Inspectorate of Prosecution in Scotland

Follow-Up Review of Fatal Accident Inquiries

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CONTENTS

INTRODUCTION

The responsibility for the investigation of any death that requires further explanation rests with COPFS. This includes any sudden, suspicious, unexpected or unexplained death and any death which has occurred in circumstances which give rise to public concern. If the death is sudden and unexplained, this accentuates the distress and heightens an already stressful situation for bereaved relatives and involvement of the procurator fiscal and an unfamiliar justice system, at a time of significant personal crisis or distress, can be bewildering and concerning.

Bereaved relatives are entitled to expect a thorough, prompt and professional investigation and to be guided through the process with sensitivity and respect. Protracted investigation and unexplained delays are likely to undermine public confidence in COPFS and, potentially, in Fatal Accident Inquiries.

What is a Fatal Accident Inquiry (FAI)?

A Fatal Accident Inquiry is a public examination of the circumstances of a death conducted before a sheriff. The procurator fiscal is responsible for presenting the evidence. Other interested parties, including nearest relatives, employers or organisations such as the Scottish Prison Service (SPS) are also entitled to lead evidence.

The purpose of an inquiry is to establish the circumstances of the death, and to consider what steps (if any) might be taken to prevent other deaths in similar circumstances.[1] The sheriff's role is to establish the facts surrounding the death, rather than to apportion blame or to find fault.[2] The FAI is a forward looking vehicle – it is a fact-finding procedure rather than fault-finding. It is not to establish civil or criminal liability.[3]

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,[4] s/he may make recommendations to prevent similar deaths happening in the future.[5]

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.[6] 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. A process which is adversarial and combative is likely to inhibit frankness and candour which in turn will diminish the impact of the inquiry and its outcome.

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[1] Section 1(3)(a) and (b) of the Inquiries into Fatal Accidents and Sudden Deaths etc. (Scotland) Act 2016[1] (the 2016 Act).
[2] Black v Scott Lithgow Limited 1990 SLT 612 *per* the Lord President (Hope) at p 615G-H.
[3] Section 1(4) of the 2016 Act.
[4] Section 26 of the 2016 Act.
[5] Section 26(1)(b) of the 2016 Act.
[6] Section 26(6) of the 2016 Act.

Any participant in the inquiry to whom a recommendation is addressed must provide Scottish Courts and Tribunals Service (SCTS) with a response in writing detailing what they have done or propose to do in response to the recommendation, or the reasons for not taking action.[7] SCTS publish this information on their website.[8]

FAIs are not usually held until a decision has been taken on whether there should be criminal proceedings.

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

The Inquiries into Fatal Accidents and Sudden Deaths etc. (Scotland) Act 2016[9] (the 2016 Act) supplemented by the Act of Sederunt (Fatal Accident Inquiry Rules) 2017 (the 2017 Rules) provide the legislative framework for such Inquiries.[10]

Type of FAIs

Mandatory Inquiries[11]

There is a requirement to hold an FAI where a death occurs in Scotland[12] as a result of a work-related accident[13] or where the deceased was in legal custody[14] or was a child required to be kept or detained in secure accommodation[15] at the time of their death. Such inquiries are referred to as “Mandatory inquiries”. 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.[16]

The FAI is a powerful vehicle to expose systematic failings and unsafe working practices and to ensure there are systems to safeguard and protect those in held in legal custody.

FAIs have been instrumental in driving up safety standards across a wide range of working environments and identifying precautions to avoid deaths occurring in similar circumstances.

Those held in legal custody are vulnerable. The holding of an FAI into deaths occurring in custody ensures that there is public scrutiny of the circumstances of the death and oversight of the way in which the state authorities have dealt with the deceased whilst in legal custody. This is critical for the maintenance of public confidence in the authorities.

[7] Section 28(1) and (2) of the 2016 Act. If a recommendation is addressed to someone who was not a participant in the inquiry they may similarly respond.
[8] Section 28(5) of the 2016 Act.
[9] Received Royal Assent on 14/01/2016.
[10] Section 36 of the 2016 Act.
[11] Section 2 of the 2016 Act.
[12] Certain offshore deaths and accidents are treated as having occurred within Scotland – s.5 of the 2016 Act.
[13] Section 2(3) of the 2016 Act
[14] Sections 2(5) Includes being imprisoned or detained in penal institution; being in police custody; being held in custody on court premises or detained in premises used by armed services as service custody premises.
[15] Section 2(4)(a) and (b) of the 2016 Act.
[16] Section 3(1)-(2) (a-e) of the Act.

Discretionary Inquiries

Where a death was sudden, suspicious or unexplained, or has occurred in circumstances which give rise to serious public concern and it is deemed in the public interest for an inquiry to be held into the circumstances of the death, the Lord Advocate can instruct an inquiry. Such inquiries are referred to as “Discretionary inquiries”.[17]

Aims/Objectives

Our thematic report on FAIs was published in August 2016. A primary aim of the report 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. The report made 12 recommendations.[18]

It is the practice of the Inspectorate to conduct follow-up inspections to promote improvement and assess the effectiveness of our recommendations and their outcomes. The follow-up review aims to assess and report on the progress that has been made against our recommendations.

Given continuing criticism of delays between the date of death and the commencement of FAIs, it is also appropriate to undertake a detailed examination of what progress has been made to reduce timescales for commencing FAIs and identify whether there are any recurring themes contributing to delay.

In light of the tragic deaths of two young people while they were in legal custody in HM Young Offenders Institution Polmont (HMYOI) in 2018, we were asked to consider, as part of this follow-up review, the merits of prioritising investigations following the death in custody of a young person and, where appropriate, to establish whether there is scope within the current system to prioritise this category of case.

In the thematic report we highlighted new provisions that were introduced by the 2016 Act, including:

- A duty for the Lord Advocate to prepare a Family Liaison Charter setting out how the procurator fiscal will liaise with the family of a person whose death may be or is subject to an inquiry; and

- Permitting a single FAI to be held into multiple deaths if they are they are as a result of the same accident or in the same or similar circumstances.

The follow-up report provides an opportunity to assess the use of and compliance with these provisions.

[17] Section 4 of the 2016 Act.
[18] The recommendations are discussed in a different order.

Methodology

Evidence was obtained from a range of sources, including:

- Follow-up interviews with key personnel at COPFS involved with the management of the Scottish Fatalities Investigation Unit (SFIU) and investigation of deaths;
- A review of relevant documentation and management information;
- Examination of a significant sample of 56 cases where an FAI had been concluded between 2016/17 and 2018/19, 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 and whether there was a criminal investigation. In each case we measured timelines between the date of the death to the start of an FAI;
- An analysis of outstanding cases requiring an FAI; and
- A review of eight cases involving the death of a young person – aged under 21 years – while in legal custody within the last five years.

We would like to thank all those that gave up their time to assist with this follow-up review and in particular the staff of the Scottish Fatalities Investigation Unit (SFIU) for their open and active participation.

KEY TERMS

Accused: Person charged with committing a crime.

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.

Case Preparer: Legal and administrative staff who interview witnesses and prepare cases for court.

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.

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

First Notice: A notice from COPFS requesting dates from SCTS for a Preliminary Hearing and the FAI. It provides the circumstances of the death, the objectives of the FAI, and other information required by the court.

Interested Party (IP): A person or entity that has a recognisable stake in the outcome of a matter before a court.

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

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.

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.

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.

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.

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

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.

CHAPTER 1 – INVESTIGATION OF DEATHS BY CROWN OFFICE AND PROCURATOR FISCAL SERVICE (COPFS)

Role of COPFS

1. The primary purpose of the investigation of sudden, suspicious, unexpected and unexplained deaths 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.

Scottish Fatalities Investigation Unit (SFIU)

2. In April 2012, SFIU assumed national responsibility for investigating all reported non-suspicious deaths. 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.

3. Within SFIU there are three geographical teams – SFIU North,[19] SFIU East[20] and SFIU West.[21] SFIU National oversees the work of all teams, including monitoring all potential FAIs, the progress of investigations and the timeliness of holding FAIs and has input on policy matters relating to deaths.

Reporting of Deaths

4. 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.

