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Inspectorate of Prosecution in Scotland

# **Thematic Review of Fatal Accident Inquiries**



August 2016

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# INTRODUCTION AND BACKGROUND

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The responsibility for the investigation of any death that requires further explanation rests with COPFS. This includes any sudden, unexpected or unexplained death and any death which has occurred in circumstances which give rise to public concern. The death of a loved one is a traumatic and distressing event. For those bereaved by sudden or unexplained death, involvement with the procurator fiscal service and an unfamiliar justice system, occurring at a time of significant personal crisis or distress, can be bewildering and concerning. All are entitled to expect a thorough and professional investigation and to be guided through the process with sensitivity and respect. Protracted investigation and unexplained delays is likely to undermine public confidence in COPFS and, potentially, in Fatal Accident Inquiries.

## What is a Fatal Accident Inquiry (FAI)?

1. A Fatal Accident Inquiry is a public examination of the circumstances of a death in the public interest. FAIs are conducted before a sheriff, following an investigation by the procurator fiscal. The procurator fiscal is responsible for presenting the evidence. Other interested parties, including nearest relatives or employers are also entitled to lead evidence.
2. Having heard the evidence, the sheriff will issue a determination that includes findings on where and when the death and any accident resulting in the death occurred and the cause of such death or accident. Where the sheriff has identified reasonable precautions which might have avoided the accident or death; defects in any system of work which led or contributed to the accident or death; any fact relevant to the death,<sup>1</sup> he/she may make recommendations to prevent similar deaths happening in the future. Determinations of public interest are published on the Scottish Courts and Tribunals Service's (SCTS) website.
3. Unlike criminal or civil proceedings, an FAI is an "inquisitorial" process where the sheriff's role is to establish the facts surrounding the death, rather than to apportion blame or to find fault.<sup>2</sup> In contrast, criminal and civil proceedings are "adversarial" in nature. In criminal proceedings the purpose is to establish whether the accused is guilty of a crime and in civil proceedings, it is often to establish legal rights or liability. FAIs are not usually held until a decision has been taken on whether there should be criminal proceedings.

## Review of Fatal Accident Inquiries Legislation

4. The law governing Fatal Accident Inquiries has recently been scrutinised by the Scottish Parliament, with the passage of the Fatal Accidents and Sudden Deaths etc. (Scotland) Bill ("the Bill"), resulting in the enactment of the Fatal Accidents and Sudden Deaths etc. (Scotland) Act 2016 ("the Act").<sup>3</sup>
5. Prior to the introduction of the Fatal Accidents and Sudden Deaths etc. (Scotland) Act 2016, the legislative framework for FAIs was governed by the Fatal Accidents and Sudden Deaths Inquiry (Scotland) Act 1976 and the Fatal Accidents and Sudden Deaths Procedure (Scotland) Rules 1977.
6. In 2009, the Scottish Government commissioned a review on the operation of the FAI legislation, led by Lord Cullen of Whitekirk (the "Cullen Review"), to ensure that Scotland has an effective and practical system of public inquiry into deaths, fit for the 21st century.

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<sup>1</sup> Section 26 of the Fatal Accidents and Sudden Deaths etc. (Scotland) Act 2016.

<sup>2</sup> *Black v Scott Lithgow Limited* 1990 SLT 612 *per* the Lord President (Hope) at p 615G-H.

<sup>3</sup> The Act received Royal Assent on 14 January 2016. Sections 36(6), 40, 41, 42 and 43 and schedule 1 came into force on the day after Royal Assent. The remaining provisions come into force on a date to be appointed by Scottish Ministers.



7. The Cullen Review made 36 recommendations. The recommendations which were addressed to the Crown Office and Procurator Fiscal Service (COPFS)<sup>4</sup> were largely implemented by the establishment of the Scottish Fatalities Investigation Unit (SFIU), a specialist unit to lead the investigation of all suspicious, sudden and unexplained deaths.
8. The Scottish Government accepted most of the recommendations made in the Cullen review and consulted on proposals to introduce legislation. The Bill was introduced to implement most of the recommendations and reform and modernise the law in relation to FAIs.

### **Inquiries into Fatal Accidents and Sudden Deaths etc. (Scotland) Act 2016**

9. The Inquiries into Fatal Accidents and Sudden Deaths etc. (Scotland) Act 2016 received Royal Assent on 14 January 2016. It repeals the 1976 Act and introduces new provisions to govern the system of FAIs in Scotland.<sup>5</sup> Other changes will be implemented through procedural rules made by the Court of Session, following consultation with the Scottish Civil Justice Council (SCJC) to the Court of Session.<sup>6</sup>
10. The Act retains the requirement to hold an FAI where a death occurs in Scotland as a result of a work-related accident or where the deceased was in legal custody at the time of their death. Such inquiries are referred to as “Mandatory inquiries”.<sup>7</sup> The Lord Advocate can decide not to hold a mandatory FAI, if satisfied that the circumstances of the death have been sufficiently established during the course of other proceedings.<sup>8</sup>
11. The Act also retains the discretion of the Lord Advocate to hold an FAI into a death which is sudden, suspicious, unexplained or has occurred in circumstances which give rise to serious public concern. Such inquiries are referred to as “Discretionary inquiries”.<sup>9</sup>
12. The main features of the Act that differ from the previous provisions are:
  - The definition of “legal custody” is redefined and mandatory inquiries are extended to include the deaths of children in secure accommodation (Section 2);
  - The Lord Advocate has discretion to hold an FAI in certain circumstances where someone who ordinarily resides in Scotland dies abroad (Section 6);
  - The Lord Advocate must prepare a family liaison charter setting out how the procurator fiscal will liaise with the family of a person to whose death an inquiry may or is to be held. The Lord Advocate must consult appropriate persons before preparing the charter; lay the charter before the Scottish Parliament and publish the charter (Section 8);
  - The Lord Advocate is to provide written reasons where a decision is taken not to hold an FAI, if requested to do so (Section 9);
  - It alters and extends those persons who may participate in an FAI (Section 11);
  - It provides greater flexibility in the location and accommodation that can be used for holding FAIs (Sections 12 and 13);
  - It provides for a preliminary hearing<sup>10</sup> system and for agreement of evidence (Sections 16 and 18);

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<sup>4</sup> Recommendations 12 to 17.

<sup>5</sup> The majority of provisions will commence on a date appointed by the Scottish Ministers.

<sup>6</sup> Section 36 of the Act.

<sup>7</sup> Section 2 of the Act.

<sup>8</sup> Section 3(1), (2)(a-e) of the Act.

<sup>9</sup> Section (4) of the Act.



- A requirement is placed on those to whom sheriffs recommendations are directed to respond or to provide reasons for not responding and SCTS will publish this information on their website (Section 28); and
  - It allows for inquiries being re-opened or for fresh inquiries to be held where there is new evidence (Sections 30, 33 and 34).
13. During the consultation process and the passage of the Bill, repeated criticisms were made of long delays between the date of death and the start of FAIs. A number of factors were advanced for these delays including:
- The need to wait for the outcome of other investigations by bodies such as the Health and Safety Executive or the Air Accidents Investigation Branch;
  - The need to obtain expert evidence;
  - The need to consider whether criminal proceedings should be instigated and, where appropriate, to conduct these first;
  - The complexity of some investigations, especially those involving medical and health and safety considerations, and the over-riding necessity of conducting deaths investigations thoroughly; and
  - The time elapsed between the death and it being reported to the procurator fiscal.

### **Aim/Remit**

14. While one, or a combination of these factors, are likely to have contributed to delays in some FAIs, the lack of analysis on a case-by-case basis of the reason(s) for any delay inhibits meaningful discussion on the impact of each of these factors. Rather than relying on anecdotal assumptions, the aim of this inspection was to obtain factual data on the causes of delay, to identify recurring themes and make recommendations to improve the efficiency and effectiveness of deaths investigations and the FAI process.

### **Methodology**

15. Evidence was obtained from a range of sources, including:
- Interviews with key personnel at COPFS involved in the investigation of deaths and preparation of FAIs;
  - Interviews with representatives from the Mental Welfare Commission, British Transport Police, Air Accidents Investigation Branch, Maritime and Coastguard Agency, Marine Accident Investigation Branch, Health and Safety Executive, Healthcare Improvement Scotland, Care Inspectorate, Central Legal Office, and the Scottish Government;
  - Interviews with criminal justice partners including social workers, sheriffs, solicitors, Police Scotland, Ministry of Justice and Scottish Legal Aid Board;
  - A review of relevant documentation; and

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<sup>10</sup> The preliminary hearing is a procedural hearing. The purpose is to adjudicate on the state of preparation of the participants to the inquiry and resolve any outstanding issues prior to the inquiry. Detailed rules to accompany the Act will provide guidance on how preliminary hearings will operate in practice.



- Examination of 88 cases where an FAI had been concluded between 2012/13 to 2014/15,<sup>11</sup> including all relevant information from the case files and COPFS IT systems. We examined a range of factors, including the type of FAI, the age of the case, the reporting agency, the use of experts, the involvement of participants including nearest relatives, whether there was a criminal investigation and reasons for adjourning proceedings. In each case we measured timelines between various milestones including the date of death to the start of an FAI.
16. We would like to thank all those that gave up their time to assist with this inspection and in particular the staff of the Scottish Fatalities Investigation Unit (SFIU) for their open and active participation.

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<sup>11</sup> Sample taken from all concluded FAIs, where a preliminary hearing was held between 2012/13 to 2014/15, representing 100% of all discretionary FAIs (18 cases) and 54% of all mandatory FAIs (70 cases).



## KEY FINDINGS

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17. While the number of deaths reported to COPFS has reduced in the last three years, there has been a significant increase in the proportion of deaths requiring investigation. This reflects:
  - An evolution in the public's attitude to death, with a greater expectation of being involved in all important decisions regarding relatives and, in obtaining more information on the circumstances of the death;
  - The increasing complexity of such investigations with advances in medical science and more sophisticated means of detecting the cause of accidents; and
  - A changing landscape with an increasing number of regulatory and scrutiny bodies that have a duty to investigate a wide spectrum of different types of deaths.
18. Against this background, the number of FAIs held is extremely low, representing 0.7% of all deaths investigated.<sup>12</sup>
19. 70% of cases examined took more than 18 months from the date of death to the start of the FAI and 28% took more than three years.
20. Lengthy periods of unexplained delays prior to the start of an FAI adversely impacts on:
  - The momentum of investigations and the operational capacity of investigating agencies – investigations characterised by lengthy intervals with intermittent requests for further inquiries to be undertaken run the risk of becoming fragmented and lacking continuity, particularly if the investigators have moved on to new investigations;
  - The well-being of potential witnesses for whom the prospect of the inquiry “hanging over them” is a source of anxiety and concern;
  - The confidence of the nearest relatives and the public; and
  - The quality of the evidence and, in some cases, the purpose of the FAI.
21. Deaths investigations, conducted in local procurator fiscal offices and during the transition to centralise the investigation of deaths, were characterised by lengthy periods of inactivity and protracted and often unfocused investigations, resulting in unexplained delays in a significant number of cases.
22. The introduction of SFIU, a national specialist unit responsible for investigating all sudden, suspicious and unexplained deaths, has significantly improved the service provided by COPFS with a 64% reduction in the time taken between the date of death to the start of the FAI.
23. Whilst we found staff in SFIU were helpful and committed to providing a high quality service, and that there was improved management of deaths investigations and FAIs, there is scope to progress mandatory FAIs more expeditiously. Further, the systems for monitoring and recording FAIs are inconsistent and varied.

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<sup>12</sup> Between 2012/13 and 2014/15.





24. The impact of a sudden death of a loved one, especially if the death was caused by a criminal act, is devastating and the distress is compounded by the trauma of having to deal with an unfamiliar criminal justice system. The lack of a single point of contact during the criminal investigation and the FAI is a source of frustration and anxiety for nearest relatives. For an organisation that aspires to deliver a world leading public prosecution and deaths investigation service, the bereaved relatives' needs must be at the heart of the process; this requires a dedicated single point of contact throughout all proceedings.
25. A lack of understanding of the purpose and scope of an FAI contributes to the nearest relatives entering into FAI proceedings and/or raising issues at an advanced stage of the investigation, leading in some cases to the FAI being adjourned and additional parties becoming participants.
26. Witnesses and participants from recent FAIs report that they found the inquiry to be adversarial and, whether intended or not, it was seen as apportioning blame. One witness, who has given expert evidence in criminal proceedings and at FAIs, described giving evidence at an FAI as "like giving evidence at a criminal trial without the safety net".
27. Whilst there are cases where COPFS is reliant on investigators from external reporting agencies, such as the Health and Safety Executive, and where COPFS has no control over the investigation and timescale for the submission of reports, such cases represent a low proportion of death reports submitted to COPFS.
28. Fatal Accident Inquiries have played a crucial role in exposing failings and defects in working practices and systems, identifying precautions to avoid deaths occurring in similar circumstances and providing oversight on the way authorities have dealt with the deceased while in legal custody. The re-iteration of the purpose of Fatal Accident Inquiries in the Act, supported and underpinned by court rules designed to reinforce that purpose by focussing on the agreement of non-contentious facts and encouraging proactive management of preliminary hearings, including early clarification of the issues that require to be examined, should assist in re-emphasising the public interest ethos of Fatal Accident Inquiries. To ensure Fatal Accident Inquiries continue to fulfil the important function that they have served requires all those involved, including COPFS, representatives of all participants and the judiciary to foster an environment that encourages transparency and frankness.



## RECOMMENDATIONS

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**Recommendation 1:** SFIU should implement monthly reconciliations of all active deaths investigations between SFIU National and the SFIU Divisions.

**Recommendation 2:** SFIU National should introduce a streamlined reporting/notification process for FAIs.

**Recommendation 3:** SFIU National should review, update and centralise all guidance and policies on the investigation of deaths.

**Recommendation 4:** COPFS should introduce an internal target for progressing mandatory FAIs.

**Recommendation 5:** Where criminal proceedings are instructed and the circumstances of a death require a mandatory FAI:

- COPFS should issue guidance requiring an instruction by Crown Counsel on whether a mandatory FAI is likely following the criminal proceedings; and
- COPFS should ensure there is a debrief between the team dealing with the criminal case and SFIU, at the conclusion of the criminal proceedings.

**Recommendation 6:** COPFS should ensure that all operational case related emails are recorded and imported into the case directory.

**Recommendation 7:** There should be a single point of contact for the nearest relatives throughout the criminal proceedings and any subsequent FAI.

**Recommendation 8:** SFIU National should explore with the Death Certification Review Service (DCRS), the possibility of the review service providing a consultative forum for SFIU to discuss medical cases.

**Recommendation 9:** COPFS should explore with the Scottish Civil Justice Council, the possibility of introducing rules to facilitate the attendance of “expert” witnesses at preliminary hearings to reach consensus on areas of agreement and identify areas of contention.

**Recommendation 10:** COPFS should provide a single point of contact for the nearest relatives in all FAIs.

**Recommendation 11:** SFIU should provide written notification to all participants on the issues COPFS intends to raise at the inquiry.

**Recommendation 12:** SFIU should agree a Memorandum of Understanding (MoU) with all investigative agencies that have responsibility to investigate the circumstances of certain types of deaths.



