Learning Objectives

- Need for death certification reform;
- Improved understanding of the Scottish Health and Legal systems;
- Better appreciation of the new Scottish review arrangements;
- Early trends in scrutiny of MCCDs in one part of the UK;
- Consideration of impact on clinical governance;
- Possible future developments.

The Scottish Medical Reviewer System - one year on

The presentation will describe the background to its introduction and the initial experience of the Death Certification Review Service since its inception on 13 May 2015. This system of proportionate, random scrutiny was brought in simultaneously throughout Scotland with the primary drivers being the improved quality of Medical Certificates of Cause of Death, better public health data and enhanced clinical governance. Examples will be provided of common errors encountered and how the service has dealt with these in a supportive, educative manner.

Dr George Fernie

George is Senior Medical Reviewer based at Healthcare Improvement Scotland where his main function is to lead the Death Certification Reviewer Service for the new system of proportionate scrutiny that was implemented in May 2015. Prior to this, he worked as a medicolegal adviser for 17 years with MDDUS then MPS during which time he was the inaugural Registrar and third president of FFLM. He has had a long-term commitment to improving quality in the NHS including completion of MCCDs and was involved in the transfer of forensic healthcare to the NHS in Scotland as the national clinical adviser to the joint network board.