[19] Located in Dundee, Aberdeen and Inverness.
[20] Located in Edinburgh.
[21] Located in Glasgow.

5. The Health and Safety Executive (HSE) and Local Authorities are responsible for the reporting of health and safety breaches to COPFS, including those that result in fatalities. Investigations involving air, rail and marine accidents 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. The Air Accidents Investigation Branch (AAIB) investigates civil aircraft accidents and serious incidents within the UK, its overseas territories and Crown dependencies. The Marine Accident Investigation Branch (MAIB) has a similar role to the AAIB for marine accidents within UK waters and accidents involving UK registered vessels worldwide and the Rail Accident Investigation Branch (RAIB) for rail accidents.

6. While COPFS has no authority to direct these investigations, it is dependent on the outcome of such investigations prior to considering the possibility of criminal proceedings or an FAI.

Health and Safety Division (HSD)

7. While the majority of deaths are investigated by SFIU, fatalities arising from potential breaches of health and safety legislation are investigated and, where appropriate, prosecuted by the national Health and Safety Division (HSD). On occasion they will also conduct FAIs.

Road Traffic Fatalities Investigation Unit (RTFIU)

8. All road traffic cases which result in death are investigated by SFIU and if a prosecution is instructed the case is prepared and prosecuted by the specialist Road Traffic Fatalities Investigation Unit (RTFIU).[22]

Homicide Team

9. Where there is evidence that the death occurred as a result of criminality, the homicide team will assume primacy of the investigation.

Police Investigations and Review Commissioner (PIRC)

10. PIRC was established at the same time as the single Police Service of Scotland. Its role is to independently investigate incidents involving the police and review the way the police handles complaints from the public. Incidents involving the police may be referred by COPFS including deaths in custody and allegations of criminality. Any PIRC investigation will be taken into consideration as part of the SFIU investigation.

[22] Established within SFIU in December 2015.

Investigation of Deaths

11. Deaths are most commonly reported to the procurator fiscal by hospital doctors, General Practitioners (GP)[23] and the police. Once a death has been reported, COPFS has legal responsibility for the deceased's body, until a cause of death has been established.

12. The reports are sent to the SFIU team 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. Such deaths are categorised as “routine deaths”.

13. In other cases, additional information and investigation may be required prior to the cause of death being ascertained. In carrying out its investigations, SFIU will review the evidence, including the post mortem and other medical reports. Statements may also be taken from witnesses; documentation may be obtained from relevant organisations and reports commissioned from specialists or experts in particular fields. Such deaths are categorised as “deaths requiring investigation”. In recent years, more extensive investigation has been necessary in the majority of deaths reported. In 2018/19, 70% of deaths required further investigation.[24]

14. This is due to:

    - An evolution in the public’s attitude to death, with a greater expectation of being involved in all important decisions regarding the death of nearest relatives and receiving a full explanation of 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.

15. 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.

16. 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.

[23] From March 2015 GPs submit reports electronically.
[24] See Chart 4 below.

Performance Target

17. COPFS has a published performance target to investigate cases which require further investigation and inform the nearest relatives of the outcome within 12 weeks of the receipt of the death report in at least 80% of cases.

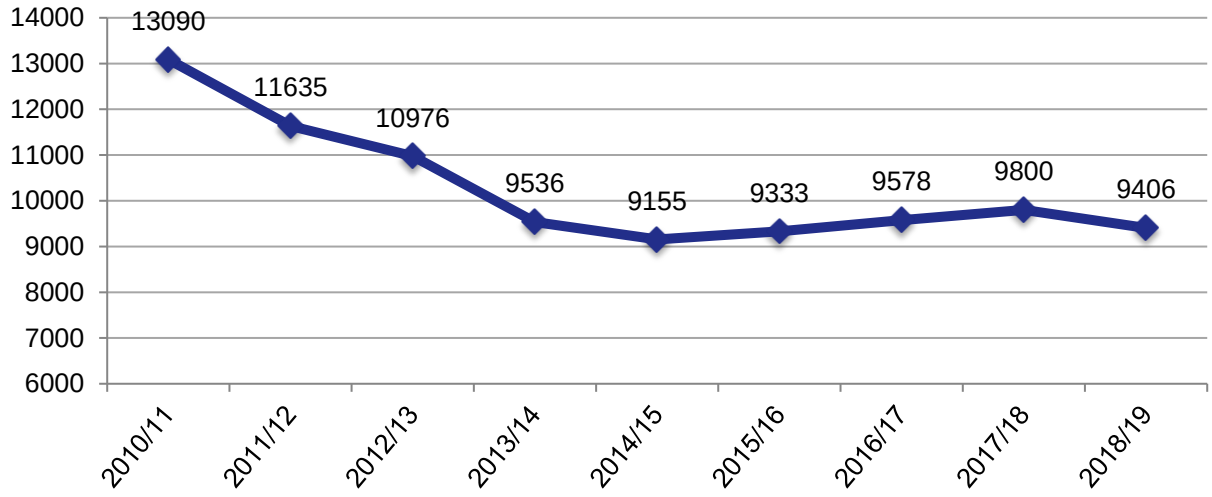
18. It also has an internal Key Performance Indicator (KPI) to close 90% of death cases within six weeks of receipt of the death report where no investigation is required.

19. **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.

Death Reports

20. Chart 1 illustrates the number of deaths reports received by COPFS between 2010/11 to 2018/19. In the thematic report there was a decrease of 30% of death reports received between 2010/11 and 2014/15. Since 2014/15 there has been a 3% increase in reports received.

Chart 1 – Death Reports Received[25]



[25] Source: COPFS MI Book.

21. Charts 2 and 3 demonstrate the number of routine deaths and deaths investigated by COPFS between 2010/11 to 2018/19.

Chart 2 – Routine Deaths[26]

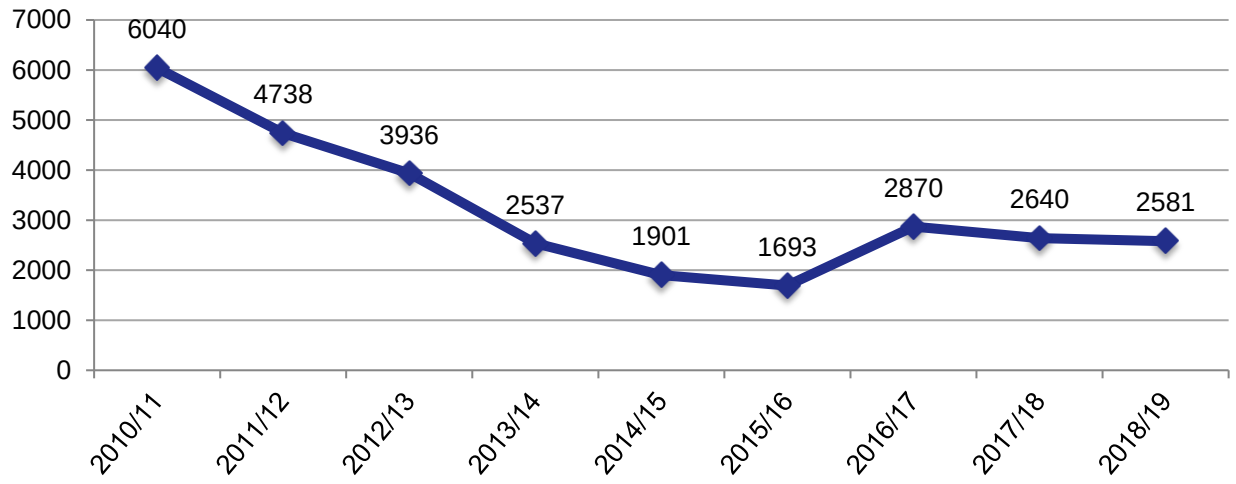
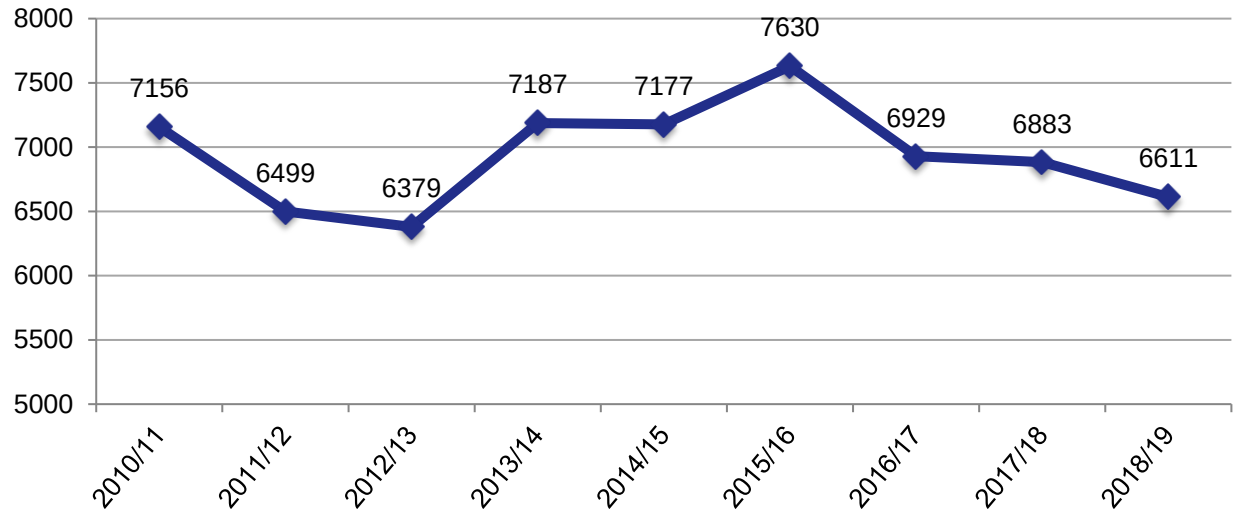