# INVESTIGATION OF DEATHS BY CROWN OFFICE AND PROCURATOR FISCAL SERVICE (COPFS)

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## Role of COPFS

29. The Lord Advocate is the ministerial head of COPFS and is responsible for the prosecution of crime and the investigation of deaths in Scotland.
30. COPFS aspires to deliver a world leading public prosecution and deaths investigation service which secures justice for the people of Scotland. One of its strategic objectives<sup>13</sup> is that deaths which need further explanation are appropriately and promptly investigated. This includes all sudden, suspicious, unexpected and unexplained deaths and any deaths occurring in circumstances which give rise to serious public concern. The primary purpose of the investigation is to ascertain a cause of death, although there are a number of other aims of the investigation, including:
  - To ensure any criminality is discovered and where appropriate, prosecuted;
  - To allay public anxieties about particular deaths;
  - To alert family members to any genetic causes of death, which may be avoidable; and
  - To maintain accurate death statistics.
31. In other parts of the United Kingdom, the coroner investigates deaths and holds inquests. Under the law coroners have two main functions. First, they seek to explain the unexplained. If the death is not from natural causes, if it is unnatural, violent, of unknown cause or occurs in custody, coroners will investigate so that answers are found, for bereaved families and the wider public. Secondly, where appropriate, coroner's report to prevent future deaths.
32. While in some respects the purpose of an inquest by the coroner mirrors that of an FAI in Scotland, we found a number of fundamental differences that precludes any meaningful comparisons between the two systems:
  - The coroner service is essentially a local service, run by individual local authorities;
  - The type of investigation that can result in an inquest in the coroner's system is much wider and include all suicides and drug and alcohol related deaths and more recently, all deaths of residents in care homes or hospitals that are subject to Deprivation of Liberty Safeguards (DoLS), usually the elderly suffering from dementia. There are also understandable differences in scale; in 2014, for example, the coroner opened 25,889 inquests<sup>14</sup> compared to 34 FAIs held in Scotland;
  - The role of the coroner differs from the procurator fiscal with the coroner presiding over both the investigation and the judicial proceedings;
  - Unlike Scotland, a jury may sit with a coroner, if the coroner believes that: the deceased died in custody or state detention and the death was violent or unnatural or the cause of death is unknown and where the death resulted in an act or

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<sup>13</sup> COPFS Strategic Plan 2015-2018.

[http://www.crownoffice.gov.uk/images/Documents/Business\\_Strategy\\_Plans/Strategic\\_Plans/COPFS%20Strategic%20Plan%202015-2018%20.pdf](http://www.crownoffice.gov.uk/images/Documents/Business_Strategy_Plans/Strategic_Plans/COPFS%20Strategic%20Plan%202015-2018%20.pdf)

<sup>14</sup> Coroners Statistics 2014, England and Wales, Ministry of Justice Statistics bulletin.

<https://www.gov.uk/government/statistics/coroners-statistics-2014>



omission of a police officer, member of a service police force or that the death was caused by accident, poisoning or disease which must be reported to a government department or inspector; and

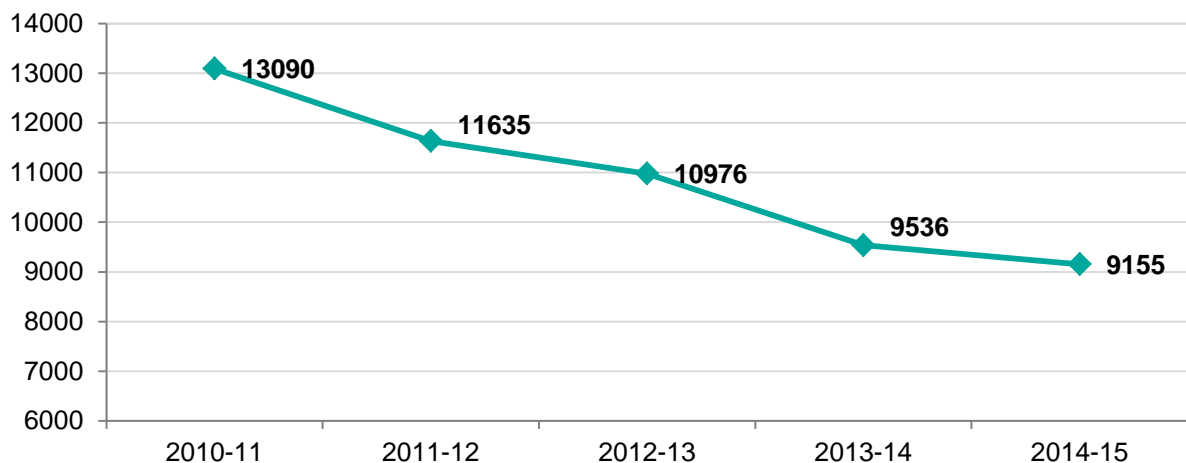
- The procedures differ with many inquests being opened and adjourned, for a variety of reasons, including allowing criminal investigations to take place.

## Statistical Data

### Death Reports Received

33. Deaths are most commonly reported to COPFS by hospital doctors, General Practitioners (GPs) and the police. Chart 1 illustrates that the number of death reports received by COPFS between 2010/11 to 2014/15 has decreased since 2010. In 2010, COPFS received 13,090 reports. This reduced to 9,155 in 2015, a decrease of 30%.

Chart 1 – Death Reports Received<sup>15</sup>



34. Once a death has been reported, COPFS has legal responsibility for the deceased's body, until a cause of death has been established. This is often provided by the procurator fiscal accepting a certificate issued by a doctor certifying the cause of death.<sup>16</sup> Such deaths are categorised as “routine deaths”.
35. If the cause of death cannot be certified or if a cause of death is believed to be known, but there are other concerns surrounding the death, further investigation may be required, such as: a post-mortem examination (also known as an autopsy), statements being obtained and liaison with nearest relatives and professionals. Such deaths are categorised as “deaths requiring investigation”.

<sup>15</sup> Source – COPFS MI Book 31/05/16.

<sup>16</sup> A certificate specifying the cause of death required to enable registration of a death with the Registrar of Births, Deaths and Marriages in Scotland.



36. Charts 2 and 3 show the number of routine deaths and deaths investigated by COPFS between 2010/11 to 2014/15.

Chart 2 – Routine Deaths<sup>17</sup>

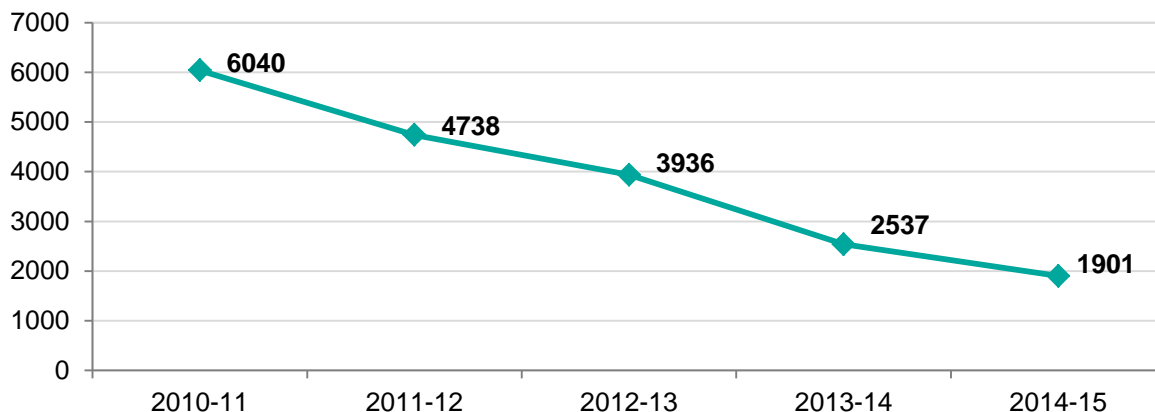
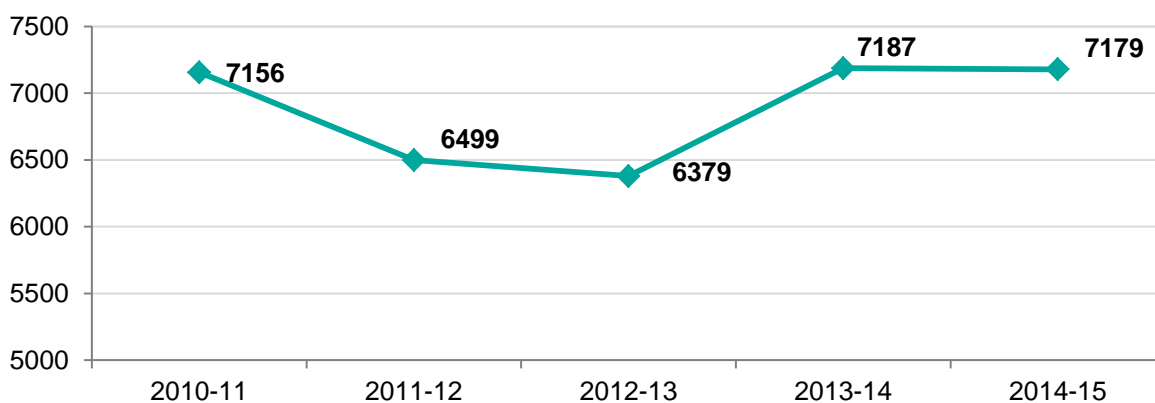


Chart 3 – Deaths Investigated<sup>18</sup>



37. Chart 4 shows the number of routine deaths and deaths investigated as a percentage of death reports received. It illustrates a significant increase in the number of deaths investigated in 2013/14 and 2014/15. This reflects:

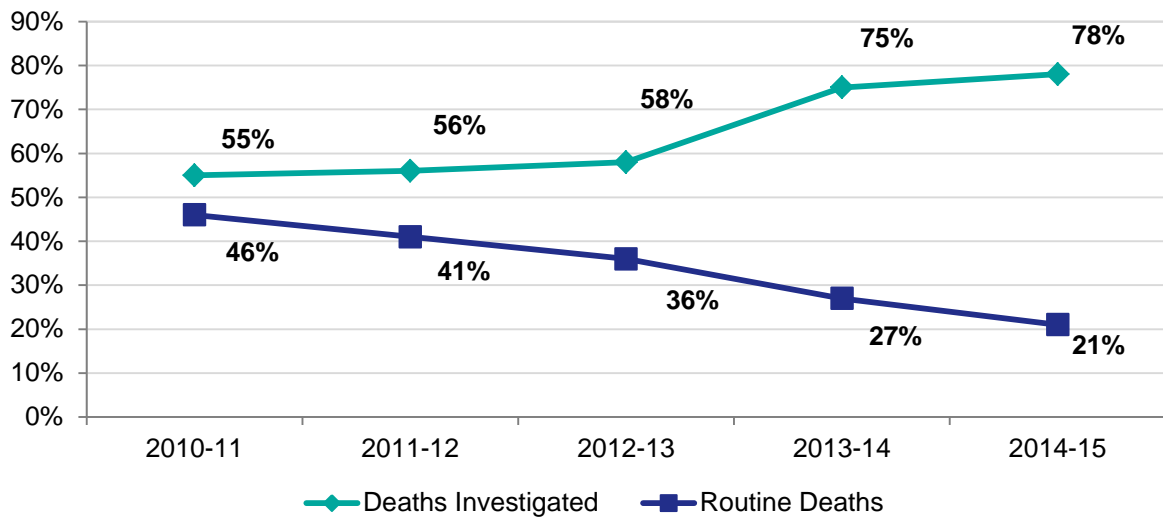
- An evolution in the public's attitude to death, with a greater expectation of being involved in all important decisions regarding relatives and, in obtaining more information on the circumstances of the death;
- The increasing complexity of such investigations with advances in medical science and more sophisticated means of detecting the cause of accidents; and
- A changing landscape with an increasing number of regulatory and scrutiny bodies that have a duty to investigate a wide spectrum of different types of deaths.

<sup>17</sup> Source – COPFS MI Book 31/05/16.

<sup>18</sup> Source – COPFS MI Book 31/05/16.



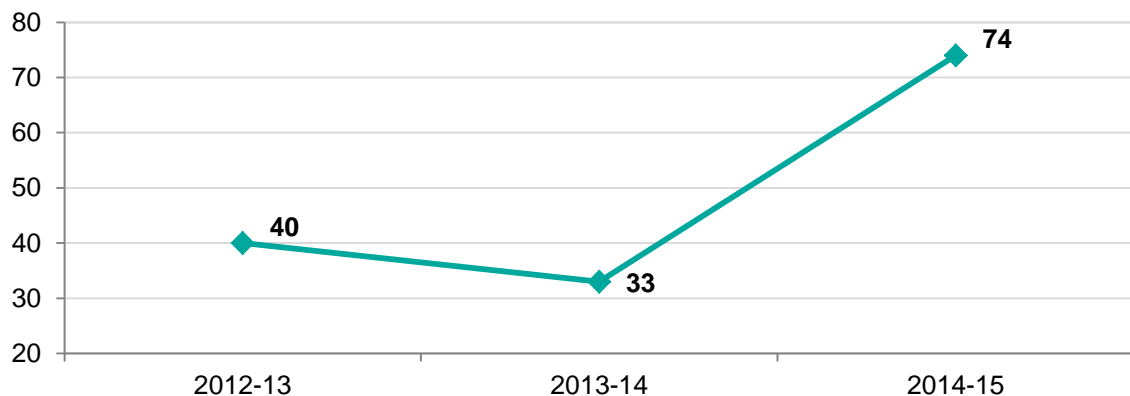
Chart 4 – Deaths Investigated/Routine Deaths as % of Reports Received<sup>19</sup>



### FAIs

38. Many deaths requiring investigation do not result in an FAI. There were 147 FAIs<sup>20</sup> held between 2012/13 and 2014/15. Chart 5 illustrates the spread of FAIs over this period.

Chart 5 – FAIs<sup>21</sup>



39. Following a reduction in the number of FAIs in 2013/14, the number more than doubled in 2014/15. This corresponds with the sharp increase in deaths investigated in 2013/14. Overall, there has been an 85% increase in the number of FAIs over the three year period. Despite this increase, the number of FAIs is extremely low, representing 0.7% of all deaths investigated.<sup>22</sup>

<sup>19</sup> Source – COPFS MI Book 31/05/16. Note: The total does not always add up to 100% due to a delay in inputting target data.

<sup>20</sup> Some FAIs may involve multiple deaths.

<sup>21</sup> Source – SFIU spreadsheet 11/11/15 (based on first Preliminary Hearing date).

<sup>22</sup> Between 2012/13 and 2014/15.



## Type of FAIs

40. Mandatory inquiries must be held when a death occurs as a result of a work-related accident or when the deceased was in legal custody. Discretionary FAIs are held at the discretion of the Lord Advocate if it is in the public interest and if there are lessons that can be learned to prevent deaths occurring in similar circumstances.

### Mandatory FAIs

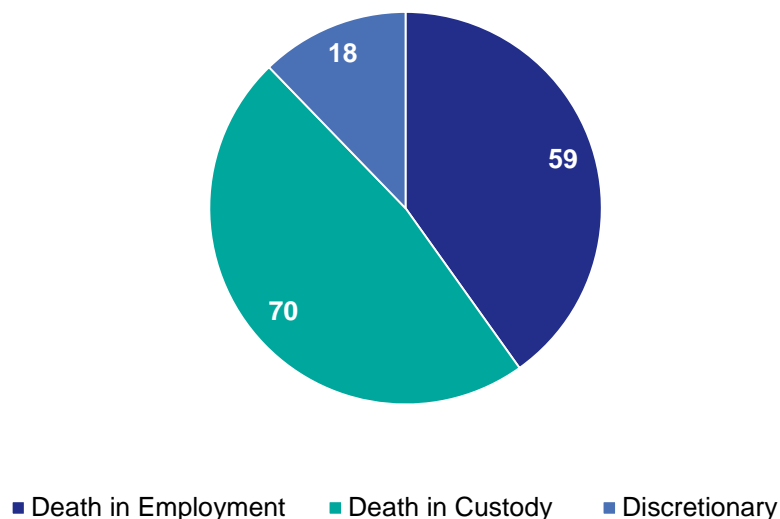
41. There were 129 mandatory FAIs held between 2012/13 and 2014/15; 31 were held in 2012/13, 30 in 2013/14 and 68 in 2014/15, representing a 119% increase over the three year period. Of the 129 mandatory FAIs, 59 concerned deaths that occurred in the course of employment and 70 concerned deaths that occurred while the deceased was in legal custody.

### Discretionary FAIs

42. There were 18 discretionary FAIs held over the same period. There were nine discretionary FAIs in 2012/13, three in 2013/14 and six in 2014/15, representing a 33% decrease over the three year period.

43. Chart 6 provides a breakdown of the type of FAIs held.

Chart 6 – Type of FAI 2012 - 2015<sup>23</sup>



<sup>23</sup> Source – SFIU spreadsheet 11/11/15, based on first Preliminary Hearing date.



## PROCESSES AND PROCEDURES

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### Who Investigates Deaths?

