of Death
MR	Medical Reviewer
MRA	Medical Reviewer Assistant

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."
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.
SFIU	Scottish Fatalities Investigation Unit
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

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