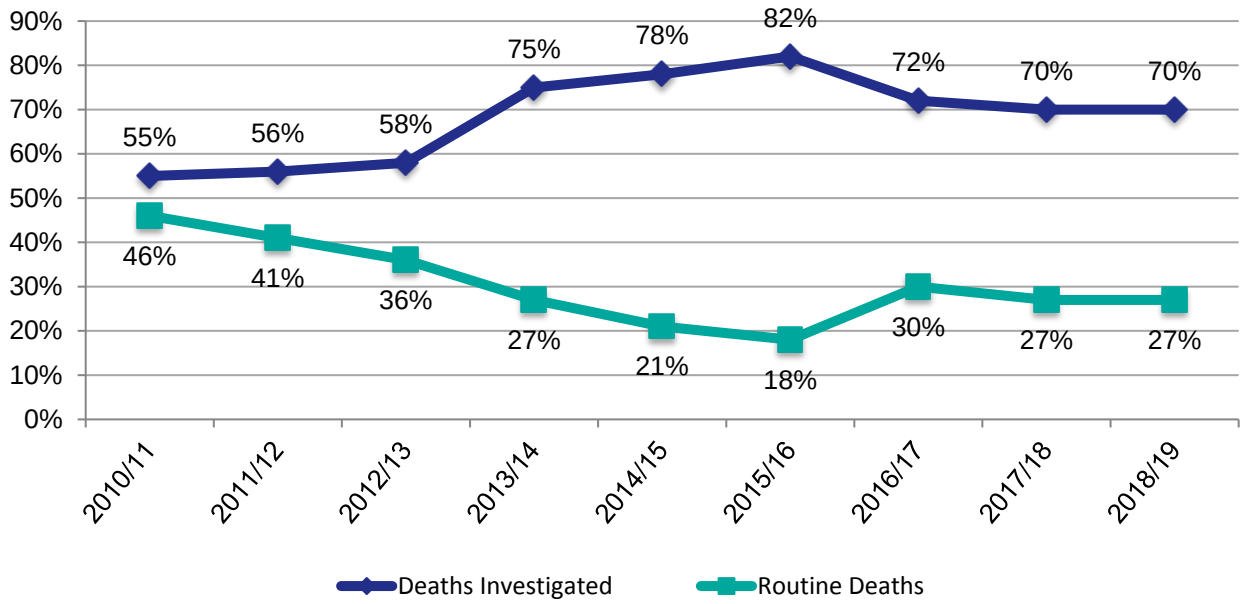
Chart 3 – Deaths Investigated[27]



22. Chart 4 illustrates the number of routine deaths and deaths investigated as a percentage of death reports received – routine deaths have increased by 6% from 2014/15 to 2018/19, while those requiring investigation have decreased by 8% over the same period.

[26] Source: COPFS MI Book.
[27] Source: COPFS MI Book.

Chart 4 – Deaths Investigated/Routine Deaths as % of Reports Received[28]



Performance Target

23. SFIU has met their target to investigate cases which require further investigation and inform the nearest relatives of the outcome within 12 weeks of the receipt of the death report in at least 80% of cases every year since 2015/16. It was met in 92% of cases in 2015/16 and in 90% of cases in years 2016/17 to 2018/19.[29]

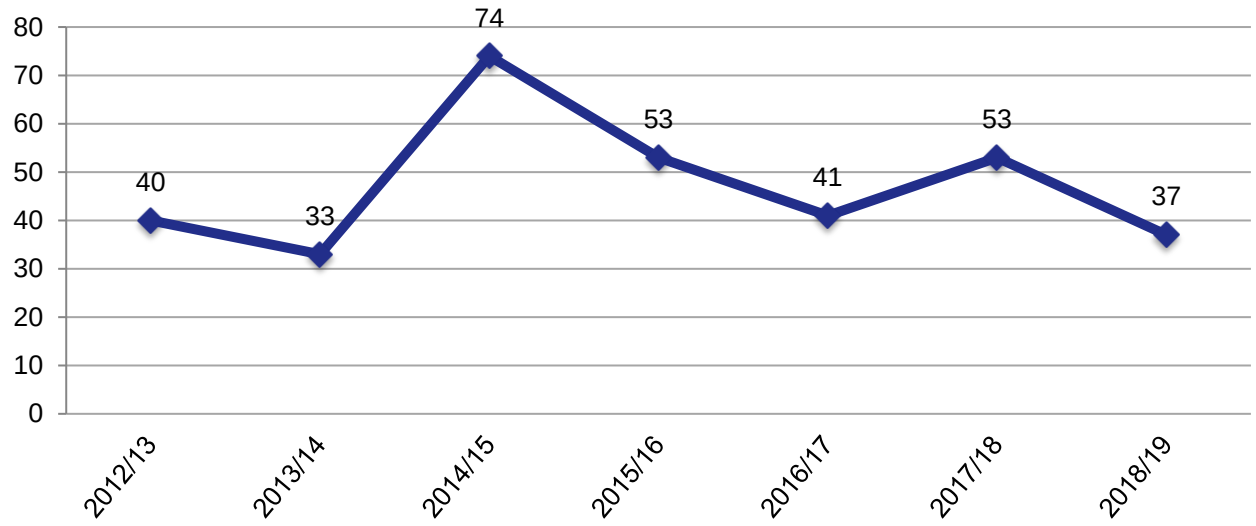
24. SFIU has also regularly met the KPI to close 90% of death cases within six weeks of receipt of the death report where no investigation is required. In 2018/19, 97% of such cases were closed within six weeks.[30]

[28] Source: COPFS MI Book. A new electronic system for doctors to report deaths was introduced in 2015. In some cases, further inquiries are instructed and a new report is provided by the police with a new reference number being generated. The electronic report from the GP is closed with a duplicate marking. To avoid counting these deaths twice we deducted any reports closed with a duplicate marking from the total deaths reported from 2015/16 onwards.
[29] Source: COPFS MI Book 15/04/19.
[30] Source: COPFS MI Book 15/04/19.

FAIs

25. Many deaths requiring investigation do not result in an FAI. There have been 131 FAIs held between 2016/17 and 2018/19. Chart 5 demonstrates the number of FAIs held from 2012/13 to 2018/19[31] with a peak of 74 in 2014/15 decreasing to 37 in 2018/19.

Chart 5 – FAIs[32]



26. The number of FAIs remains extremely low, representing 0.6% of deaths investigated between 2016/17 to 2018/19.

Mandatory FAIs[33]

27. There were: 37 mandatory FAIs concluded in 2016/17; 45 in 2017/18 and 37 in 2018/19, totalling 119 over the three year period.