44. The procurator fiscal is responsible for investigating the circumstances of any death that requires further explanation and for presenting evidence at the FAI. Prior to 2010, investigations into the circumstances of a death were conducted in local procurator fiscal offices under the direction of the local procurator fiscal. Recognising a lack of consistency in the approach and quality of such investigations, there has been a progressive move towards greater specialisation in the investigation of deaths in COPFS.

### Scottish Fatalities Investigation Unit (SFIU)

45. In 2010 SFIU was established as the national specialist unit responsible for investigating all sudden, suspicious, accidental and unexplained deaths. When launched in its initial form, it assumed responsibility for policy at a national level with the investigation of deaths still managed at local level under the direction of SFIU.
46. In April 2012, as part of the re-structuring of COPFS, SFIU assumed national responsibility for investigating all non-suspicious deaths from the death being reported to COPFS to the point of closure. Their role is to investigate and prepare all death reports to the highest possible standard, to apply policy and practice consistently, to ensure that appropriate and timely decisions are taken in every case and progress deaths investigations expeditiously.
47. Within the new structure three SFIU divisions were located in three geographical COPFS Federations – SFIU North, SFIU East and SFIU West. SFIU National oversees the work of all divisions, including monitoring all potential FAIs and has input on policy matters relating to deaths. The heads of the three SFIU divisions report directly to the head of SFIU National who is responsible for the strategic oversight and efficient running of the Unit.

### Health and Safety Division (HSD)

48. Whilst the vast majority of death reports are investigated by SFIU, fatalities arising from potential breaches of health and safety legislation reported by the Health and Safety Executive (HSE) are investigated and prosecuted by the national Health and Safety Division. The increased profile of health and safety crimes and the complexity of many health and safety cases led to the creation of the Health and Safety Division in 2009. HSD was established to work closely with law enforcement to bring a more strategic approach to the prosecution of health and safety cases and ultimately drive up safety standards in workplaces throughout Scotland through robust investigation and prosecution of those who failed to discharge their health and safety obligations.

### Investigation of Deaths by SFIU

49. Deaths are most commonly reported to the procurator fiscal by hospital doctors, General Practitioners (GP)<sup>24</sup> and the police, although reports may also be sent from other investigative bodies such as HSE. The reports are sent to the SFIU division that covers the geographical area where the person died. In many cases, after a brief discussion or minimal enquiry, a medical practitioner will issue a certificate specifying the cause of death. In other cases, additional information and investigation may be required prior to the death being certified. In carrying out its investigations, SFIU will review the evidence, including the

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<sup>24</sup> From March 2015 GPs submit reports electronically.





post-mortem and other medical reports. Statements may also be taken from witnesses and reports commissioned from specialists or experts in particular fields. As shown in Chart 3, in recent years, more extensive investigation has been necessary in more than 75% of deaths reported.

50. Once the evidence has been gathered, decisions will be made on how to proceed, including whether criminal charges should be pursued or an FAI should be held.
51. FAIs vary enormously in their nature and complexity. They can range from inquiries into the death of a person in custody by natural causes, where there are no issues of concern, to inquiries involving complex medical matters or technical inquiries into the cause of a helicopter accident.

## Monitoring FAIs

52. With the creation of SFIU there is a centrally managed system of case monitoring and data collection. All mandatory and discretionary FAIs are entered by each division onto the COPFS computer-based case-tracking system and management information system known as PROMIS. Data derived from PROMIS is used to populate the COPFS Management Information Book (MI Book) which provides a range of management information in a readable format. The overview of all cases where an FAI may be held enables SFIU National to identify emerging trends or issues.
53. If a mandatory FAI is to be held, a report should be sent to SFIU National by the relevant geographical SFIU division dealing with the death investigation within six weeks of receipt of the death report. These reports are known as 'First Stage Reports'.
54. If a discretionary FAI is being considered, an initial report should be sent to SFIU National providing details of the perceived issues and seeking confirmation of the proposed direction of the investigation. Again, such reports should be submitted within six weeks of receipt of the death report. SFIU National then provides guidance and advice on lines of further investigation that may be required. A further report, known as a 'Second Stage Report,' is sent to SFIU National at the conclusion of such inquiries. Thereafter, SFIU National sends a report to Crown Counsel<sup>25</sup> outlining the issues and providing a recommendation on whether or not a discretionary FAI is in the public interest. Crown Counsel will issue instructions to SFIU as to whether an FAI is to be held, what additional work may be required and whether any additional expert evidence or opinion should be sought to be presented at an FAI.
55. The purpose of reporting FAIs to SFIU National is essentially two-fold. It provides:
  - An independent check on the progress of the case; and
  - An overview of the circumstances of all FAIs.

**Annex A** provides a flowchart outlining the role of COPFS in the investigation of sudden, suspicious, and unexplained deaths and the various stages of an FAI.

## Performance Targets

56. SFIU is subject to the following targets:
  - The published COPFS performance target is to investigate cases which require further investigation and inform the nearest relatives of the outcome within 12 weeks

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<sup>25</sup> The Law Officers (Lord Advocate and Solicitor General) and Advocates Deputes.



of the receipt of the report in at least 80% of cases. For 2015/16 this target was met in 92% of cases and, so far, in 2016/17,<sup>26</sup> it has been met in 88%.<sup>27</sup>

- COPFS introduced an internal target in 2014 that, following receipt of Crown Counsel's instruction (CCI) to hold an FAI, all applications<sup>28</sup> should be submitted to the relevant court within eight weeks of the instruction. Since its introduction, the eight week target has been successfully implemented in 75% of all cases.<sup>29</sup>

57. In the three divisions of SFIU, there are differing approaches to monitoring and reporting cases. We found that the SFIU divisions did not routinely inform SFIU National of mandatory FAIs or cases where a discretionary FAI was being considered until a report requesting CCI was submitted. Further, the six week target is routinely not met by any of the SFIU divisions.
58. Part of the reason for the disparity in approach is a lack of clarity by SFIU staff on when first stage reports and mandatory FAIs should be reported and the target for submitting such reports.
59. Guidance on the investigation and reporting of deaths largely pre-dates SFIU and in many respects is out of date. More recent guidance and instruction, including the introduction of the new internal target to seek the authority of the court to hold an FAI within eight weeks of CCI, is often circulated by email which is of little assistance to new members of staff or where there has been a change in personnel.
60. In many cases, the six week target is unrealistic as the information required to report the case in a meaningful way is not available. For example, in 54% of cases we examined, the post-mortem report<sup>30</sup> was not available within six weeks of the death being reported. In cases where a discretionary FAI is being considered, the views of the nearest relatives and some extended investigation, often including the opinion of an expert, is usually necessary to form an overview of relevant issues.
61. While both SFIU National and the SFIU divisions monitor the progress of deaths investigations and FAIs, there is no formal reconciliation between the SFIU divisions and SFIU National. To compensate for deficiencies in the reporting process, SFIU National relies on data recorded in the MI Book to ensure it has an accurate overview of all active cases and FAIs.
62. The Act expressly provides for a single inquiry to be held into the deaths of more than one person, whether or not they occurred in the same sheriff court jurisdiction, if it appears to the Lord Advocate that the deaths occurred as a result of the same accident, or otherwise in the same or similar circumstances.<sup>31</sup> To maximise the use of this provision, SFIU National requires a system to ensure that it receives early notification of the circumstances of all deaths where a mandatory or discretionary FAI may be appropriate.
63. A simplified, streamlined system of notification providing essential details and highlighting any areas of concern, with the ability to seek advice in problematic cases, rather than requiring a detailed report in every case would provide SFIU National with early notification of the nature of the case and the likelihood of an FAI. The introduction of a formal reconciliation process of all active cases between the SFIU divisions and SFIU National would provide reassurance that both SFIU National and the SFIU divisions were fully sighted on the

<sup>26</sup> Source – COPFS MI Book 31/05/16.

<sup>27</sup> Source – COPFS MI Book 31/05/16.

<sup>28</sup> The 1976 Act requires an application to hold a FAI to be made to a sheriff, narrating briefly the circumstances of the death.

<sup>29</sup> Source - SFIU FAI database 18/05/16.

<sup>30</sup> In four cases there was no post-mortem and in two cases the date the post-mortem report was received was unknown.

<sup>31</sup> Section 14 of the Act.



progress of cases, the number of mandatory FAIs to be held and the number of cases where a discretionary FAI was being considered.

### **Recommendations 1, 2 and 3**

1. SFIU should implement monthly reconciliations of all active deaths investigations between SFIU National and the SFIU Divisions.
2. SFIU National should introduce a streamlined reporting/notification process for FAIs.
3. SFIU National should review, update and centralise all guidance and policies on the investigation of deaths.



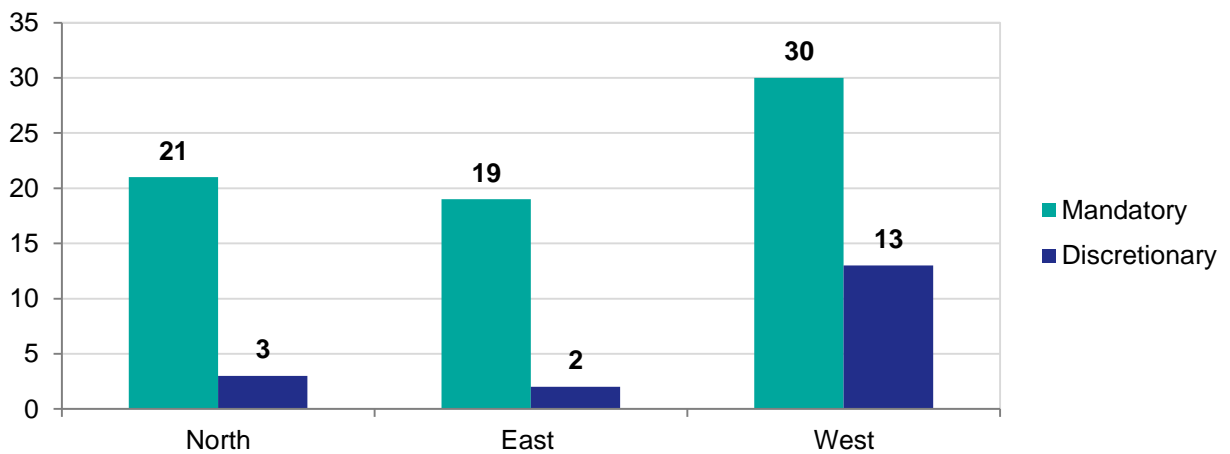
# CASE REVIEW

## Analysis of Case Review

64. We examined 88 cases between 2012/13 to 2014/15, where there had been a preliminary hearing and the FAI had concluded, representing 100% of all discretionary FAIs<sup>32</sup> and 54% of all mandatory FAIs.<sup>33</sup> The sample included 35 mandatory cases relating to deaths while in legal custody and 35 relating to deaths while in employment.<sup>34</sup>

Chart 7 provides a breakdown of the cases examined by type of FAI and SFIU divisions.

Chart 7 – FAI Case Review<sup>35</sup>



65. Table 1 illustrates the average number of working days that elapsed between various stages from the date of death to the start of the FAI.

<sup>32</sup> 18 cases.

<sup>33</sup> 70 cases.

<sup>34</sup> Of the 35 mandatory FAIs related to death in employment, eight were investigated by HSD.

<sup>35</sup> SFIU database at 5/11/15



Table 1 – Average Number of Working Days

	Date of death to initial inquiries being instructed	Date of death to date case is allocated	Date of death to date of court application	Date of death to date of Preliminary Hearing	Date of death to FAI
All cases <sup>36</sup>	20	212	534	619	659
All, excluding cases with a substantive criminal investigation <sup>37</sup>	9	178	465	551	589
Work-related deaths <sup>38</sup>	13	169	322	400 <sup>39</sup>	446
Deaths while in custody <sup>40</sup>	28	135	428	500	548
HSD cases <sup>41</sup>	3	370	893	1008 <sup>42</sup>	964
Discretionary cases <sup>43</sup>	22	354	902	989	1064

66. The timeline for concluding cases where there was a substantive criminal investigation prior to holding an FAI tends to be significantly longer than for cases where there is no such consideration.<sup>44</sup> To provide a more representative timeline, we measured the time elapsed between the various stages of investigation, excluding such cases.
67. The findings show that HSD and discretionary cases take longer to investigate than mandatory cases. This reflects the tendency of such cases to involve more complex issues and, in some cases, reliance on external reporting agencies.

## Effectiveness of Investigation

68. To evaluate the impact of SFIU, we measured timelines in the following categories:
- All cases<sup>45</sup>
  - Cases dealt with by local procurator fiscal offices prior to operational responsibility transferring to SFIU on 2 April 2012 (PFO cases)
  - Cases initially reported to and dealt with by local procurator fiscal offices and then transferred to SFIU after 2 April 2012 (transition cases)

<sup>36</sup> 88 cases.

<sup>37</sup> 75 cases (13 cases were assessed as having a substantial criminal investigation).

<sup>38</sup> 27 cases (of the 35 work-related deaths, eight were progressed by HSD and are recorded under 'HSD' heading).

<sup>39</sup> Three cases did not have a PH.

<sup>40</sup> 35 cases.

<sup>41</sup> Nine cases (eight work-related deaths and one discretionary).

<sup>42</sup> There was no PH in one case.

<sup>43</sup> 17 cases (One was progressed by HSD and is recorded in the HSD heading).

<sup>44</sup> 13 cases were assessed as having a substantial criminal investigation.

<sup>45</sup> Excludes nine HSD cases as they were not progressed by SFIU.



- Cases reported to and dealt with by SFIU (SFIU cases)
- Cases reported in 2014/15

69. Table 2 shows the average number of working days that elapsed between the various stages from the date of death to the start of the FAI.

Table 2 – Average Working Days (excluding HSD cases)

	Date of death to initial inquiries being instructed	Date of death to date case is allocated	Date of death to date of court application	Date of death to date of Preliminary Hearing	Date of death to FAI
All cases <sup>46</sup>	22	196	494	577	624
All excluding cases with a substantive criminal investigation <sup>47</sup>	9	164	441	526	570
PFO cases <sup>48</sup>	18	356	869	1144 <sup>49</sup>	1003
Transition cases <sup>50</sup>	34	284	672	765	829
SFIU cases <sup>51</sup>	9	60	217	276 <sup>52</sup>	316
2014/15 cases <sup>53</sup>	3	19	102	150	186

70. The findings demonstrate a positive trend with the average number of days between the date of death to the start of the FAI reducing from 1,003 days (3.9 years) for cases dealt with by local procurator fiscal offices, to 829 (3.2 years) during the transition period, to 316 (1.2 years) for cases dealt with by SFIU and 186 days (0.7 years) for SFIU cases dealt with in 2014/15.

71. The results found in the time taken to progress cases dealt with by procurator fiscal offices should be taken with a 'health warning', in that five out of the seven cases examined related to discretionary FAIs which generally take longer and one case took over five years from the date of death to the start of the FAI.

72. In April 2012, SFIU took over operational responsibility for deaths investigations. Almost all active deaths investigations, including cases of some age, were transferred from local procurator fiscal offices.

<sup>46</sup> 79 cases, of which 10 were assessed as having a substantial criminal investigation.

<sup>47</sup> 69 cases.

<sup>48</sup> Seven cases.

<sup>49</sup> Two cases did not have a preliminary hearing.

<sup>50</sup> 38 cases of which nine had substantive criminal investigations.

<sup>51</sup> 34 cases of which one had substantive criminal investigation.

<sup>52</sup> One case did not have a preliminary hearing.

<sup>53</sup> Five cases.



73. SFIU operated a policy of prioritising the oldest and newest cases in an attempt to work through the backlog and ensure that new cases were dealt with effectively. This approach resulted in periods of inactivity in a significant number of cases, including some where the investigation had been substantially progressed, prior to transferring to SFIU.
74. This is evidenced by cases during the transition period,<sup>54</sup> taking on average 765 days from the date of death to preliminary hearing compared to 276 days for cases progressed by SFIU<sup>55</sup> and 150 days for the five cases dealt with in 2014/15.<sup>56</sup>
75. The case study below exemplifies the type of delay that arose.

In July 2011, the local procurator fiscal's office received a report of the death of a prisoner who had committed suicide. As the death occurred in custody, a mandatory FAI was required. Initial lines of inquiry were instructed and statements, the post-mortem report and other productions were submitted by the police within a couple of months of the death. The nearest relatives were contacted and advised of the ongoing investigation.

In the three months prior to the case transferring to SFIU in April 2012, there was no evidence of any other substantive work being undertaken. Following the transfer to SFIU, there was another period of inactivity until February 2013 when a report was sent to SFIU National.

In early 2014, several witnesses were interviewed and thereafter an application was made to the court for the authority to hold an FAI. In April 2014, the FAI was commenced – a timeline of just under three years.

Given the case was non-contentious and relatively straightforward, the delays – where the case was not progressed – are inexplicable. The determination was issued by the sheriff two days after the FAI concluded.

76. The findings confirm that the specialisation of investigation of deaths has increased efficiency and improved the service provided by COPFS. They also highlight a lack of robust and effective change management arrangements to progress cases whilst the move was made to centralise the investigation of deaths. A more incremental transition between the procurator fiscal offices and SFIU, in conjunction with a proactive triage system to identify straightforward cases where little investigation was required, was likely to have enabled more cases to have been progressed expeditiously.

## Reporting of Deaths and Initial Inquiries

77. We found that 91% of case reports were received from reporting agencies in three working days or less. In three cases where there was a delay in the submission of the report, one was due to the body of the deceased not being discovered until sometime after the death and in the other two cases, the reporting agency was in constant discussion with COPFS regarding the investigation and lines of inquiry being pursued.
78. On receipt, cases were progressed efficiently. In 81% of cases examined, SFIU divisions instructed preliminary inquiries, such as ordering statements, photographs and productions, on receipt of the death report or within 10 working days or less.
79. We found delays by the reporting agency to respond to requests to obtain additional information in 12 cases. Of these, seven cases were reported by the police and five by HSE.

<sup>54</sup> 47 cases – Includes: 13 discretionary FAIs (1 was dealt with by HSD and 7 involved a criminal investigation) and 34 mandatory FAIs (8 were dealt with by HSD of which 3 involved a criminal investigation).

<sup>55</sup> 34 cases – 16 mandatory deaths in custody and 18 mandatory deaths while in employment.

<sup>56</sup> 5 cases – 2 mandatory deaths in custody and 3 mandatory deaths while in employment.



While the police experienced difficulties tracing witnesses in one case, in the others there were substantial delays in submitting statements and productions, despite numerous reminders from COPFS. In two of the seven cases reported by HSE, the submission of the final report took significantly longer than 12 months after the date of death.

## Allocation of Cases

80. We found significant variations in the time taken to allocate cases to an investigator with the average being 153 days from instructing initial inquiries.<sup>57</sup> The variations arose due to:
- Different practices in the allocation of cases by the SFIU divisions – SFIU West await the receipt of statements and the completion of other inquiries prior to allocating cases, resulting in cases being allocated some weeks or, on occasion, months after the post-mortem. In contrast, SFIU East and North divisions allocate cases within days of the post-mortem; and
  - The time required to complete initial lines of inquiry in more complex Health and Safety Division and discretionary FAIs, prior to the case being allocated to prepare for an FAI.
81. The different practices between the SFIU divisions and HSD to allocating cases skews the data and limits our ability to draw any conclusions based solely on the timeline to allocate cases. There were, however, examples where delays in allocating cases resulted in the FAI proceedings being unnecessarily protracted as demonstrated in the following case studies.

A case involving a death in custody where the deceased died of natural causes was reported to the local procurator fiscal office in January 2012. The post-mortem report and statements were submitted by late February 2012. There was no further work undertaken until the case was allocated in October 2012 – nine months later.

Following allocation, the case was dealt with expeditiously with an application for authority to hold an FAI being submitted to the court in February 2013 and the preliminary hearing taking place in March 2013. The case was non-contentious and the circumstances of the death were agreed by joint minute.<sup>58</sup>

HSE submitted a report in 2010 regarding a death at work. Further inquiries were instructed by HSD and HSE submitted additional statements and reports in late 2011. 23 months elapsed before the case was allocated to an investigator to progress. Once allocated, the investigation concluded quickly with the FAI being held within three months. Many of the facts surrounding the death were agreed in a joint minute, significantly shortening the FAI.

82. Prior to SFIU being introduced and during the transition period when cases were transferred to the newly formed SFIU, there was a high turnaround of staff resulting in frequent re-allocation of cases. Cases were re-allocated in 46 out of the 88 cases we examined. 35 of the 46 cases occurred during the transition process. The following case study exemplifies the lack of continuity.

<sup>57</sup> Excludes cases involving a substantial criminal investigation.

<sup>58</sup> A document setting out agreed uncontroversial facts.





A death involving medical issues was reported to the local procurator fiscal office in October 2006. Following receipt of the report, eight principal deutes had involvement with the case, variously instructing different inquiries and commissioning reports until it was allocated to a senior depute to prepare for the FAI in November 2010.

The case was re-allocated in January 2011 to another senior depute, then again in November 2011 and for a third time in March 2012. During this period the case was progressed by a case investigator.

During the course of the investigation, there were a number of protracted periods of inactivity. In total, there were 13 members of staff who interacted with the case. The FAI finally commenced in January 2013, some six years and three months after the date of death.

83. A lack of ownership and continuity often results in an unfocused investigation, work being duplicated and undoubtedly impacts negatively on the relationship with the nearest relatives. Early allocation of cases and continuity of investigator counters such difficulties with positive outcomes as demonstrated in the following case study.

A mandatory FAI involving a death at work was reported to SFIU in January 2014. Statements and reports were ordered the day after the case was received by the case investigator. A meeting took place between the case investigator and the legal representatives for the nearest relatives in February 2014 to discuss issues and identify any concerns. There was continuing regular contact with the nearest relatives throughout the investigation.

The statements and reports requested were submitted within a month and a first stage report was sent to Crown Counsel less than two months after the date of the death. CCI to hold an FAI were received within three weeks and an application was made to the court to hold the FAI the following week. All non-contentious evidence, including the pathology findings was agreed.

The FAI was scheduled for September 2014 and concluded in one day. Overall, the case was dealt with efficiently and expeditiously and attracted positive feedback from the nearest relatives.

84. The significant reduction in time between instructing initial inquiries and allocating cases by SFIU is a positive development.

## Investigation and Preparation of FAIs

85. 70% of cases<sup>59</sup> examined took longer than 18 months from the date of death to the start of the FAI. This includes 36 mandatory FAIs, 17 discretionary FAIs and all nine cases investigated by HSD.<sup>60</sup> 44 (71%) of these cases were dealt with in whole, or in part, by the local office prior to SFIU being established. Only 10 of the 34 (29%) cases progressed by SFIU took more than 18 months demonstrating a significant improvement.

## Disclosure

86. We found only one case where an FAI was delayed due to a failure to disclose information timeously.

<sup>59</sup> 62 cases.

<sup>60</sup> HSD cases are discussed at page 47.



## Mandatory FAIs

87. We found initial work was instructed timeously in all cases. Delays, thereafter, were often due to a combination of a number of factors but the main contributory reasons for delays were as follows:
- In 19 cases there were significant delays in allocating cases for investigation, a number of cases were re-allocated due to workload or staff leaving the unit and, in others, there were lengthy periods of inactivity with no obvious explanation;
  - In three cases, there was significant HSD involvement prior to the case being transferred to SFIU;
  - In four cases, there were significant delays in obtaining reports and information from reporting agencies and other investigatory bodies;
  - In three cases, there were lengthy periods of inactivity following the transfer of the cases from procurator fiscal offices to SFIU;
  - In the remaining seven cases, there were differing reasons including late intimation of issues that the nearest relatives wanted investigated, a change of direction of the investigation requiring additional inquiries to be carried out and significant delays in receiving statements and productions from the police due to a specialist toxicology machine being broken delaying confirmation of the cause of death.

## Discretionary FAIs

88. On average discretionary FAIs took 4.2 years between the date of death to the start of the FAI. 11 discretionary FAIs concerned an examination of the medical treatment received by the deceased. In the remaining six cases, there had been a criminal prosecution or an extensive criminal investigation.
89. All of the cases involved complex issues, requiring expert reports to be commissioned. Cases requiring expert evidence are by their nature more complex and often contentious, with evidence and conclusions being disputed, which in turn, can lead to further experts being instructed. Cases with multiple experts also present logistical difficulties, including identifying dates when all parties are available to attend the FAI.
90. Other factors that contributed to the delay in progressing these cases included:
- Difficulties in locating some witnesses;
  - Delays in allocating cases;
  - Late notification of the FAI by COPFS to potential interested parties; and
  - Delays in obtaining additional information from the police – in part due to difficulties in tracing witnesses.

## Impact of Delays

91. Lengthy intervals of unexplained delays prior to the start of an FAI adversely impacts on:
- The momentum of investigations and the operational capacity of investigating agencies – investigations characterised by lengthy intervals with intermittent requests for further inquiries to be undertaken run the risk of becoming fragmented



and lacking continuity, particularly if the investigators have moved on to new investigations;

- The well-being of potential witnesses for whom the prospect of the inquiry “hanging over them” is a source of anxiety and concern;
- The confidence of the nearest relatives and the public; and
- The quality of the evidence and, in some cases, the purpose of the FAI.

In a determination relating to a death in custody, the sheriff criticised a delay of almost three years that had elapsed after the death of the deceased to the start of the inquiry, stating:

“Understandably the memory of many witnesses was affected by the length of time that has elapsed since the deceased’s death...I have little doubt that had the inquiry been held timeously, witnesses’ memories would have been fresher, particularly in respect of critical evidence about the interaction between the paramedics, the deceased, and the police”.

“The purposes of this inquiry were, inter alia, to identify reasonable precautions which might have prevented his death, to consider defects in systems of working in place at the relevant time and generally to overview working practices with a view to future improvement. The delay in holding this inquiry has undermined these purposes.”

92. In contrast to criminal proceedings, there are no legal time limits governing FAIs. During the passage of the Bill, some parties advocated the introduction of time limits by which an FAI had to be held and others advocated the introduction of an early hearing system for mandatory inquiries, to provide families with information on the progress of the investigation and to provide some judicial management.
93. The introduction of time limits was not endorsed primarily due to the wide variety of circumstances that may require to be investigated, including reliance on specialist technical expertise and the need for criminal proceedings to take precedence. The commitment by COPFS to introduce a family liaison charter setting out information to be made available to families and timescales for the giving of information obviated the need for an early hearing system. The Act enshrined the requirement for the Lord Advocate to prepare and publish a family liaison charter.
94. We acknowledge that delays in progressing FAIs are reducing and the management of FAIs by SFIU has significantly improved. However, the review shows that mandatory FAIs dealt with by SFIU, many of which are not complex, take on average 14 months from the date of death to the start of an FAI. In comparison in solemn criminal proceedings, the trial must commence within 140 days of the accused being remanded or 12 months after the accused’s first appearance at court.
95. An organisation that seeks to deliver a sensitive, responsive, and thorough investigation, that meets public expectations and takes account of the well-being of potential witnesses involved in such investigations, must ensure that the investigation of deaths that may result in criminal proceedings or an FAI are afforded the highest priority.
96. To reflect that priority, COPFS should introduce an internal target for progressing mandatory FAIs. We recognise that the over-riding requirement is for a thorough and detailed investigation and that some cases will require more time than others, for example, some HSE investigations into deaths that occur in employment and those involving criminal proceedings. However, an internal target for the commencement of the FAI after the receipt of the death report would impose more focus and rigour when dealing with such cases.



#### Recommendation 4

COPFS should introduce an internal target for progressing mandatory FAIs.

#### Application for an FAI

- 97. COPFS is reliant on SCTS to allocate court time and dates for the inquiry. Historically, there were difficulties in obtaining court time due to the pressure of other court business. This was more acute if the FAI was estimated to take a few weeks to conclude.

Discussion commenced with SCTS to allocate court time for a three week period in December 2011. The initial dates identified in April 2012 did not suit the nearest relatives and due to a lack of available courts due to the pressure of other business, FAI dates were offered in August or September 2012. It was eventually agreed to allocate dates in late October 2012 with a preliminary hearing set down for September 2012. At the preliminary hearing, the FAI was adjourned again as the nearest relatives indicated they wished to get an additional report. The FAI was then adjourned for another three months due to the sheriff being unavailable.

The FAI commenced in May 2013. After hearing evidence for two weeks, it was adjourned due to the unavailability of an expert witness on behalf of the nearest relatives. Further difficulty was experienced securing dates that suited the legal representatives for the nearest relatives and one of the interested parties. Dates were eventually identified in December 2013. Again, due to pressure on the diaries of the interested parties the hearing of submissions was postponed until March 2014, some 10 months after the commencement of the FAI.

- 98. More recently FAIs have been afforded greater priority in the SCTS timetable. Our case review shows a decrease in the time between presenting the application to the court for the authority to hold an FAI and the preliminary hearing. We found that SFIU staff are in regular contact with Sheriff Clerks regarding the allocation of dates and with the exception of inquiries that are likely to take some time or involve logistical difficulties, court time is made available within a reasonable timescale.

Description	Average Working days	FAIs held in 2012	2013	2014
Court Application to Preliminary Hearing	74	95	66	66

- 99. As highlighted in our review, there are some recurring factors identified as adding delay, including the possibility of criminal proceedings, the use of expert witnesses, reliance on external reporting agencies and late intimation of issues and participation by nearest relatives and interested parties. We undertook further analysis of cases with these features to ascertain their impact and identify any remedial actions.



## CRIMINAL PROCEEDINGS

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100. To prevent the possibility of criminal proceedings being prejudiced by evidence aired at an FAI, where the civil standard of proof 'on balance of probabilities' applies, as opposed to the higher criminal standard of 'beyond reasonable doubt,' criminal proceedings will normally take precedence over any other proceedings, including FAIs.

### Case Review

101. There were six cases in our review where there were both criminal proceedings and an FAI. In all but one, the FAI followed the prosecution. The case where the prosecution followed the FAI concerned a death in the course of employment investigated by HSE, where on the basis of evidence elicited at the FAI, the prosecutor recommended there was sufficient evidence to prosecute the employer. The company subsequently pled guilty to a contravention of health and safety legislation.
102. The FAI legislation provides that the Lord Advocate can exercise discretion not to hold a mandatory FAI, if the circumstances have been sufficiently aired during criminal proceedings.<sup>61</sup> There are, however, some cases where the public interest goes beyond establishing culpability for the death and the wider circumstances of the death require to be fully examined to prevent deaths occurring in similar circumstances. This often requires different lines of inquiry to be pursued as illustrated in the case below.

Following a prosecution for the murder of a prisoner who was being held in segregation in a medical wing, an FAI was held to explore the suitability of the accommodation where the prisoner was held, including; the number of people in a cell; the use of medical wings for segregation purposes; and the adequacy of risk assessments for prisoners suffering mental health issues. While not the focus of the criminal case, the procedures and systems for treating prisoners with medical conditions raised issues of wider public concern.

103. There were seven cases where, following a thorough criminal investigation, a decision was made not to prosecute. There are a number of reasons for such decisions, including insufficiency of evidence or where the circumstances do not constitute a crime or merit criminal proceedings. Where the circumstances do not justify criminal proceedings, there may nonetheless be issues of public concern that require to be aired in an FAI to allay public fears. For instance, the collision of the RED-L Super Puma offshore helicopter, following a catastrophic gearbox failure resulting in the loss of 16 lives, gave rise to considerable public concern, given that this type of helicopter was the main mode of transport to and from offshore installations.
104. Cases including those with a substantive criminal investigation took on average 659 days from the date of death to the start of the FAI, compared to 589 days for those where criminality was excluded. It is inevitable that cases where there is a prosecution prior to an FAI will take longer to conclude as there are, in effect, two separate investigations. The overriding priority is for COPFS to conduct a thorough investigation where criminal proceedings are in contemplation. The move to greater specialisation in the investigation of deaths has been mirrored in the investigation of serious crime with specialist teams investigating any death where there is suspected criminality, including homicides, road traffic fatalities and deaths caused through the unlawful supply of illegal drugs.

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<sup>61</sup> Section 3(1) of the Act.