28. Of the 119 mandatory FAIs, 45 concerned deaths that occurred in the course of employment and 74 while the deceased was in legal custody.

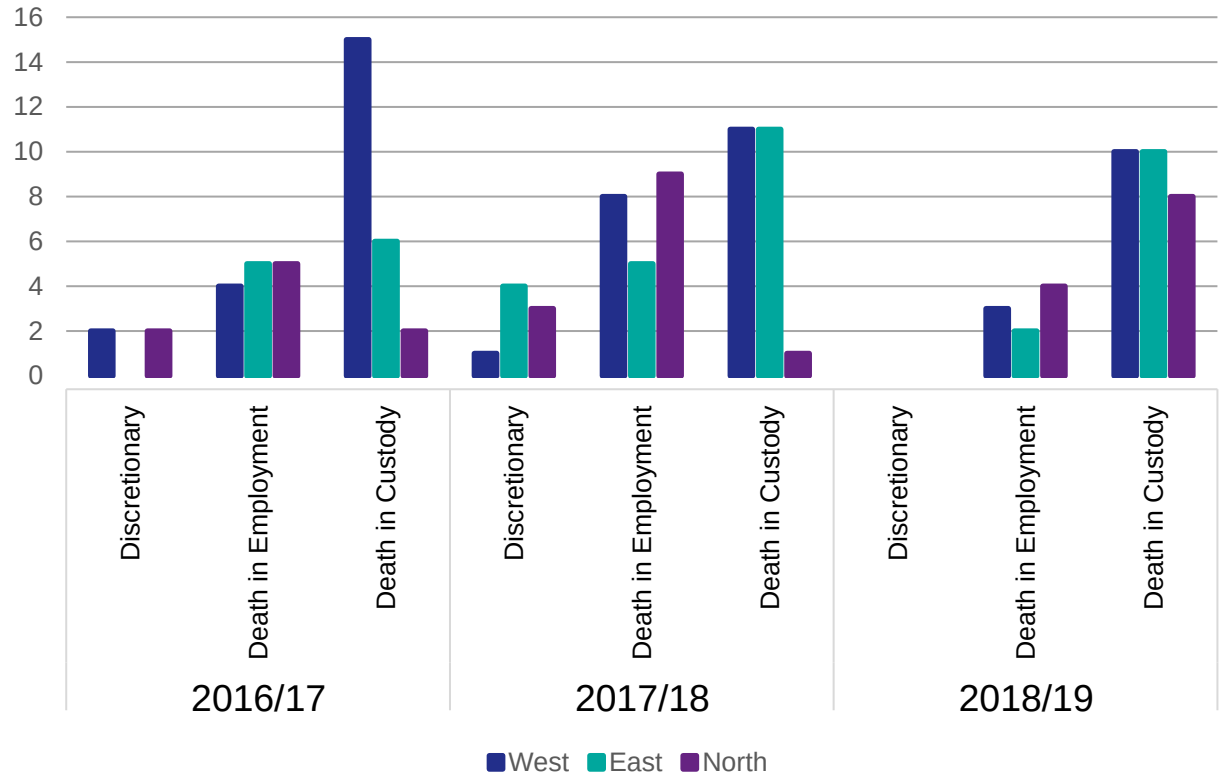
[31] Some FAIs may involve multiple deaths.
[32] Source: IPS FAI Thematic Report 2016 and the SFIU FAI spreadsheet as at 02/04/19 (based on 'Date of FAI').
[33] Source: SFIU spreadsheet as at 02/04/19 based on 'Date of FAI'.

Discretionary FAIs[34]

29. There were 12 discretionary FAIs over the same period.

30. Chart 6 provides a breakdown of the type of FAIs and by SFIU geographical teams.

Chart 6 –Type of FAIs and SFIU team 2016/17 to 2018/19[35]



[34] Source: SFIU spreadsheet as at 02/04/19 based on 'Date of FAI'.
[35] Source: SFIU as at spreadsheet 02/04/19 based on 'Date of FAI'.

CHAPTER 2 – PROCESSES AND PROCEDURES

Monitoring FAIs

31. All mandatory or discretionary FAIs or any complex deaths should be reported to SFIU National by the relevant geographical SFIU team dealing with the death investigation. This provides:

- An independent check on the progress of the case;
- An overview of timescales for completing investigations and holding FAIs; and
- An overview of the circumstances of all FAIs.

32. In the thematic report we found:

33. There were differing approaches to monitoring and reporting cases in the three geographical teams – they did not routinely inform SFIU National of mandatory FAIs or cases where a discretionary FAI was being considered until late in the investigation when a report was sent seeking Crown Counsel's instructions (CCI).

34. The six week target for reporting cases to SFIU was routinely not met by any of the SFIU teams often due to relevant information such as the post mortem report not being available.

35. There was no formal reconciliation of information held by SFIU teams and SFIU National.

36. Guidance on the investigation and reporting of deaths was out of date and often circulated by email which was of little assistance to new members of staff or where there had been a change in personnel.

We recommended:

1) SFIU National should introduce a streamlined reporting/notification process for FAIs.

2) SFIU should implement monthly reconciliations of all active deaths investigations between SFIU National and the SFIU Teams.

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

Action Taken

Recommendation 1

37. A streamlined process for reporting deaths to SFIU National was introduced in October 2018. The heads of the geographical teams are responsible for completing an abbreviated form (known as an eF1), replacing the more detailed first stage report, notifying SFIU of deaths where:

    - a mandatory FAI is required;
    - a discretionary FAI may be instructed; and
    - any death which is complex, unusual, high profile or may attract media attention.

38. If the case preparer wishes to seek guidance from SFIU National or Crown Counsel in relation to an ongoing investigation then s/he can report by way of the more detailed First Stage report.

39. The guidance issued states that the eF1 should be saved in the case directory and a copy sent to SFIU National electronically where they are recorded on a master spreadsheet.

40. The process provides for early intimation of mandatory/potential discretionary FAIs and more complex cases.

41. We found that such cases were being intimated to SFIU by emailing the eF1 form which was then entered onto a spreadsheet. However, contrary to the guidance the forms are not being saved in the electronic case directory and within the email account they are not categorised in a systematic manner; some have the procurator fiscal office reference number; others the name of the deceased; and others have no identifying characteristics in the subject heading of the email.

42. Historically death cases were not recorded electronically and we were advised that the culture in the SFIU teams is to save documentation in a shared drive in SFIU folders or in hard copy papers rather than in the electronic case directory. This reflects what we found in this review. It results in information relating to a death being retained in different places and in different formats making it difficult to have an overview of the investigation. It is also out of step with the way COPFS operates in all other areas of its business.

43. Within SFIU, there is an ongoing modernisation project with a number of work streams, headed by a senior legal manager. One work stream is to ensure that all documentation is recorded in the case directory. Where we did find evidence of some documentation being scanned into the case directory, it did not conform to standard naming conventions[36] making it difficult to identify what was there without opening all of the documents, a cumbersome process.

Status: In progress

[36] Naming documents in a structured manner.

Recommendation 2

44. All FAIs are recorded on a COPFS IT system known as the Management Information Book (MI Book) and, as discussed above, the heads of the SFIU geographical teams report all mandatory and potential discretionary FAIs through the eF1 process. A designated person within SFIU National undertakes a monthly reconciliation between those recorded on the MI Book and those reported by the eF1 process.

Status: Achieved

Recommendation 3

45. This is also being progressed as a work stream within the SFIU modernisation project. It aims to produce a one-stop-shop of guidance contained in a SFIU Manual of Practice.

46. It is anticipated that it should be completed by December 2019 following slippage of the initial target to complete the manual by April 2019.

Status: In Progress

New Recommendation

To provide a clear audit trail in each case the work stream to record all information in the case directory should be prioritised and documents should be recorded and named in a structured manner.

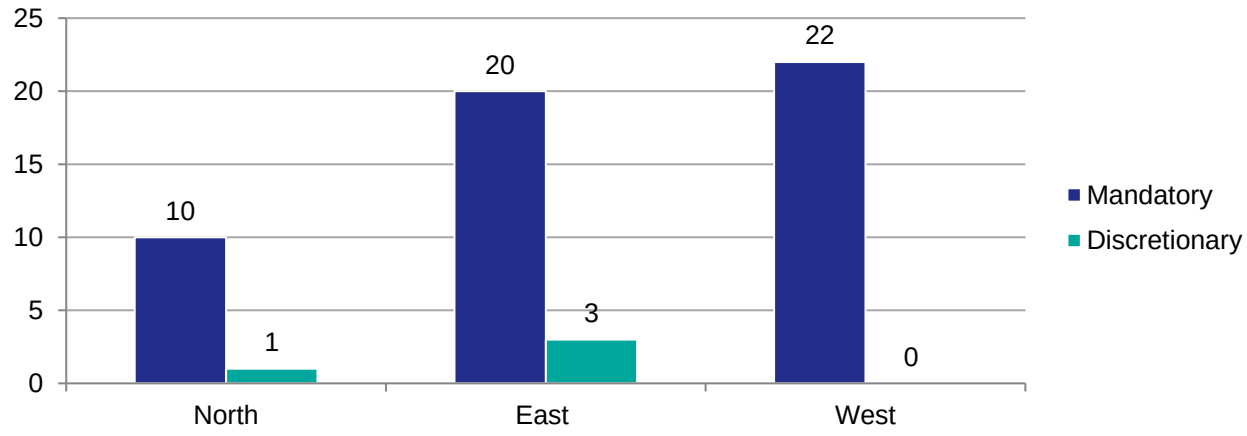
CHAPTER 3 – CASE REVIEW

Cohort

47. There were 131 FAIs concluded between 2016/17 and 2018/19.[37] We examined a statistically significant sample of 56 cases: 52 mandatory FAIs and four discretionary FAIs representing 44% of all mandatory FAIs and 33% of all discretionary FAIs. The sample included 33 mandatory cases relating to deaths while in legal custody and 19 relating to deaths while in employment.

48. Chart 7 provides a breakdown of the cases by type of FAI and SFIU teams.

Chart 7 – FAI Case Review



49. Table 1 illustrates the average number of working days that elapsed between the date of death to the date of the first notice[38] and to the start of the FAI.

[37] Source: SFIU spreadsheet as at 02/04/19 based on 'Deaths Closed' (119 mandatory and 12 discretionary cases).
[38] Prior to the 2016 Act, it was known as an application for an FAI.

Table 1 – Average Number of Working Days

	Date of death to date of First Notice	Date of death to FAI
All cases[39]	434	522
All, excluding cases with substantive criminal investigation[40]	403	481
Work-related deaths[41]	352	416
Deaths while in custody[42]	433	519
Discretionary cases[43]	614	763
HSD cases[44]	488	606
Cases with Experts[45]	631	759

50. 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. This reflects the tendency of such cases to involve more complex issues and, in some cases, reliance on external reporting agencies. Similar considerations apply to HSD cases. To provide a more representative timeline, we measured the time that elapsed from date of death to the first notice and the start of the FAI, excluding cases with a substantive criminal investigation and HSD cases. We also did a separate timeline for cases progressed solely by HSD and for cases involving expert reports/witnesses.

51. In comparison to the findings in the thematic review, all categories between the date of death to the FAI have decreased although the time between the death and the first notice has increased for both mandatory work-related deaths and deaths in custody.

52. As an organisation that seeks to deliver a sensitive, responsive, and thorough investigation, that meets public expectations, we advocated that COPFS must prioritise the investigation of deaths that may result in criminal proceedings or an FAI. We recommended that:

Recommendation 4

COPFS should introduce an internal target for progressing mandatory FAIs.

[39] 56 cases.
[40] 47 cases – nine cases were assessed as having a substantial criminal investigation. Of these five were progressed by HSD.
[41] 14 cases – three were excluded as they were progressed entirely by HSD.
[42] 30 cases – three cases were excluded as they had a substantive criminal investigation.
[43] 4 cases (three discretionary FAIs relate to the same incident).
[44] 7 cases – includes 5 cases where there was a substantive criminal investigation and two work-related cases.
[45] 18 cases.

Action Taken

Recommendation 4

53. COPFS introduced an internal KPI in September 2018 for all cases requiring further investigation, not concluded within the published target of 12 weeks, to be concluded or, if an FAI is required, to have the first notice lodged within 12 months.

54. The KPI was applied to all existing death investigations, including all mandatory FAIs, resulting in a proportion of cases that were already older than 12 months being included.

Status: Achieved

Compliance with the KPI

Case Review

55. 66% (37) of the 56 cases took longer than 12 months from the date of death to the date of the first notice. This includes 33 mandatory FAIs and all four discretionary FAIs. 12 of the 66% were entirely or partly investigated by HSD.

56. Of the 52 mandatory FAIs, only 37% (19 cases) had a first notice lodged within 12 months.[46]

57. On average the mandatory FAIs took 19.5 months from date of death to lodging the first notice and 23 months to the FAI.

58. On average the discretionary FAIs took two years 11 months from the date of death to the start of the FAI.

59. We examined the cases that took more than 12 months from the date of death to the date of the first notice. The six cases involving a mandatory FAI that had a substantive criminal investigation are discussed in Chapter 4.

[46] In seven cases where there was no record of the first notice, the date of when the advert was placed or intimation of the FAI was made to the nearest relatives was used.

Mandatory FAIs

60. We found delays were often due to a combination of factors of which the main contributory reasons were:

- Delays in allocating cases for investigation and/or re-allocating due to staff shortages, workload or staff leaving the team
- Lengthy periods of inactivity
- Delays in obtaining reports, information, documents or statements from reporting agencies and other agencies/investigatory bodies
- Time taken to obtain expert reports
- Late intimation of issues the nearest relatives wanted investigated and/or late involvement of interested parties in the FAI process

61. The contributory factors varied to some extent depending on which SFIU team had ownership of the case.

North Cases

62. Of the seven cases where there was delay:

63. With the exception of two cases, the delay was due to lengthy periods of inactivity. There was evidence that some cases were not progressed due to staff shortages and long term absences with one case only being progressed when it was transferred to the RTFIU. In one case it took ten months to receive the HSE report, although the procurator fiscal had been advised two months after the date of death that the HSE report was in draft form and nothing was done to chase up the report. In the remaining case it took seven months to receive the HSE report and a further seven months for the procurator fiscal to apply for the FAI.

West Cases

64. Of the **eight** cases where there was delay a more complex picture emerged:

65. In **four**, there were delays in allocating cases for investigation.

- **One** was then re-allocated causing significant delay.

66. Other contributory factors causing delays were:

- In **two** there was lengthy periods of inactivity with no obvious explanation, compounded in one by significant delays in obtaining additional information from the police and in the other by a period of six months to obtain the HSE report and a further period of four months to obtain an expert report.
- In **one**, although progress was made with the investigation, a late referral to PIRC to investigate one aspect delayed the application for an FAI. There were also a number of preliminary hearings to allow interested parties further time to prepare before the FAI commenced.

67. In **two** the delay was largely as a result of efforts to engage with nearest relatives and/or other interested parties and to ensure any concerns were investigated prior to the FAI commencing. Additionally, in one expert evidence had to be obtained and a PIRC investigation was also being conducted into associated matters.

68. In **one** the submission of the HSE report took one year, the procurator fiscal lodged the first notice seven months later and after a further three months the FAI commenced.

69. In **one** there was a significant period of inactivity following allocation of the case and it took a further five months to receive necessary expert reports.

East Cases

70. Of the **twelve** cases where there was delay we found:

71. In **seven**, re-allocation of the cases had fragmented and hampered progress in the investigation causing significant delays. Three had been re-allocated a number of times due to staff leaving the unit. Other contributing factors to delay in the seven cases were:

- In three there were lengthy periods of inactivity with evidence in two that this was due to staff shortages and/or workloads. These delays were also compounded by the time to request and/or receive expert reports, information from the police or other agencies and in one case by late intimation from the nearest relatives that they wanted to be represented at the FAI and were awaiting legal aid.
- In three there were significant delays in the police or other agencies providing additional information, documentation or statements requested. These delays were also compounded in two cases by the time taken to explore and obtain expert reports with evidence that it had not been possible to progress this more quickly due to workload. In the other case there had also been a delay in obtaining court dates for the preliminary hearing and a number of continued preliminary hearings were necessary before the FAI commenced.
- In one it took seven months for the HSE report to be submitted.