## Liaison between SFIU and Criminal Investigators

105. Following the conclusion of a criminal trial, the case is transferred to SFIU to progress the FAI. At that time, there is often a meeting with the nearest relatives to introduce the person who will deal with the FAI. While the focus of the criminal proceedings and the FAI differ, we found that there is considerable scope for more effective liaison between those involved in the investigations. In particular:

- With the exception of cases dealt with by HSD, the decision as to whether there should be an FAI tends to be treated as a separate process that requires to be determined at the conclusion of criminal proceedings. As a result, there is no consideration of the different lines of inquiry that may be required for the purpose of an FAI until the conclusion of the criminal proceedings. This results in the SFIU team effectively starting afresh once the criminal investigation is concluded. While acknowledging that some issues may not be apparent at the outset of a criminal investigation, the possibility of an FAI, particularly in mandatory cases, should be considered at an early stage and raised in the report submitted to Crown Counsel for an instruction on whether to prosecute. This is the commendable approach taken by HSD who regularly seek Crown Counsel's instructions as to whether a prosecution and/or an FAI are appropriate. Providing early notification to SFIU of the possibility of an FAI would enable SFIU to maintain a watching brief on the criminal proceedings and engage in regular dialogue with the team dealing with the prosecution. At the very least there should be a debrief between the two teams at the conclusion of the criminal proceedings.
- Following prosecution, the possibility of an FAI is not always prioritised and there can be a delay in forwarding the case papers to the deaths investigations team.

Following a prosecution for the murder of a prisoner, the case papers were not transferred to the deaths unit for investigation and consideration of an FAI for almost a year.

106. An early indication of the possibility of an FAI and a debrief would prevent such delays.

### Recommendation 5

Where criminal proceedings are instructed and the circumstances of a death require a mandatory FAI:

- COPFS should issue guidance requiring an instruction by Crown Counsel on whether a mandatory FAI is likely following the criminal proceedings; and
  - COPFS should ensure there is a debrief between the team dealing with the criminal case and SFIU, at the conclusion of the criminal proceedings.
- There is a lack of communication and exchange of information between the criminal and SFIU teams. A particular difficulty arises due to the increasing reliance on electronic correspondence – of which a substantial amount is sent from and held within personal email accounts. This information is not always imported into the electronic case record or printed and placed in the case papers resulting in an incomplete picture of the investigation and the various lines of inquiries conducted by the criminal team. This requires to be addressed by reinforcing the necessity of importing this information into the case directory or depositing all emails in an accessible folder which is imported into the case directory at the conclusion of the criminal case.





### **Recommendation 6**

COPFS should ensure that all operational case related emails are recorded and imported into the case directory.

- In almost all cases, we found that there was no handover meeting with the nearest relatives by the prosecutor dealing with the criminal case and SFIU. In some cases continuity was provided by a Victim Information and Advice (VIA) officer who retained contact with the nearest relatives throughout the criminal and FAI proceedings. VIA is a specialist unit within COPFS, providing a service to victims, witnesses and bereaved families. VIA provide updates on the progress of cases, practical advice and support. The continued presence of the VIA officer, with whom the bereaved family had built up a rapport throughout the criminal proceedings, was greatly appreciated.

107. However, this approach was not uniformly applied and there were cases where the lack of a single point of contact throughout both proceedings was a source of dissatisfaction and in some cases distress for nearest relatives.

108. The impact of an unexpected death of a loved one, especially if the death was caused by a criminal act, is devastating and the distress is compounded by the trauma of having to interact with an impersonal criminal justice system. If COPFS wants to aspire to deliver a world leading public prosecution and deaths investigation service, the bereaved relatives' needs must be at the heart of the process; this requires a dedicated single point of contact available throughout all proceedings.

### **Recommendation 7**

There should be a single point of contact for the nearest relatives throughout the criminal proceedings and any subsequent FAI.



## EXPERT EVIDENCE

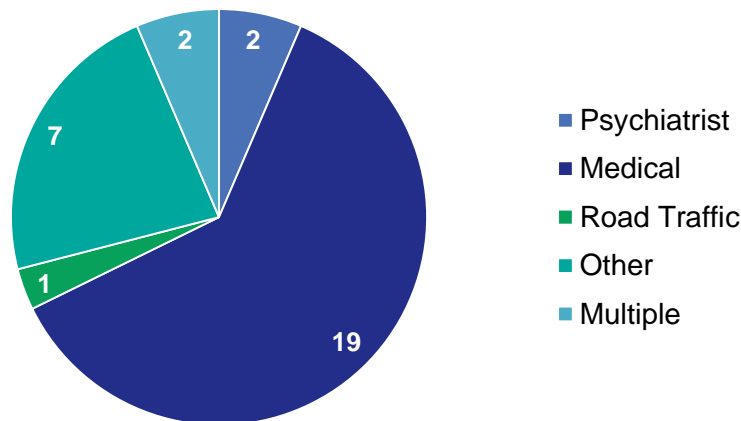
109. The need to obtain expert evidence is often cited as a factor that can impact on the length of time taken to investigate and commence an FAI.

### Case Review

110. In 31 of the 88 cases examined, expert reports were commissioned by COPFS for the purpose of an FAI. In 18 of the 31 cases, expert reports were also commissioned by interested parties.<sup>62</sup> Experts were instructed by COPFS in 16 mandatory FAIs (23%) and in 15 discretionary FAIs. Medical professionals constituted, by far, the main body of experts instructed in both mandatory and discretionary FAIs (61%). Other experts came from a range of fields, including road traffic collision investigators and pharmacology.

111. Interested parties instructed experts in 26 cases, including eight cases where COPFS did not obtain independent expert reports.

Chart 8 – Type of Crown Expert



112. Cases with expert evidence are by their nature more complex and often more contentious, with evidence and conclusions being disputed, which in turn can lead to further experts being instructed.

113. FAIs involving experts took, on average, 769 days from the date of death to the preliminary hearing<sup>63</sup> compared to 530 days for FAIs with no expert evidence.

114. We found that the average time from the date of instruction of experts to receipt of their reports was 86 days<sup>64</sup> with the longest period being 287 days and the shortest 7 days.

115. Of the 31 cases where COPFS instructed an expert, we found five cases where the failure to submit reports timeously added unnecessary delay to the investigation and in some cases resulted in the FAI being adjourned. The following case study exemplifies delays that can arise with multiple experts being commissioned.

<sup>62</sup> Including nearest relatives, employers in two instances, a manufacturer, and DVLA.

<sup>63</sup> Included two cases where there was a substantive criminal investigation.

<sup>64</sup> Calculation relates to 28 cases. In two cases there was no data available on the dates reports were instructed or received.





Following a death in hospital in October 2007, the nearest relatives expressed unhappiness with the treatment received by the deceased. Following a meeting with the family, COPFS instructed reports on the care of the deceased leading up to his death from two medical experts. The reports were commissioned in September 2009 but were not submitted within agreed timescales. On receipt of the reports, COPFS instructed a further expert in November 2011. That report was received in October 2012. The findings were discussed with the pathologist and resulted in yet another expert report being commissioned in October 2012. This report was received in May 2013.

At the preliminary hearing, the nearest relatives sought an adjournment as they had instructed a different pathologist, and they wished to consider the instruction of other experts. This built in further delay as other participants required time to examine these reports. The FAI was adjourned to May 2013 due to the unavailability of the sheriff and parties prior to that date. The FAI commenced in May and heard evidence for two weeks before being adjourned due to an expert for the nearest relatives being unavailable. Due to difficulties in obtaining dates when all parties were available, the FAI was adjourned to December 2013. The determination was issued in July 2014, some six years and nine months after the date of death.

116. Whilst the need to obtain expert reports has the potential to add delay to an investigation, as evidenced in the five cases from our review, in the majority of cases involving experts, we found reports were submitted timeously. Overall, cases with experts instructed by COPFS took longer to progress than those without. This was due to the time taken to identify experts, the complexity of the cases and the need to instruct additional experts.

### Identification of Experts

117. Given the relatively small jurisdiction of Scotland, identifying and commissioning independent experts can be problematic, particularly in more specialised fields where there are a limited number of experts. In a case involving the safety of cots, SFIU experienced great difficulty identifying an independent expert to test a particular type of cot and provide a report due to the limited number of manufacturers in this field. To assist with identifying experts, SFIU has compiled and maintains a directory of professionals. The directory includes experts from a wide range of fields, including radiology, cardiothoracic surgery, oncology, neurosurgery and general practitioners.
118. Commissioning reports and subsequently requiring “experts” to attend at court to give evidence can, in some cases, substantially increase the cost of an FAI. Having access to a source of expertise to obtain early professional advice can greatly reduce the need to commission expert reports and provide answers for the nearest relatives at an early stage. In many cases, the pathologist instructed by COPFS is able to provide more information on the circumstances and cause of death and often meets with nearest relatives to assist their understanding of the cause of the death.

### Death Certification Review

119. New arrangements for death certification and registration were introduced on 13 May 2015 with the establishment of the Death Certification Review Service (DCRS) run by Healthcare Improvement Scotland (HIS). The review service has been set up to provide independent checks on the quality and accuracy of Medical Certificates of Cause of Death (MCCD) in order to:
- Improve the accuracy of MCCDs;



- Provide better quality information about causes of death so that health services can be better prepared for the future; and
  - Ensure that the processes around death certification are robust and have appropriate safeguards in place.
120. The DCRS team consists of a number of reviewers who are all experienced medical practitioners based in Aberdeen, Glasgow and Edinburgh.
121. As part of the checking process, the review service alerts SFIU to any deaths that should have been reported to COPFS. There is, therefore, regular engagement between SFIU and DCRS. Given the independence and expertise of the DCRS, it may provide a potential source of medical expertise with which SFIU could discuss problematic cases and perhaps shortcut decisions as to whether a death certificate should be accepted or whether the circumstances of the death merit further investigation. Alternatively the DCRS may be able to signpost COPFS to an appropriate expert or have a degree of expertise within the team that SFIU can utilise. The possibility of DCRS providing a source of expertise should be explored by SFIU.

### **Recommendation 8**

SFIU National should explore with the Death Certification Review Service (DCRS), the possibility of the review service providing a consultative forum for SFIU to discuss medical cases.

### **Agreement of Expert Evidence**

122. Complex cases involving a number of specialities can result in a plethora of experts being instructed. The presence of witnesses with differing and opposing views can result in the proceedings becoming more adversarial.
123. We heard from expert witnesses that they found FAI proceedings to be increasingly adversarial and combative and whether, intended or not, it was seen as apportioning blame. Some experts have declined to become involved in cases that may result in an FAI due to their negative experience. One witness, who has given expert evidence in criminal proceedings and at FAIs, described giving evidence at an FAI as “like giving evidence at a criminal trial without the safety net”.
124. To mitigate this trend, we commend practices designed to encourage experts to identify and agree all non-contentious facts and clarify at the outset the issues where there is a divergence of opinion that require to be aired in court. This approach adopts aspects of the concept of concurrent evidence which is practiced in Australia and to a lesser extent in England and Wales. Concurrent evidence involves experts exchanging reports, identifying areas of disagreement and, after all experts are sworn in, giving evidence on the same topic sequentially in effectively a panel session. It is colloquially known as “hot tubbing”.
125. A variation of this approach is illustrated by the following case study.



The circumstances of the death of a commercial diver who died in the course of his employment were investigated by HSE. Following an extensive investigation, including instructing a number of reports from diving specialists, HSE submitted a report to HSD, concluding that there was no basis for a criminal prosecution. As the death occurred in the course of employment, a mandatory FAI was held. The investigation of the circumstances of the death and preparation for the FAI meant that the FAI was not held until 32 months after the death, understandably causing distress and frustration for the nearest relatives.

There were three interested parties represented at the FAI, including a member of the family representing the nearest relatives. Prior to the FAI the depute dealing with the case met with the nearest relatives and assisted by explaining the nature of the productions that the Crown intended to lead as evidence during the FAI.

Following a meeting with the interested parties, a 13 page joint minute was agreed and submitted to the court, resulting in 15 witnesses not having to attend to give evidence.

At the preliminary hearing the sheriff was advised that there were five expert reports commissioned by interested parties. The sheriff continued the preliminary hearing to seek further information on their qualifications and proactively encouraged the experts to meet to discuss and share their views on the cause of the death and agree any uncontroversial facts.

While there was a degree of concordance among the experts as to the possible causes of the death, each expert had a favoured view. Having had an opportunity to consider reports of all of the experts, and discuss their views, the pathologist gave evidence, setting out the contending theories which had been advanced by each of the experts commissioned by the interested parties. Their position was advanced and clarified through questioning the pathologist. The sheriff ultimately concluded that all of the causes of death advanced by the expert evidence were based to a greater or lesser extent on speculation with none adequately explaining the factual evidence and the post-mortem findings and as a result she was unable to conclude anything other than the deceased had died while saturation diving.

The proactive encouragement to agree facts and to focus on the differences of opinion as to the cause of death undoubtedly shortened the inquiry.

126. We received positive feedback from sheriffs on the benefits of an approach designed to encourage experts to identify facts where there is agreement and the issues where there is a divergence of opinion. It enables issues to be explored at the inquiry, to be identified in advance, allowing judicial management of the evidence relevant to establishing the circumstances of the death. Such direction at an early stage in the proceedings provides the nearest relatives with a more informed understanding of the purpose of the inquiry and can avoid frustration and disappointment with the outcome of the FAI.
127. One sheriff advised that if the parties have not discussed and crystallised the issues that are disputed and relevant prior to the preliminary hearing, she adjourns the hearing for a short period for the parties to reach agreement on facts that are non-contentious and to clarify the scope and nature of any contested issues. The outcome is then recorded as part of the court minutes.
128. Logistical difficulties of getting experts together to reach a consensus on areas of agreement and contention were highlighted as a recurring impediment to the efficiency of FAIs.



129. The introduction of mandatory preliminary hearings<sup>65</sup> provides an opportunity to formalise such discussions as part of the preparation of an FAI. If face-to-face meetings are logistically difficult, the use of modern technology, including video conferencing facilities and email provide alternative options.
130. In cases involving multiple experts from the same discipline, consideration should be given to seeking the attendance of all “experts” at the preliminary hearing to facilitate discussion and clarify areas of contention. The potential benefit of narrowing the focus of the inquiry and consequentially shortening the length of the proceedings should more than compensate for the inconvenience of attending at the preliminary hearing. An ancillary benefit of experts attending the preliminary hearing is the opportunity to resolve timetabling issues.
131. This approach is consistent with the fact finding “inquisitorial” purpose of an FAI. Enabling “experts” to engage openly with each other, prior to the inquiry, to explain the basis of their opinion and why they discount others, should enhance the clarity and quality of their evidence. It may also assist in re-emphasising the “inquisitorial” purpose of the FAI.

### **Recommendation 9**

COPFS should explore with the Scottish Civil Justice Council, the possibility of introducing rules to facilitate the attendance of “expert” witnesses at preliminary hearings to reach consensus on areas of agreement and identify areas of contention.

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<sup>65</sup> Section 15 of the Act.



## INVOLVEMENT OF NEAREST RELATIVES AND INTERESTED PARTIES

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132. The death of a loved one is a traumatic and distressing event. If the death is sudden and unexplained, it accentuates the distress and heightens an already stressful situation. The involvement of the procurator fiscal at such a time can be confusing and concerning.

### Liaison with Bereaved Relatives

133. During the passage of the Bill, one of the recurring themes was inconsistency in the level of communication with nearest relatives – both in relation to the timing and regularity of contact and the amount of information provided. To retain confidence in the investigation and any subsequent FAI, communication must be timely, clear, consistent, empathetic and tailored to the bereaved relatives' needs.

134. The impact of a loved one's death is personal and the reactions of nearest relatives can vary widely. Family dynamics can be complex with different reactions from different family members. Some wish to grieve privately and for any proceedings to be dealt with expeditiously and as discreetly as possible. In eight cases we examined, the nearest relatives chose not to engage with the procurator fiscal and wanted no involvement with the FAI.

### Case Review

135. We found evidence of regular contact with nearest relatives in 66 cases (75% of all cases reviewed). The nearest relatives were informed timeously of the investigation by COPFS and kept updated on the progress of the case, including the decision to hold an FAI. There were examples of excellent communication with the case investigator keeping nearest relatives updated on any significant developments, responding to all their queries, seeking their views on whether there should be an FAI and supporting them at the FAI. Regular contact with the nearest relatives, who are often bewildered by the involvement of COPFS, plays an important role in providing reassurance and making the process more bearable.