72. In **two** there were lengthy periods of inactivity. In one although there was a delay in the police providing a statement, due to difficulties in tracing a witness, significant time had elapsed between the original request and it being chased up. There was evidence that this had been due to staff shortages in the team.

73. In **one** the investigation lacked focus and a large amount of time was spent investigating medical matters where no concerns had been raised and with no foundation based on the expert report that had been obtained.

74. In **one** there were difficulties obtaining a statement from an essential witness and delays due to instructing additional inquiries to address concerns raised by the nearest relatives. A number of preliminary hearings were also necessary before the FAI commenced.

75. In **one** a delay in the initial allocation of the case followed by a period of inactivity were the main causes of delay compounded by the time taken for the police to provide necessary documentation.

Discretionary FAIs

76. On average the discretionary FAIs took approximately two years and nine months between the date of death to the start of the FAI.

77. There were four discretionary FAIs but one was held for the death of three spectators at the Jim Clark Rally in May 2014 which was conjoined with the death of another spectator that occurred in a motor rally in Skye. Prior to the FAI there had been a thorough investigation to ascertain if criminal proceedings were appropriate. Two expert reports had been obtained by the Crown. Following the decision not to commence criminal proceedings in April 2016, an FAI was instructed in November 2016. While there was a delay in making the application for the FAI, the sheriff highlighted a number of procedural issues that had to be resolved before the FAI could commence, including the fact that until there was a legislative change in 2016, it was not competent for a single sheriff court to deal with deaths which had occurred in different jurisdictions. The legislative change made it possible for the Crown to seek to hold the Inquiry in relation to the deaths occurring in the Highland and Borders regions in a single court. While the two accidents were separate and unconnected, there was the common feature that deaths of spectators had occurred in the course of an organised motor sport event of the same general character. As these events were closely connected in time, and because there had been only two (2006 and 2009) similar events in the recent past anywhere in the UK, it was understandably felt that there was a public interest for there to be formal consideration of issues of safety at motorsport events of that nature.

78. The first notice was lodged in December 2016 and there were a number of continued preliminary hearings before the FAI commenced in July 2017. There were eight interested parties that participated in the inquiry and over 100 witnesses gave evidence. During the inquiry there was an adjournment to allow an expert witness to consider the evidence that had been led. It concluded on 28 September 2017 with the determination being issued on 20 November 2017. It made a number of recommendations designed to improve the safety at such events.

79. The other discretionary inquiry concerned the death of a young man who had, prior to his demise, sought medical assistance and who had discharged himself from a specialist mental health clinic. A period of two years and three months elapsed from the date of death to the commencement of the FAI. SFIU received a psychiatric expert report on the care that the deceased had received at the clinic within six weeks. It was provided to the relevant Health Board for comment, to obtain an update on any actions taken to address any of the concerns raised and for the outcome of their internal review. It took over four months to receive the internal report from the NHS, contributing to the overall delay of 15 months from receipt of the initial expert report to Crown Counsel's final instructions.

80. Discretionary inquiries tend to involve more complex issues, requiring expert reports to be commissioned.

Impact of Delays

81. 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 distress of the nearest relatives;
- Public confidence; and
- The quality of the evidence and delays in implementing any recommendations felt necessary in light of the conclusions of the inquiry and, in some cases, the purpose of the FAI.

82. In contrast to criminal proceedings, there are no statutory legal time limits governing FAIs. In response to calls for time limits to be introduced during the passage of the Fatal Accidents and Sudden Deaths Bill, COPFS gave a commitment to introduce a Family Liaison Charter setting out information to be made available to families and timescales for the giving of information. The Act introduced a requirement for the Lord Advocate to prepare and publish a family liaison charter.[47]

83. While acknowledging that deaths investigations must be thorough, they must also be completed as promptly as possible. While some investigations are complex, often requiring expert evidence, and some involve a criminal investigation making compliance with the KPI difficult, there are many that are relatively straightforward. It is therefore disappointing that more cases in our review did not have a first notice lodged within 12 months.

84. In criminal cases, COPFS must commence a trial within 12 months of an accused person appearing at court and within 140 days if remanded. In the vast majority of cases COPFS investigates and prosecutes such cases within these timescales, including Health and Safety offences, historical institutional sexual crimes, homicides and complex frauds. If such cases can be progressed within these tight timescales, excluding cases where there is an extensive criminal investigation, there is no reason, other than resources as evidenced at paragraphs 63 and 71 above, that FAIs cannot be completed within similar timescales.

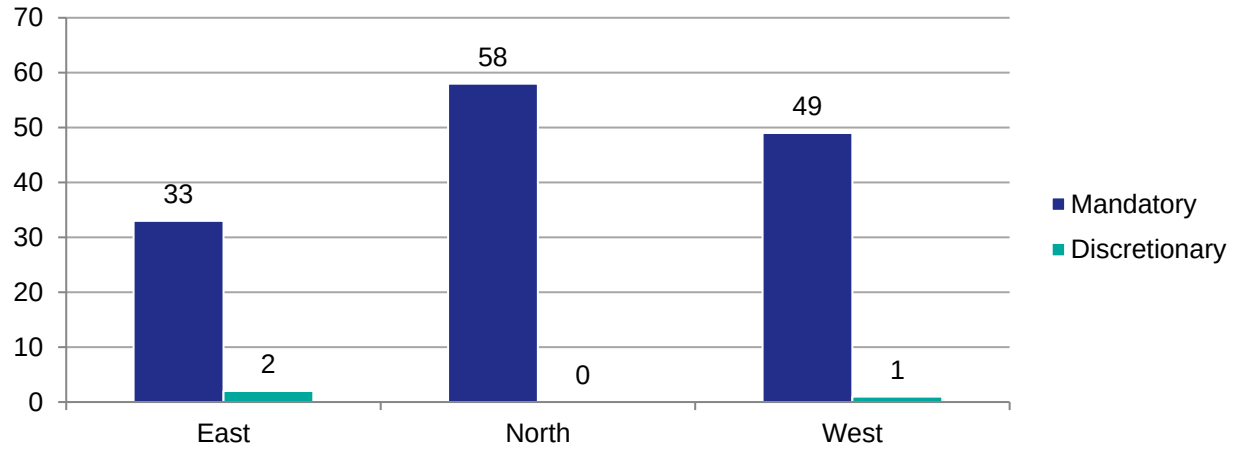
[47] Section 8 of 2016 Act.

Current COPFS FAI Workload

85. There are currently 143 cases where an FAI has been instructed but not concluded.[48] 140 mandatory FAIs; 51% (71) relating to a death while in custody; 49% (69) relating to a death while in employment and three discretionary FAIs.

86. Chart 8 provides a breakdown of current FAIs by type and SFIU team.

Chart 8 – Outstanding FAIs

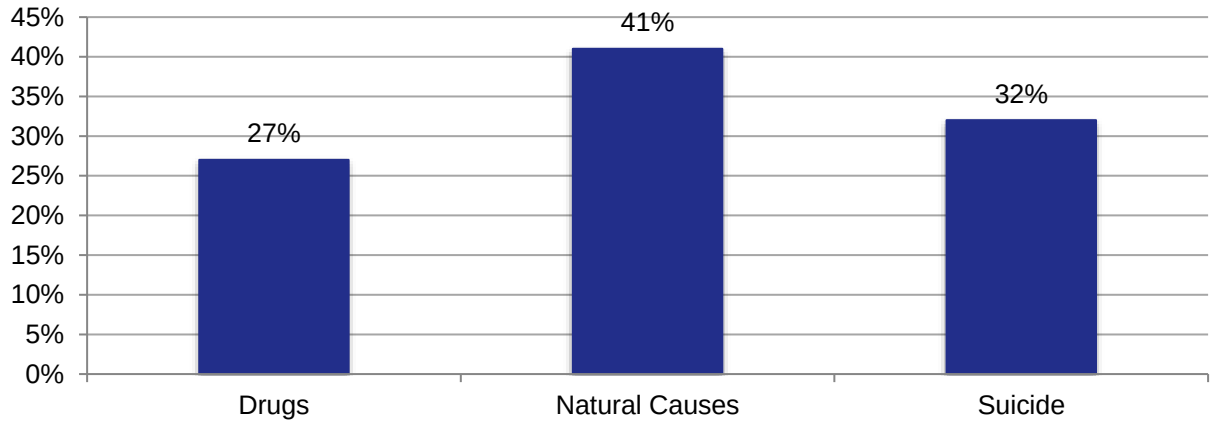


87. Of the 71 deaths in custody, 65 (92%) occurred in prison and six (8%) in police custody.

88. 68 were male and three were female.