The case investigator investigating a death at work wrote to the nearest relatives the day after the post-mortem, explaining the role of COPFS in investigating deaths and invited them to get in touch if they had any issues or wished to raise any concerns.

There were regular letters to the nearest relatives keeping them informed of the investigation and offering a meeting when the post-mortem report was received. A further meeting was arranged to discuss the content of a Marine Accident Investigation Branch report.

The investigator advised the nearest relatives of all significant stages during the FAI process, including when the notice intimating the FAI was due to be published, aware that they resided in a small community.

The nearest relatives attended the FAI and expressed satisfaction with the approach taken by the prosecutor. The investigator subsequently wrote to all seven family members providing a copy of the determination.



136. In 14 of the cases examined, we found contact to be irregular and sporadic. While there was early contact, either in writing or by telephone, to advise that the circumstances of the death were being investigated, communication thereafter was intermittent and – in one case there was no contact with a nearest relative for the best part of three years.
137. Lack of contact with the nearest relatives generally mirrored periods of inactivity or when reports were awaited.

Following receipt of a police report involving a death at work, SFIU contacted the deceased's brother, despite the deceased's wife being named as the next of kin in the police report, to advise that the deceased's body was to be released.

Seven months later, the legal representatives of the deceased's wife wrote seeking an update on the investigation. No reply was sent for a further three months – 10 months after the date of the death – when a response was sent apologising for the delay and the failure to provide the information requested. The nearest relatives were advised that the circumstances of the death would require to be aired at a mandatory FAI. A meeting was offered, but declined.

### **Victim Information and Advice (VIA)**

138. SFIU West and HSD National have a dedicated VIA officer. We found that the presence of a VIA officer who could offer practical advice and support throughout the investigation and the FAI proceedings was greatly valued by bereaved families.

Following a criminal trial, a mandatory FAI was held to explore issues regarding the circumstances of the death that had not been the focus of the criminal trial. The VIA officer who had been the constant point of contact during the criminal proceedings, contacted the family to advise of the possibility of an FAI and seek their views. A senior investigator from SFIU became a point of contact for the family, but to provide continuity the VIA officer also retained contact throughout the investigation, providing regular updates. The VIA officer and senior investigator were present during the FAI. On receipt of the determination, the senior investigator met with the family to answer any queries they had regarding the findings of the sheriff.

### **Family Liaison Charter**

139. During the Justice Committee's consideration of the FAI Bill, the Solicitor General advised that COPFS was in the process of formulating a charter which would set out various milestones where families would be given specific information on the progress of the investigation and timescales to provide clarity to families on how and when they would be communicated with by COPFS during deaths investigations.
140. During the passage of the Bill, COPFS produced a draft charter and following consultation with various stakeholders and organisations with an interest in this area, published the charter in February 2016.
141. The charter sets out: how and when initial contact will be made with the nearest relatives in deaths investigations; what information the nearest relatives can expect to receive; the key stages where updates on progress will be given throughout the investigation and; what contact and information will be given during any criminal proceedings and at the FAI. Crucially, information will be provided in a manner agreed by the nearest relatives and COPFS at the outset. Where a personal meeting takes place or where there has been





telephone contact (if that is the preferred method of contact), this will be followed up with a letter containing a summary of those discussions.

142. A process map of the various stages is provided at **Annex B**.
143. By introducing the charter, COPFS has demonstrated a commitment to the nearest relatives to keep them informed of progress at specific stages of the investigation, in a manner suitable to them. This should address the issue of irregular and sporadic contact identified in our case review.
144. It does not, however, address the frustration experienced by some bereaved relatives caused by a lack of a single point of contact to provide information and support. This arises due to cases being re-allocated and the absence in many FAIs of a referral to VIA.
145. We recognise that the fluidity of staff and unpredictable absences may inevitably result in changes of personnel, but given the relatively low number of FAIs, COPFS should endeavour to provide a single point of contact for the nearest relatives in all FAIs.

### **Recommendation 10**

COPFS should provide a single point of contact for the nearest relatives in all FAIs.

## **Participation of the Nearest Relatives and Interested Parties**

146. The spouse of the deceased, or the nearest relative, is entitled to participate in inquiry proceedings.<sup>66</sup> In 42 cases examined, the nearest relatives chose to attend and participate in the FAI or obtained legal representation. In 17%<sup>67</sup> of FAIs reviewed, we found late intimation by the nearest relatives that they wished to participate in the FAI resulted in proceedings being adjourned or delayed.
147. We found that the purpose of the FAI was not always fully understood by nearest relatives. For some it was regarded as a forum to attribute fault or blame and apportion liability to a particular person or organisation or to raise issues regarding matters that were not relevant to establishing the circumstances and cause of the death. Examples of issues that the nearest relatives wished to raise at FAIs included:
  - General conditions in prisons;
  - Treatment received by the deceased in prison;
  - Medical treatment received by the deceased for injuries or illness unrelated to the cause of death and;
  - Procedures for prisoners at risk when there was no evidence of depression or suicidal thoughts expressed by the deceased.
148. It is understandable that families, still in shock and grieving following the sudden death of a loved one as a result of a crime or tragic circumstances, will struggle to absorb and understand the system for the investigation of deaths and FAI proceedings.

<sup>66</sup> Those entitled to be represented has been extended in the new Act.

<sup>67</sup> 15 cases.



149. We found that early contact by SFIU to advise that an FAI was likely was typically followed up with a letter to the nearest relatives advising that they were entitled to participate in the inquiry and providing information on likely dates for the inquiry. There were variations in the information provided, but in general we found that there was minimal explanation of:
- The purpose of the FAI;
  - The core issues likely to be explored at the FAI;
  - The process and procedures that will apply at court; and
  - Information and advice on obtaining legal representation.
150. We heard from legal representatives who appear on behalf of interested parties that they are often unclear on the issues that will be raised at the FAI. We were advised that the application to the court seeking authority for an FAI is not routinely disclosed by COPFS and that they are often unsighted on the interested parties notified by SFIU, although it was acknowledged that they had never requested a copy of the application or information on interested parties.
151. As the organisation responsible for investigating and conducting the FAI, COPFS is best placed to advise the nearest relatives of the purpose of the FAI and the issues likely to be explored. To assist the nearest relatives and provide greater clarity on the purpose of the inquiry, we heard that it would assist all participants if there was written notification of the following information:
- A brief narration of the circumstances of the death;
  - The purpose of the FAI; and
  - The issues intended to be explored.
152. It was advocated that this information could be incorporated into the application for the FAI or issued as a separate document accompanying the correspondence advising potential participants of the FAI. The provision of this type of information was compared to the narrative setting out the criminal conduct in an indictment or a complaint in criminal proceedings. If any of the participants wished to raise other issues at the FAI, this could be canvassed at the preliminary hearing to allow early adjudication by the sheriff on whether the issues were relevant and would assist in ascertaining the circumstances of the death.
153. The provision of such information would also provide bereaved relatives with a document that they could digest in their own time and use to inform discussion with legal representatives, if they so wished.
154. This approach is consistent with the undertaking given to the Justice Committee<sup>68</sup> by the Solicitor General to provide notification of all of the issues intended to be raised at the inquiry in the application to the court and to embed this practice as part of the new preliminary hearings system.

### **Recommendation 11**

SFIU should provide written notification to all participants on the issues COPFS intends to raise at the inquiry.

<sup>68</sup> Justice Committee Meeting report. Columns 21/22 (page 15), 26 May 2015.  
<http://www.parliament.scot/parliamentarybusiness/report.aspx?r=9969&mode=pdf>





155. In most cases the interests of the bereaved relatives and the public interest coincide, but there are occasions where the nearest relatives wish to pursue a different approach or disagree with the outcome of the investigation by COPFS. Where public interest considerations differ from those of the nearest relatives, it presents difficulties for the prosecutor and can result in a breakdown of the relationship between the nearest relatives and the procurator fiscal.
156. Where there is a divergence of views between COPFS and the nearest relatives, it is preferable for the nearest relatives to obtain independent representation. To facilitate independent representation, SFIU should provide early notification of the issues it intends to explore at the FAI and enclose guidance to the nearest relatives on obtaining legal representation, if they wish other issues to be explored.
157. In order to apply for legal aid and allow any legal representative sufficient time to prepare for the inquiry, the guidance should recommend that if they chose to be legally represented they should instruct a solicitor on receipt of the intimation of the dates for the preliminary hearing and the FAI.



## ROLE OF OTHER REGULATORY AND INVESTIGATIVE BODIES

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158. In addition to COPFS there is a wide range of other organisations and agencies that have a duty to investigate certain types of deaths. The creation of new regulatory and scrutiny bodies has further populated this landscape. NHS Boards,<sup>69</sup> Healthcare Improvement Scotland (HIS),<sup>70</sup> the Mental Welfare Commission for Scotland,<sup>71</sup> the Care Inspectorate,<sup>72</sup> Local Authorities,<sup>73</sup> Child Protection Committees and the Scottish Prison Service, are some of the bodies that have duties to investigate certain types of deaths. In many cases, the death will also be reported to the procurator fiscal.
159. It is not uncommon for two or three agencies to have an interest in the circumstances of a death and to undertake parallel investigations. A death in a care setting could, for example, involve the Care Inspectorate, the Mental Welfare Commission, HSE and the Local Authority. The involvement of different agencies can be confusing and stressful for the nearest relatives and those involved with the investigation or inquiry. This is exacerbated if there is a lack of co-ordination and communication between the agencies involved.
160. During the passage of the Bill, a more streamlined system of investigation into deaths of persons detained under mental health legislation was advocated with the current system described as being “confusing and having gaps”.<sup>74</sup> A commitment to undertake a review of the arrangements for investigating the deaths of such patients has been enacted in the Mental Health (Scotland) Act 2015, which provides that a review must be carried out within three years of the provision coming into force.<sup>75</sup> COPFS also issued amended guidance to General Practitioners, in February 2016, requiring deaths of persons subject to compulsory treatment under mental health legislation; detained under the Mental Health (Care and Treatment) (Scotland) Act 2003 or Part VI of the Criminal Procedure (Scotland) Act 1995; or subject to a community based compulsory treatment order or compulsion order to be reported to the procurator fiscal.
161. Whilst the nature and extent of such investigations vary, there is a common objective to ensure that any lessons learned are brought to the attention of those who are in a position to implement measures to prevent similar circumstances arising again. To that extent, it mirrors the over-riding purpose of an FAI. Given the expert and specialised knowledge of such organisations, any findings and recommendations following their investigation into a death is clearly of interest and relevance for any investigation conducted by COPFS. The outcome of such investigations may provide sufficient information to inform a decision on whether any further investigation or proceedings are required or, at the very least, assist in directing the investigation and reducing duplication of work.

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<sup>69</sup> NHS boards carry out “adverse event reviews” where there are concerns about the circumstances of a death.

<sup>70</sup> Healthcare Improvement Scotland has an active role in reviewing deaths from suicide and promoting any lessons learned across the NHS.

<sup>71</sup> The Mental Welfare Commission for Scotland has statutory powers to carry out investigations or hold inquiries where there are concerns about the care or treatment of somebody with a mental illness, learning disability or related conditions.

<sup>72</sup> The Care Inspectorate regulates social care, social work and child protection services. It is a legal requirement that the death of a person using a care service is reported to the Care Inspectorate.

<sup>73</sup> Local authorities have systems in place to review some deaths, through a critical incident review or multi-agency review type process.

<sup>74</sup> Stage 1 Report on Inquiries into Fatal Accidents and Sudden Deaths etc. (Scotland) Bill, 13th Report, 2015 (Session 4).

<sup>75</sup> Section 37 of the Mental Health (Scotland) Act 2015.



162. We found that SFIU regularly receives and takes cognisance of the outcome of investigations conducted by Health Boards, the Care Inspectorate, the Mental Welfare Commission and reports commissioned by Child Protection Committees. In 28 of the 88 cases in our review, there were reports commissioned by other investigative bodies. These included five joint Scottish Prison Service (SPS) and NHS reports (known as SIDCAARs),<sup>76</sup> five critical incident reports compiled by NHS Boards and two reports from the Scottish Ambulance Service.
163. There is increasing awareness of the role and responsibilities of the various agencies and the need to co-ordinate inquiries and promulgate lessons learnt.

SFIU investigated the death of a person who had been under the care of psychiatric services on a voluntary and involuntary basis for more than 10 years. After being discharged from a psychiatric hospital, he was reported missing and subsequently found dead, believed to have fallen from a height. The investigation focussed on a number of issues, including his diagnoses, treatment and discharge.

The relevant Health Board conducted a Critical Incident Review and the Mental Welfare Commission and Healthcare Improvement Scotland considered whether they should also instruct an investigation. The investigator in SFIU commissioned a report from a consultant psychiatrist to review the medical records of the deceased and provide an opinion on the treatment received by the deceased.

The report was shared with the Health Board and other interested parties, including the Mental Welfare Commission. The outcome was an agreed set of actions to be implemented by the Health Board. The investigator facilitated contact between all parties, including the nearest relatives.

164. To further improve working relationships and raise awareness of the role of COPFS and the work of SFIU, the head of SFIU in conjunction with representatives from HIS, have delivered presentations to a number of NHS boards.
165. Recognising the need for effective communication and co-ordination between various bodies with investigatory powers, a multiple-body group, containing representatives from a number of bodies with statutory duties,<sup>77</sup> was established to raise awareness of the breadth of responsibilities of each organisation and improve co-ordination between the various organisations when dealing with investigations that cut across different sectors. Of particular focus was ensuring that there are effective information sharing protocols and liaison arrangements between the organisations.

<sup>76</sup> Apparent Self Inflicted Death in Custody Audit Analysis and Review Report.

<sup>77</sup> Included representatives from the Care Inspectorate, COPFS, the General Teaching Council, HSE, Mental Welfare Commission, Scottish Public Services Ombudsman and the Scottish Social Services Council.



### Good Practice

To promote learning between COPFS and the NHS, SFIU and HIS agreed a protocol whereby SFIU will, through HIS, share the result of any investigation involving a medical death with the relevant health board and practitioners that were involved in treating the deceased. This may result in SFIU convening and facilitating a meeting with representatives from the NHS board, including those involved in the care of the deceased, and the nearest relatives to discuss their concerns.

In many cases, in response to the findings of an internal critical incident review by the NHS board and subsequent SFIU investigation, the board will have taken action to address specific concerns or systematic deficiencies. This may involve increased training, the introduction or revision of protocols or procedures or a transfer of resources.

In a small number of cases, the issues raised may have wider repercussions for the NHS or a particular speciality within the NHS. To cascade any lessons learnt from such cases, SFIU provides an anonymised summary of their findings and lessons learnt to HIS, which following input from medical clinicians, is circulated to a targeted audience. For example, if there is a specific issue arising from general practice, HIS will circulate learning points through their GP primary care network.

While acknowledging the challenge of disseminating information throughout a large organisation, the protocol is a positive development, encouraging collaborative discussion and a mechanism to enable lessons learnt in specific cases to reach a wider audience.

166. While internal investigations can be extremely informative and enable deficiencies identified to be remedied as early as possible, there are some cases where the public interest requires a thorough and public examination of the circumstances of the death. The FAI provides a platform for such an examination and for the sheriff to make recommendations that may prevent deaths occurring in similar circumstances. The recommendations carry judicial weight and under the new Act, there is a requirement for the person or organisation, to which the recommendation is directed, to provide a response within eight weeks after receipt of the determination or to provide reasons why no response will be provided.<sup>78</sup> In cases that have generated public concern, the FAI is an effective vehicle to ensure action is taken through the publicity it generates and to provide public reassurance that the actions recommended will be implemented to avoid a similar occurrence.

### Primacy of Investigation

167. We heard from a number of organisations who conduct investigations into the circumstances of a death that they would welcome greater clarity on whether it is appropriate to carry out internal investigations where criminal proceedings and/or an FAI are in contemplation. We were advised that internal investigations were often put on hold until the conclusion of any criminal investigation and proceedings. This resulted in significant delays in instigating an internal investigation.
168. The need to ensure that evidence in criminal proceedings is not prejudiced is an important public interest consideration but it requires to be balanced against the need to address any deficiencies or inadequacies of practice as soon as possible to prevent any deaths arising in similar circumstances. Delaying internal investigations can also adversely impact the well-being of staff within organisations.