89. Chart 9 provides a breakdown of the recorded cause of the death of those in prison or HMYOI.

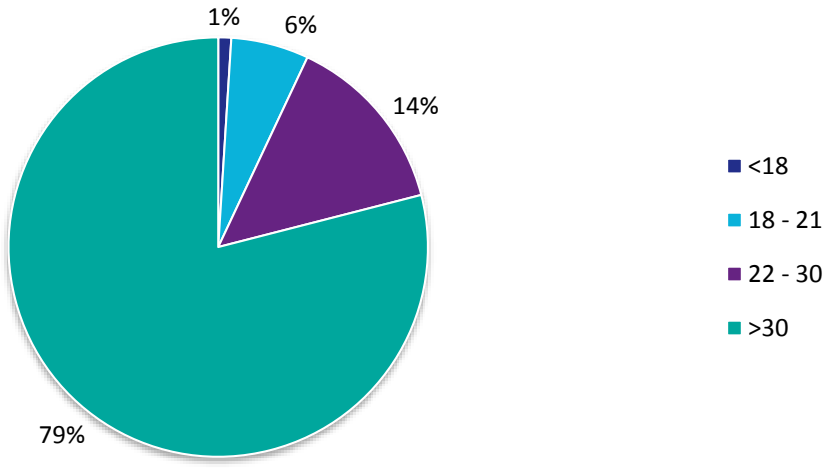
Chart 9 – Deaths in Custody[49]



90. Chart 10 provides a breakdown by age of the 71 deaths in custody.

[48] Source: MI Book as at 30/04/19.
[49] As categorised by SFIU.

Chart 10 – Age profile of deaths in custody



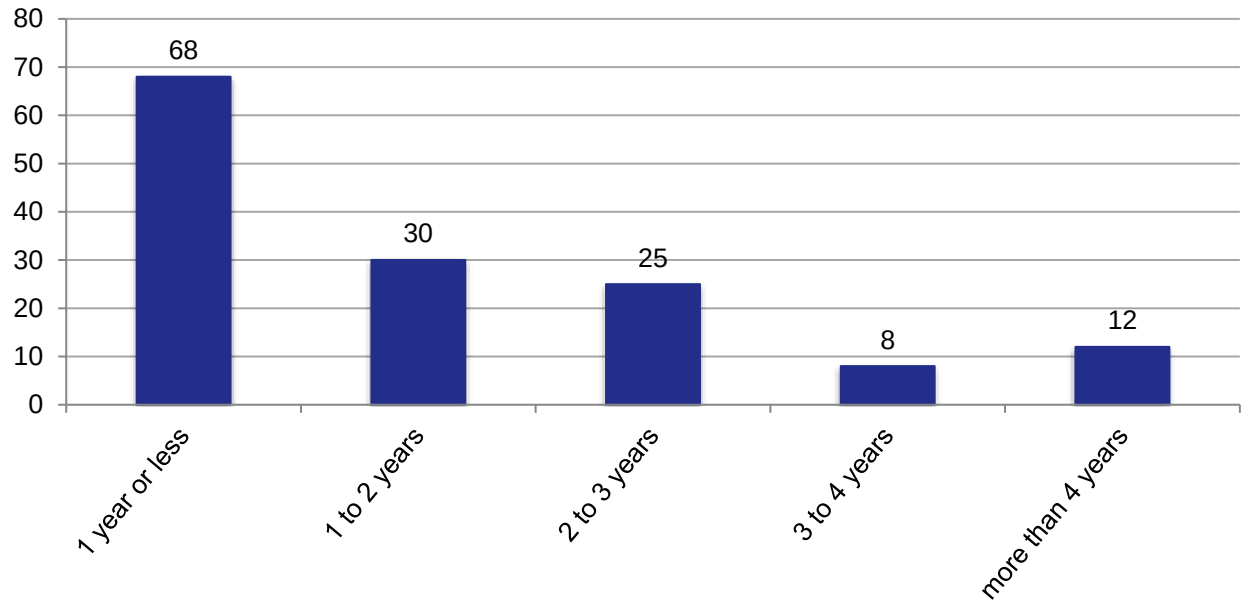
91. There was one (1%) death of a person aged under 18, four (6%) were aged between 18 and 21, 10 (14%) between 22 and 30 and 56 (79%) were over 30 years of age.

92. Of the 23 suicides in prison, four were under 21 years of age.

Age profile of all outstanding FAIs[50]

93. Currently there are 52% (75) of all outstanding FAIs (143) older than 12 months; 30 are older than a year; 25 are older than two years; eight are older than three years; and 12 are still ongoing after four years.[51] 12 have dates for a preliminary hearing and the FAI.[52]

Chart 11 – Age profile of all outstanding FAIs



[50] Source: MI Book as at 30/04/2019.
[51] Eight deaths relate to one incident.
[52] As at 12/06/19.

94. The age profile of outstanding FAIs remains a concern. Failing to deal with FAIs expeditiously not only impacts on the nearest relatives, it causes distress and concern for potential witnesses including prison and police officers who may have to give evidence at the FAI.

95. Lengthy delays also have the potential to devalue the purpose of the FAI. In many cases, by the time the FAI is held, measures recommended by other inquiries/reviews have been implemented. While it is proper to consider whether any immediate measures are required to prevent deaths in similar circumstances, the FAI is the primary vehicle to examine the circumstances and make recommendations but to do so the timelines require to be significantly improved.

96. Given the greater scrutiny of the circumstances of deaths, the low number of discretionary FAIs is surprising. Discretionary FAIs have historically played an important role in driving up standards of safety in a number of forums, including football matches, medical care and in professions such as diving and dentistry.

Modernisation Project

97. We heard that the failure to progress FAIs is partly due to procurator fiscals having to deal with newly reported deaths while carrying an FAI workload. Inevitably priority is given to dealing with the newly reported deaths; discussing the cause of death with GPs; liaising with nearest relatives and instructing post mortems and other initial inquiries. We were advised that available time to progress FAIs is estimated to be 40% for a full time depute and 20% for a part time depute.

98. The manager of the modernisation project has recently ring-fenced two procurators fiscal in SFIU North to deal solely with some of the older FAIs. This has reaped positive results with an increase in FAIs being concluded. Given the criticism of the lack of progress to deal with FAIs timeously, it is somewhat surprising that a dedicated resource to conduct FAIs has not been introduced earlier. Such an approach mirrors the move towards greater specialisation that COPFS has employed in other areas such as sexual offices, homicides and health and safety cases.

99. We support the move to have a dedicated FAI team to deal with the delays. Procurators fiscal within the team should rotate to maintain expertise on all areas of deaths investigations.

100. As part of the modernisation project work is ongoing to develop an electronic “pathway document” designed to record key milestones and the progress of the case in one place. It also seeks to focus more on obtaining all relevant documentation and statements at an early stage of the investigation and, in particular, to agree a Memorandum of Understanding (MoU) with the Scottish Prison Service (SPS) and National Health Service (NHS) on the type of information that they require to provide as a matter of routine, including medical records, risk assessments etc following any death in custody to expedite the investigation. This would address one of the factors identified as causing delays in our case review.

101. The timetable for the modernisation project has slipped but it is anticipated that most work streams should be completed by the end of this year.