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<sup>78</sup> Section 28 of the Act.



169. Contrary to the perception held by some investigative bodies, COPFS recognises that there can be competing interests and, where criminal proceedings are in contemplation or are being taken, it is essential, for the proper performance of their respective responsibilities that investigative bodies liaise with COPFS to discuss the scope and nature of any investigation or any other actions proposed.
170. Situations can arise that require agencies to take immediate remedial action. HSE will, for example, issue a safety alert where there is a specific safety issue that, without immediate action being taken, could result in a serious or fatal injury. This could arise through the identification of dangerous equipment, processes, procedures or substances. HSE will notify users and other stakeholders of the danger and any steps that need to be taken to rectify the fault or protect people against it. If criminal proceedings are in contemplation, HSE will liaise with COPFS and discuss the content of such notices to ensure there is no prejudice to future proceedings. This was the approach taken when following the death of a person with Legionnaires disease and a number of other suspected cases in Edinburgh in 2012, the HSE issued a Health and Safety Alert in relation to legionella risks from cooling towers and evaporative condensers.
171. Similarly, if there are public protection or safety issues, these should not be delayed regardless of whether there are criminal proceedings being contemplated.
172. One example of parallel investigations being undertaken by SFIU and Renfrewshire Child Protection Committee concerned the death of a young baby. The circumstances of the death resulted in a prosecution. During the criminal investigation, and after discussion with COPFS on the scope and nature of the proposed investigation, Renfrewshire Child Protection Committee carried out a serious case review into the circumstances of the death. The serious case review was concluded within a year of the death and made a number of recommendations which were implemented. Following the conclusion of the criminal trial, a decision was taken to hold an FAI to address wider concerns regarding the care of the child. The FAI was held four years after the death.
173. If the Child Protection Committee had to await the conclusion of the criminal proceedings and the FAI, as we heard occurs in some cases, it would have resulted in an unacceptable delay in the implementation of the recommendations that flowed from the serious case review. Many of the recommendations that were subsequently included in the sheriff's determination, issued four years after the death, had already been implemented as a result of recommendations made in the serious case review. There were some wider recommendations for organisations other than those representing social workers, including the provision of mandatory training of general practitioners on the guidance and protocols relating to child protection and the distribution of medical information to those working with children of substance misusing parents or carers.
174. To provide reassurance and clarity to other investigative agencies, there should be a streamlined, transparent and proportionate investigatory framework, with a clearly defined hierarchy of investigation. Ideally, at the outset, the various issues that require to be considered and the appropriate lead organisation should be identified and the respective roles of those with a duty to investigate clarified to ensure that a joined up approach is taken in the overall investigation of the incident or death.



175. To assist, SFIU should agree a Memorandum of Understanding, similar to the MoUs with reporting agencies such as HSE, with all of the investigative agencies that have responsibilities to investigate certain types of deaths. The memorandum should specify the roles and responsibility of each agency, the nature of investigations that may be undertaken, likely timescales, points of contact for those who have authority to instruct an internal investigation and arrangements for information sharing.

### **Recommendation 12**

SFIU should agree a Memorandum of Understanding (MoU) with all investigative agencies that have responsibility to investigate the circumstances of certain types of deaths.



## REPORTING AND REGULATORY AUTHORITIES

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176. While the police are the main source of reports submitted to COPFS, there are other agencies that have particular technical expertise to investigate and report specific types of deaths. Agencies involved in investigations that may result in an FAI include HSE, MAIB and AAIB. COPFS is dependent on the outcome of such investigations prior to considering the possibility of criminal proceedings or an FAI.

### Health and Safety Executive and Local Authorities

177. HSE and Local Authorities (LAs) are responsible for the reporting of health and safety breaches to COPFS, including those that result in fatalities. The investigation seeks to determine underlying causes and ensure that action has been taken by the duty holder to manage any ongoing risk and prevent similar incidents occurring in the future. Following investigation, HSE or the LA will submit a report to HSD with a recommendation on whether there is sufficient evidence for a prosecution.

178. The FAI legislation provides that the Lord Advocate can exercise discretion not to hold a mandatory FAI, if the circumstances have been sufficiently aired during criminal proceedings.<sup>79</sup> On receipt of a report from the HSE or a LA, HSD considers the evidence and submits a report to Crown Counsel seeking an instruction on whether there should be a prosecution and/or whether there should be an FAI. If all the salient facts are likely to be addressed in the criminal proceedings, COPFS can dispense with holding an FAI, alleviating the need for witnesses and nearest relatives to attend court on a second occasion. The written submission by COPFS to the Justice Committee during the passage of the Bill, advised that in 59% of cases, involving deaths in the course of employment reported to HSD, where there were criminal proceedings which had concluded in the last four years, no mandatory inquiry was held as the circumstances of the death had been fully addressed in the criminal proceedings.<sup>80</sup> There are some cases where wider issues regarding the circumstances of the death are not explored in the criminal proceedings and require exposure at an FAI, such as defects in working practices.

179. Historically, issues over which organisation was to lead certain investigations resulted in delays. Over recent years there has been a concerted effort to improve the working relationship between HSE, the police and HSD. When HSE or Local Authorities and/or the police are involved in investigating work-related deaths, including deaths of non-employees, they follow the principles contained in the Work-Related Deaths Protocol for Scotland (WRDPS), which sets out the framework for effective liaison between these parties (and others) when investigating such deaths. The protocol clarifies that the police has primacy for investigations where corporate homicide is a consideration. For all other investigations involving potential breaches of health and safety law, HSE assumes primacy.

180. HSE will decide if the circumstances of the death fall within their remit which flows from the regulatory framework of the Health and Safety Act 1974. There have been cases where HSE has declined to investigate as the circumstances are not considered to fall within their area of responsibility. Examples include road traffic deaths at work or deaths within custody or care settings where there is no evidence of systematic failures.

181. The absence of any regulatory body to investigate such cases presents difficulties as the police may not have the relevant expertise.

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<sup>79</sup> Section 3(1) of the Act.

<sup>80</sup> COPFS written submission to Justice Committee, page 6.  
[http://www.parliament.scot/S4\\_JusticeCommittee/Inquiries/FA21.\\_COPFS.pdf](http://www.parliament.scot/S4_JusticeCommittee/Inquiries/FA21._COPFS.pdf)





## Timescales for Investigation of Health and Safety Cases

182. COPFS has no authority to direct HSE to carry out investigations nor does it have any control over timescales for the submission of reports.
183. HSE has an internal target to investigate and submit reports to COPFS within 12 months of receiving primacy. Of the seven cases in our review, where HSE was the main investigative body, five cases were reported within the 12 month target. In the remaining two cases, the HSE report was submitted 17 months and 15 months after HSE acquired primacy. Both cases involved some complexity; in one there were technical issues requiring specialist expert analysis and the other involved legal considerations regarding liability between different employers.
184. In five of the cases reported by HSE and dealt with by HSD, at least a year elapsed after receipt of the report from HSE to the start of the FAI. In three cases, there were protracted discussions as to whether there was sufficient evidence to prosecute before an FAI could be considered; in two of the cases, HSE reversed an initial recommendation to prosecute following further discussion with HSD and HSE colleagues. One case involved complex technical issues and a number of expert witnesses were commissioned by various participants. In the remaining case, an interval of 19 months before the case was allocated was the primary reason for the delay between the date of death and the start of an FAI.
185. In addition to the seven cases reported by HSE, they provided supplementary reports at the request of COPFS in 14 cases in our review. In 2 out of the 14 cases, the supplementary report took longer than 12 months to submit.
186. In a follow-up report on an inspection of the HSD published by the Inspectorate last year, we commented favourably on the enhanced effectiveness of HSD as evidenced by a significant increase in the throughput of cases and improved working relationships between HSD and specialist reporting agencies.<sup>81</sup>

## Air Accidents Investigation Branch (AAIB), Marine Accident Investigation Branch (MAIB) and Rail Accident Investigation Branch (RAIB)

187. Investigations involving air, rail and marine accidents are fortunately not frequent but the nature of such incidents, with potential multiple fatalities, are high profile and of considerable public concern. Specialist investigatory bodies with particular expertise in these areas are responsible for investigating the cause of such incidents.
188. The Air Accidents Investigation Branch investigates civil aircraft accidents and serious incidents within the UK, its overseas territories and Crown dependencies. It also provides assistance and expertise to international air accident investigations and organisations – most recently AAIB investigators assisted Norwegian investigators with the investigation into the cause of the Super Puma crash in May 2016.
189. The AAIB inspections are independent and impartial and often involve complex technical and aviation issues.

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<sup>81</sup> <http://www.gov.scot/Publications/2015/08/9101>





190. The primary aim of the AAIB is to improve aviation safety globally by determining the cause of air accidents and serious incidents, and making safety recommendations intended to prevent recurrence – it is not to apportion blame or liability. The AAIB does not investigate for, or report to, prosecution authorities. To encourage co-operation and candour, AAIB do not identify witnesses who have provided information and it has a statutory obligation not to disclose statements obtained to third parties, including prosecutors.
191. To alleviate public anxiety and to highlight any potential safety issues that require to be addressed immediately, the AAIB may release a special bulletin at an early stage providing preliminary findings of their initial investigation. At the conclusion of the investigation, AAIB publishes a report containing recommendations directed to the appropriate body or person.
192. The MAIB has a similar role to that of the AAIB for marine accidents within UK waters and accidents involving UK registered vessels worldwide and the RAIB for rail accidents. Akin to AAIB, their remit is to improve safety and prevent similar accidents occurring rather than to apportion blame or liability. Findings and recommendations made by AAIB, MAIB and RAIB are often adopted by sheriffs in their determination following an FAI.
193. Prosecutors are reliant on the technical and specialist expertise of the AAIB, MAIB and RAIB to identify the cause of any accident which will in turn inform the direction of any criminal investigation. As with HSE investigations, COPFS has no authority to direct these investigations. While, the AAIB, RAIB and MAIB aim to conduct investigations involving fatalities within 12 months, this is dependent on the complexity of the case and the ever changing landscape of priorities they face. Cases where criminal proceedings or an FAI are in contemplation tend to fall within the complex case category.
194. The case involving AAIB from our case review is such an example. It involved the investigation into the cause of the crash of a Super Puma helicopter in Aberdeen. The investigation was complex and required detailed examination of evidence of a technical nature. While AAIB provided an early indication of their findings in a press release published three months after the accident, the full investigation resulting in their final report took 31 months. Following consideration of the AAIB report and a thorough investigation by COPFS, including commissioning expert reports, a decision was taken to hold an FAI. The FAI commenced almost five years after the incident.
195. There were two cases investigated by MAIB in the case review. In one case, the MAIB submitted the investigation report to COPFS within six months of the date of the death and in the other within 12 months. There were no cases involving the RAIB in our case review.
196. The divergence in the role and purpose of investigations by COPFS and these specialist investigative agencies can complicate criminal investigations. AAIB, RAIB and MAIB inspectors will not provide opinion evidence, but will give evidence on factual matters referred to in their reports. The inability of COPFS to access statements obtained by these specialist agencies can result in duplication of investigation with the police obtaining statements from witnesses on behalf of COPFS who have already given statements to AAIB, RAIB or MAIB. In the investigation into the Super Puma crash, the manufacturer of the helicopter provided details of relevant witnesses to COPFS who then instructed the police to obtain statements.
197. To assist with the investigation of such cases, COPFS, the AAIB, RAIB, MAIB and the police have agreed a Memorandum of Understanding recognising the different roles of each organisation and setting out arrangements to ensure effective communication and liaison between all parties during the investigation of an incident or accident. The MAIB, RAIB and AAIB provide witnesses with a copy of their statement and will advise witnesses that they can provide a copy to the police or COPFS, if they so choose.



198. We are aware of public concern regarding delays in FAI proceedings where there have been investigations conducted by authorities such as AAIB. The absence of any authority for COPFS to direct such investigations or influence the priorities of other agencies and the different purpose of the investigation conducted by AAIB and similar agencies that inhibits their ability to share statements and information clearly impedes on the ability of COPFS to progress such cases. While COPFS may undertake some ancillary investigation, the priority is to ensure that any investigation is thorough and of the highest standard and decisions on whether there should be criminal proceedings or an FAI will be influenced and dependent on the findings of the specialist investigative body.



## THE ROLE AND MANAGEMENT OF FAIs

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199. FAIs have played a crucial role over the years in exposing failings and defects in working practices and systems, identifying precautions to avoid deaths occurring in similar circumstances and providing oversight on the way authorities have dealt with the deceased while in legal custody.
200. FAIs provide a public airing of the circumstances of a death to allow relatives to hear from those involved what happened so that they have a better understanding of the full circumstances. They also ensure that reasonable measures to prevent a recurrence are identified and that lessons are learned by those with an interest in and the means of preventing such a recurrence
201. The public exploration of the tragic circumstances that have resulted in a death have been instrumental in driving up safety standards across a wide range of working environments.
202. Those held in legal custody are particularly vulnerable. The holding of an FAI into such deaths ensures that there is public scrutiny of the circumstances of the death and on the way in which the state authorities have dealt with the deceased whilst in legal custody. This is important for the maintenance of public confidence in the authorities.
203. There is greater emphasis than ever on accountability but it often goes hand in hand with seeking to hold a person or organisation responsible or culpable. The FAI is a forward looking vehicle – it is a fact-finding procedure rather than fault-finding. It seeks answers not only for bereaved relatives but the wider public.
204. Witnesses cannot be compelled to answer any questions which may incriminate them and the sheriff's determination may not be founded upon in any other judicial proceedings.<sup>82</sup>
205. This is intended, in part, to encourage a full and open exploration of the circumstances of the death in an environment where witnesses are able to give frank evidence without concern that it will be used in any other proceedings.
206. However, this does not mean that the sheriff is precluded from reaching findings which may infer fault where it is proper to do so. In the words of I HB Carmichael: "*The whole object of impartial public inquiry is to get at the truth, to expose any fault where fault is proven to exist, and in all cases to see to it so far as humanly possible that the same mistake, when it arises through fault or any other reason, is not made in the future*". The public interest, in whose name inquiries are held, requires and deserves no less.<sup>83</sup>
207. We heard from a wide range of persons who had recent experience of FAIs that they found the inquiry to be adversarial and, whether intended or not, it was seen as a vehicle to seek to apportion blame and culpability for the death. Employers from different occupations advised that the adversarial atmosphere of some inquiries while conducted in a public forum had adversely impacted on the well-being of staff involved and on their colleagues by association.
208. During the passage of the Bill, the Justice Committee reported, "*that it was struck by the lack of clarity surrounding the purpose of an FAI and a lack of understanding of the intention of inquiries held in the "public interest"*".<sup>84</sup> This resonates with our findings.

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<sup>82</sup> Section 26(6) of the Act.

<sup>83</sup> Sudden Deaths and Fatal Accident Inquiries 3<sup>rd</sup> Edition, paragraphs 5-63 and 5-76.

<sup>84</sup> Justice Committee, Stage 1 Report into the Fatal Accidents and Sudden Deaths etc. (Scotland) Bill, 13<sup>th</sup> Report, 2015 (Session 4).



209. To emphasise the purpose of FAIs, the Act includes a provision explicitly stating that the purpose of an inquiry is to establish the circumstances of the death, and consider whether any precautions could be taken to prevent other deaths in similar circumstances.<sup>85</sup> To reinforce the inquisitorial nature of an FAI, it narrates in the body of the Act that it is not the purpose of an FAI to establish criminal or civil liability.<sup>86</sup>
210. These provisions are to be welcomed. The FAI is a powerful vehicle to expose systematic failings, unsafe working practices and to safeguard and protect those in held in legal custody. A process which is adversarial and combative is counter-productive – it is likely to inhibit frankness and candour which in turn will diminish the impact of the inquiry and its outcome.
211. As highlighted lengthy delays also impact on the value and relevance of inquiries.
212. Echoing sentiments expressed in the Cullen Review, some representatives who regularly appear on behalf of interested parties in FAIs, suggested that adopting a more informal approach, analogous to that used in employment tribunals, and dispensing with the wearing of wigs and gowns and participants being seated may lessen the “adversarial” nature of inquiry proceedings.
213. As advocated in this report, a more systematic approach to clarifying the purpose and scope of the inquiry; proactive sharing of evidence, including expert reports, to crystallise the issues that are likely to be disputed; and early adjudication on the relevancy of the issues raised by interested representatives may assist in re-emphasising the inquisitorial role of the inquiry.
214. We recognise that this approach is being implemented in some cases, but its application is patchy. As the Right Honourable Lord Gill stated in his evidence to the Justice Committee:<sup>87</sup> *“In any inquiry of this nature, effective case management is the key to the whole thing. There has to be effective case management in the preparatory stages, and then, once the inquiry starts, efficient and competent chairmanship is required to ensure that the inquiry addresses the relevant points”*.
215. The new Act requires a preliminary hearing to be held before every FAI unless the sheriff dispenses with the requirement.<sup>88</sup> The preliminary hearing is critical to both the efficient management of FAIs and managing the expectations of the participants.
216. Preliminary hearings were held in 84 of the 88 cases in our review. Feedback on the importance of the role of preliminary hearings to the efficient running of the FAI was unanimously positive. The following case study illustrates the positive impact of proactive management at the preliminary hearing.

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<sup>85</sup> Section 1 of the Act.

<sup>86</sup> Section 1 (4) of the Act.

<sup>87</sup> May 2015.

<sup>88</sup> S16: Further provision on the content and purpose of preliminary hearings is to be made by court rules.



At a preliminary hearing in an FAI relating to a death in custody, the sheriff sought to be addressed on:

- The nature of the evidence, in general terms, of the witnesses;
- The issues that interested parties intended to raise;
- Whether the executions of service for the interested parties were served;
- The status of the witness citations; and
- Whether COPFS intended to examine further an expert witness.

The nearest relatives intimated that they wished to explore the police dealings with the deceased and the medical treatment that he obtained prior to his death. It was emphasised that the focus of the inquiry was the cause of the death.

At the FAI, while there was evidence of the police dealings with the deceased up to and at the time of his death, the main focus of the inquiry was the cause of death and evidence was heard from a toxicologist and a pathologist. The consequences of the use and abuse of various drugs was pivotal.

217. The management of FAIs at Glasgow Sheriff Court was widely commended by those who have regular contact with FAIs.

### Good Practice

At Glasgow Sheriff Court, to improve efficiency of the usage of court time for FAIs and identify and plan future business, a number of new measures have been implemented:

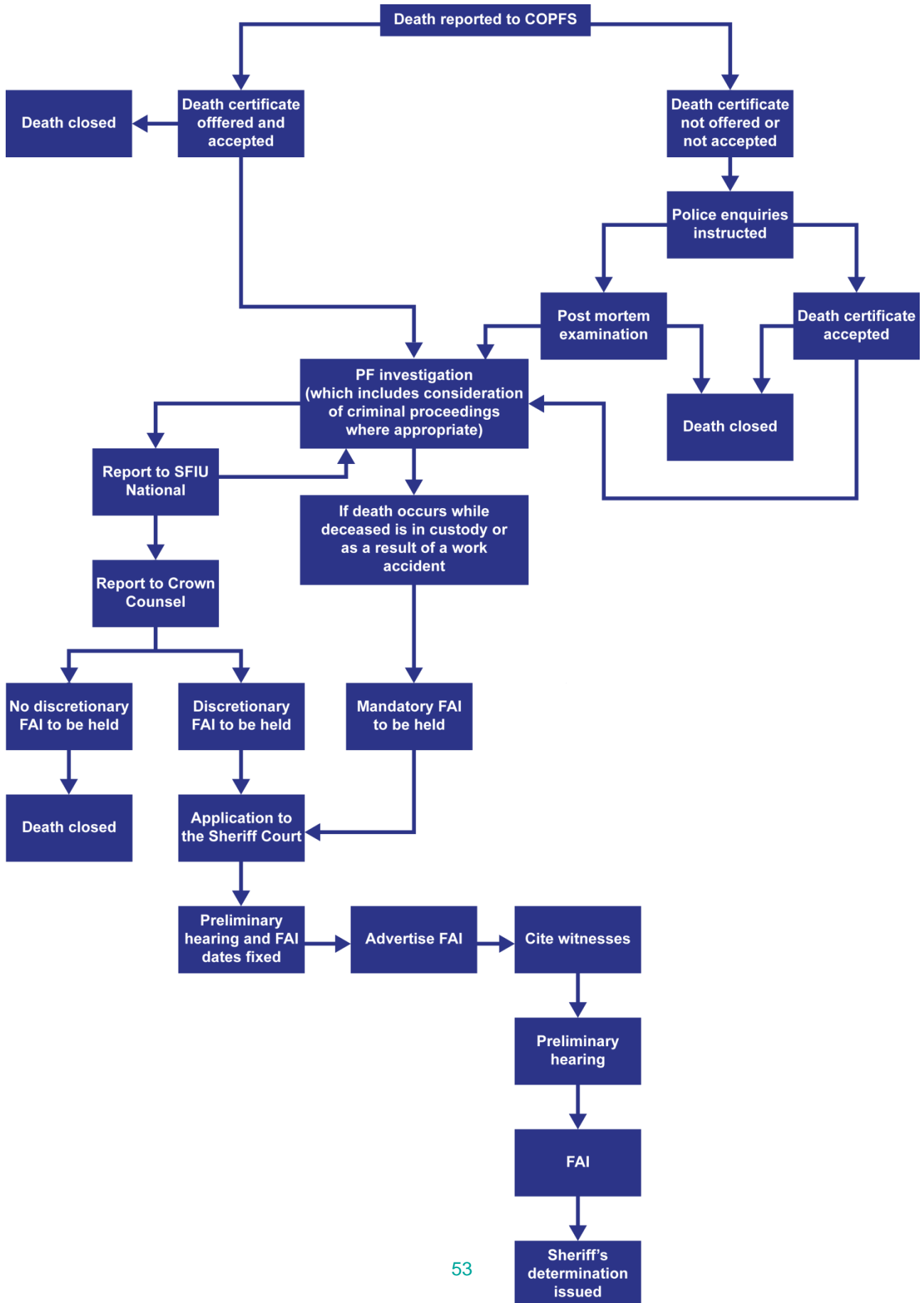
- A week of court time is allocated each month to hold FAIs. If it is not required, SCTS is advised and the allocated time is diverted back to criminal or civil matters;
- Where possible, the sheriff meets with the depute conducting the case when the application to hold an FAI is lodged, facilitating early identification of the nature of the inquiry and issues that may arise;
- The sheriff and depute engages with the Clerk of Court to obtain dates for an early preliminary hearing;
- Where possible, the sheriff identified for the FAI will conduct the preliminary hearing – if this is not possible, the outcome of any issues raised and any actions instructed by the sheriff at the preliminary hearing are recorded in the court minutes;
- If there is scope to agree evidence, the sheriff adjourns the preliminary hearing to allow all parties to identify areas of agreement and contention.

Overall, this proactive approach has reduced the number of FAIs waiting to commence and substantially increased court usage.

218. The re-iteration of the purpose of FAIs in the Act, supported and underpinned by court rules designed to reinforce that purpose by focussing on the agreement of non-contentious facts and encouraging proactive management of preliminary hearings, including early clarification of the issues that require to be examined, should assist in re-emphasising the public interest ethos of FAIs. To ensure FAIs continue to fulfil the important function that they have served requires all those involved, including COPFS, representatives of all participants and the judiciary to foster an environment that encourages transparency and frankness.



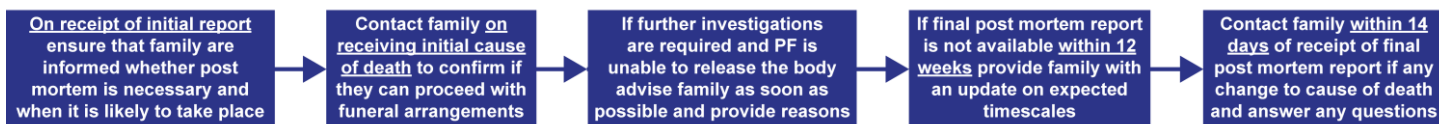
# Annex A – COPFS FAI Process Flowchart



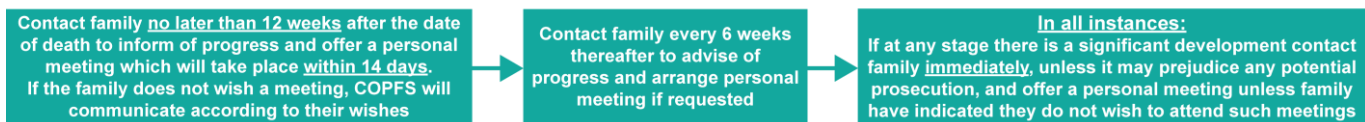


# Annex B – Family Liaison Charter

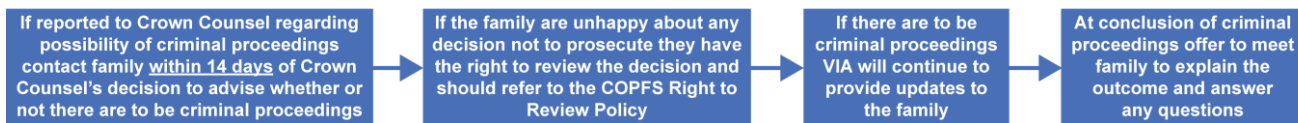
## Initial Report and Post Mortem



## Further Investigation



## Criminal Proceedings



## Fatal Accident Inquiry







## Annex C – Glossary of Terms

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### ***Air Accidents Investigation Branch (AAIB)***

Part of the Department of Transport. Investigates civil aircraft accidents and serious incidents within the UK, its overseas territories and Crown dependencies.

### ***Accused***

Person charged with a crime.

### ***Adjournment***

A break during court proceedings or suspension to another hearing.

### ***Advocates Depute***

Advocates Depute are prosecutors appointed by the Lord Advocate. Advocates Depute prosecute all cases in the High Court and present appeals in the Appeal Court.

### ***Affidavit***

A written statement confirmed by oath or affirmation, for use as evidence in court.

### ***Bail***

Release from custody of an accused person until the trial or next hearing.

### ***Care Inspectorate***

The independent regulator of social care and social work services across Scotland.

### ***Case Investigator***

Legal and Administrative staff who interview witnesses and prepare cases for court.

### ***Central Legal Office (CLO)***

National legal department for the NHS.

### ***COPFS Federation Structure***

The division of COPFS into four Federations, each led by a Procurator Fiscal.

### ***Coroner***

An official who holds inquests into violent, sudden or suspicious deaths in England and Wales.

### ***Crown Counsel***

The Law Officers (Lord Advocate and Solicitor General) and Advocates Deputes.

### ***Crown Office and Procurator Fiscal Service (COPFS)***

The independent public prosecution service in Scotland. It is responsible for the investigation and prosecution of crime in Scotland. It is also responsible for the investigation of sudden, unexplained or suspicious deaths and the investigation of allegations of criminal conduct against police officers.

### ***Crown Prosecution Service (CPS)***

Principal prosecuting authority for England and Wales.

### ***Death Certificate***

Term commonly used to refer to the medical certificate of cause of death required to enable registration of a death with the Registrar of Births, Deaths and Marriages in Scotland.

### ***Determination***

Written or oral findings made by a sheriff at the end of a FAI which may include recommendations to prevent similar deaths.



**Fatal Accident Inquiry (FAI)**

A court hearing presided over by a sheriff which publicly enquires into the circumstances of some sudden, unexplained or suspicious deaths.

**Health and Safety Division (HSD)**

Division within Crown Office and Procurator Fiscal Service responsible for the investigation and/or prosecution of health and safety related offences and deaths.

**Health and Safety Executive (HSE)**

National independent body responsible for regulating the health and safety sector and investigating breaches of health and safety law.

**Health Improvement Scotland (HIS)**

The national healthcare improvement organisation for Scotland and part of the NHS.

**Interested Party (IP)**

A person or entity that has a recognisable stake in the outcome of a matter before a court.

**Joint Minute of Agreement**

A document setting out agreed uncontroversial facts.

**Law Officers**

The Law Officers are the Lord Advocate and the Solicitor General for Scotland.

**Law Society**

The independent professional body for solicitors. It promotes the highest professional standards and rule of law.

**Lord Advocate**

The Ministerial head of COPFS. He is the senior of the two Law Officers, the other being the Solicitor General.

**Marine Accident Investigation Branch (MAIB)**

Part of the Department of Transport. It investigates marine accidents and serious incidents within the UK, its overseas territories and Crown dependencies.

**Maritime and Coastguard Agency (MCA)**

UK executive agency working to prevent the loss of lives at sea and responsible for implementing British and International maritime law and safety policy.

**Mental Welfare Commission (MWC)**

Established by the Mental Health Act to ensure law and regulations are upheld within the mental health sector.

**Nearest relatives**

Closest family to the deceased.

**Petition**

Formal document served on interested parties. It gives notice of issues that will be raised at a FAI.

**Post-Mortem Examination (also known as Autopsy)**

Dissection and examination of a body after death to determine the cause of death conducted by a medically qualified pathologist.

**Precognition**

An interview of a witness by a procurator fiscal or defence lawyer taken to prepare for a court case.



### ***Preliminary Hearing***

A procedural hearing. The purpose is to adjudicate on the state of preparation of the Crown and interested parties and to resolve all outstanding issues prior to the inquiry.

### ***Principal Procurator Fiscal Depute (PPFD)***

A senior Legal Manager.

### ***Procurator Fiscal***

Legally qualified prosecutors who receive reports about crimes from the police and other agencies and make decisions on what action to take in the public interest and where appropriate prosecute cases. They also look into deaths that require further explanation and where appropriate conduct Fatal Accident Inquires and investigate criminal complaints against the police.

### ***Productions***

Items/exhibits produced at court as part of the evidence.

### ***PROMIS***

(Acronym for **Prosecutor's Management Information System**). COPFS computer-based case-tracking and management system.

### ***Scottish Courts and Tribunals Service (SCTS)***

Supports justice by providing the people, buildings and services needed by the judiciary, courts, Office of the Public Guardian and devolved tribunals.

### ***Scottish Fatalities Investigation Unit (SFIU)***

A national specialist division within COPFS responsible for investigating all sudden, suspicious, accidental and unexplained deaths in Scotland with dedicated teams in each COPFS Federation.

### ***Scottish Legal Aid Board (SLAB)***

A non-departmental public body of the Scottish Government responsible for managing legal aid.

### ***Scottish Prison Service (SPS)***

A public service-led delivery agency which is legally required to deliver custodial and rehabilitation services for those sent to it by the courts.

### ***Senior Procurator Fiscal Depute (SPFD)***

An experienced prosecutor who deals with more complex cases.

### ***Sheriff and Jury***

Serious criminal cases heard in the Sheriff Court by a jury.

### ***Solemn Proceedings***

Prosecution of serious criminal cases before a judge and jury in the High Court or Sheriff Court.

### ***Solicitor General***

The Lord Advocate's deputy. She is also a Minister of the Scottish Government.

### ***Stand-by Arrangement***

An arrangement with witnesses to attend at court on a specific date and time.

### ***Summary Proceedings***

Prosecutions held in the Sheriff or Justice of the Peace Court before a judge without a jury.

### ***Victim Information and Advice (VIA)***

A COPFS dedicated Victim Information and Advice service.

Inspectorate of Prosecution in Scotland  
Legal House 2nd Floor  
101 Gorbals Street  
Glasgow G5 9DW

Telephone: 0141 420 0378

E-mail: [IPS@gov.scot](mailto:IPS@gov.scot)



Scottish Government  
Riaghaltas na h-Alba  
[gov.scot](http://gov.scot)

### **About the Inspectorate of Prosecution in Scotland**

IPS is the independent inspectorate for the Crown Office and Procurator Fiscal Service. COPFS is the sole prosecuting authority in Scotland and it also responsible for investigating sudden deaths and complaints against the police which are of a criminal nature.

IPS operated on a non-statutory basis from December 2003. Since the coming into effect of the Criminal Proceedings etc (Reform) (Scotland) Act 2007 Sections 78 and 79 in April 2007 the Inspectorate has been operating as a statutory body.

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