Resourcing

102. In August 2018, COPFS received a significant increase in funding to allow for the recruitment of up to 140 additional permanent members of staff. One of the priorities for the additional resource was to shorten the time taken to conclude deaths investigations. SFIU was allocated a number of additional staff ranging across the grades. While there has been a 23% increase in the staffing complement from April 2018 to April 2019, there is still a shortfall of eight members of staff including four procurators fiscal.[53] When in place the SFIU complement will have increased by 42%. Clearly, it takes time to induct and train new staff and factors such as staff leaving or absences due to maternity leave or illness impact on staff complements but, given the age profile of outstanding FAIs, fulfilling the SFIU complement requires to be addressed as a priority.

[53] As at 04/07/19.

CHAPTER 4 – CRIMINAL PROCEEDINGS

103. 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

104. There were nine cases in our review where there was a substantive criminal investigation followed by an FAI. Only one resulted in a prosecution.

105. Five were investigated by the Health and Safety Division (HSD) including three deaths that arose from the same incident, one was investigated by RTFIU and one by the homicide team. Of the two remaining cases, in one there was an initial investigation by PIRC and in the other there was an initial investigation by HSD prior to it transferring to SFIU.

106. As discussed at paragraph 77, a discretionary FAI was held for the death of three spectators at the Jim Clark Rally in May 2014. A mandatory FAI was held for the other six cases; three related to deaths in employment and three to deaths in custody.

107. Of the mandatory FAI cases investigated by HSD:

- In one a year elapsed prior to the HSE report being received. The case was then re-allocated on two occasions with the FAI eventually taking place two years and eight months later.
- In another there was a 10 month investigation following receipt of the HSE report and a further six months elapsed before the FAI.
- In another, involving extensive investigation into SPS procedures there was a four and a half year delay between the death and the FAI. While there was an initial delay receiving the HSE report, it was compounded by a failure to progress the case from April 2016 to March 2018. The sheriff was critical of the delay in the determination.

108. In the remaining three cases:

- In one the initial PIRC investigation took five months. Thereafter there was a period of 13 months of inactivity before the case was allocated and progressed.
- In one following a seven month investigation by RTFIU, it was transferred back to SFIU. The first notice was lodged just over 10 months later.
- In the case that resulted in a prosecution (see case study below) the accused was convicted of murder and sentenced in November 2014. There was a six month gap before the death investigation was allocated and another year before the first notice was lodged (18 months after the prosecution had concluded). Evidence

was provided on 16 days over four months. The sheriff's determination was published 42 months after the death.

109. The FAI legislation provides that the Lord Advocate can exercise discretion not to hold a mandatory FAI, if the circumstances have been sufficiently established during the criminal proceedings.[54] 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 and to allay public fears as demonstrated in the case study below.

> Following a prosecution and conviction for the murder of a prisoner by his cell mate Crown Counsel instructed that an FAI should still be held to consider issues of wider public concern. The focus of the FAI was to explore risk assessments regarding cell sharing that were carried out by the Scottish Prison Service and, in particular, to consider whether it was appropriate and reasonable to co-locate the deceased with his cell mate and the system of recording previous events in a prisoner's record.
>
> The Sheriff found that the death may have been prevented if a bullying marker had been added to the Risks and Conditions record of the cell mate relating to a previous assault and that there was a system defect arising from the lack of adequate guidance on training for SPS staff on the recording of entries within Risks and Conditions records.
>
> While there was evidence that measures had been put in place to remedy the defects found, the Sheriff recommended that SPS commence a proposed review of the system of risks and conditions and give effect to any recommendations arising from that review.

110. In our review, the nine cases with a substantive criminal investigation took on average two years and eight months (734 workdays) compared to one year and eight months (481 workdays) for all cases. Where there is a criminal prosecution before an FAI, it is inevitable that the FAI proceedings will take longer than 12 months to commence. It is also likely that cases where there is a substantive criminal investigation prior to an FAI will take longer to conclude as there are, in effect, two investigations. The over-riding priority is for COPFS to conduct a thorough investigation where criminal proceedings are in contemplation.

[54] Section 3(1) of the 2016 Act.

Liaison between SFIU and Criminal Investigators

111. Following the conclusion of a criminal trial, if there is to be an FAI, the case is transferred to SFIU. In the thematic report we noted that there was considerable scope for more effective liaison between those involved in the criminal investigation and SFIU. To improve the transition between the criminal investigation and those preparing FAIs, we made the following recommendations:

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.

Recommendations 5 and 6

Action Taken

112. A pro forma document to be completed by the homicide team at the conclusion of their investigation, advising of the circumstances of the death, any Crown Counsel Instructions (CCI), any relevant documentation/discussions and a record of the liaison with the nearest relatives, has been agreed with SFIU. It contains a section to record any CCI on whether there should be an FAI if there are no criminal proceedings. If there is no instruction, it flags up the need for SFIU to seek an early instruction.

113. Similar pro forma handover templates are currently being progressed with RTFIU and HSD.

114. In the three discretionary cases in our case review, where there was a substantive criminal inquiry relating to the deaths at the Jim Clark rally, we noted that there was early intimation by Crown Counsel that an inquiry would be held if there were no criminal proceedings.

115. Reminders have been issued to SFIU staff to ensure that all operational emails and documents are entered into the case directory. Given our earlier observations regarding the lack of eF1 forms and other information being imported into the case directory, it appears there is still some way to go before there is a full electronic record in death cases.

Status: In progress

CHAPTER 5 – EXPERT EVIDENCE

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

Case Review

117. Expert reports were commissioned by COPFS for the purpose of an FAI in 19 of the 56 cases. In six of the 19 cases, expert reports were also commissioned by interested parties.[55] Experts were instructed by COPFS in 15 mandatory FAIs and in all four discretionary FAIs. The main types of experts were those with expertise of prison systems and procedures, medical and forensic psychiatrists.

118. 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.

119. FAIs involving experts took, on average, two years and four months (631 days) from the date of death to the first notice, and two years and nine months (759 days) to the FAI.

120. Of the 19 cases where COPFS instructed an expert, we found nine cases where this contributed to the timeline of the investigation. In six cases, COPFS instructed experts and in three cases, COPFS and interested parties instructed experts.

121. In the **nine** cases where instructing an expert contributed to delays, we found:

- In **two** cases it took six months from allocation to identify and instruct an expert and then a further five months in one and 11 months in another to receive the reports;
- In **one** case nine months elapsed from the date of allocation to an expert being instructed and a further five months for COPFS to receive the report;
- In **one** case, a year elapsed from allocation before an expert was instructed and a further four months before the report was received;
- In **two** cases at a late stage in the investigation, following judicial comments, a different expert with more in-depth experience of working within a prison environment was instructed. In one the second expert was instructed three years and one month after the date of death and in the other it was four years and two months;
- In **three** cases two experts were instructed one year and three months after the date of death and the reports took five months and six months to be received.

122. Whilst the need to obtain expert reports has the potential to add delay to an investigation, in the majority of cases involving experts, it was not a significant factor.

[55] Including nearest relatives, employers in two instances, a manufacturer, and DVLA.

Death Certification Review Service

123. 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 often meets with nearest relatives to assist their understanding of the cause of the death.

124. In the thematic report, we referred to the establishment of the Death Certification Review Service (DCRS) run by Healthcare Improvement Scotland (HIS), to provide independent checks on the quality and accuracy of Medical Certificates of Cause of Death (MCCD). The DCRS team has a number of reviewers who are all experienced medical practitioners.

125. We advocated that:

> ### Recommendation 7
>
> 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 7

Action Taken

126. COPFS has explored the possibility of the DCRS providing a consultative forum to discuss medical cases. While the DCRS has not entered into a formal agreement with COPFS, there is ongoing informal discussion, where appropriate, and they have taken referrals from GPs signposted by SFIU.

Status: Achieved

Agreement of Expert Evidence

127. Complex cases involving a number of specialities can result in a plethora of experts being instructed with differing and opposing views. This often results in the proceedings becoming more adversarial.

128. To mitigate this trend, we commended 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 is consistent with the fact finding “inquisitorial” purpose of an FAI. We recommended:

> ### Recommendation 8
>
> 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 8

Action Taken

129. The 2017 FAI rules[56] introduced provisions designed to encourage agreement of experts and focus the inquiry on areas of contention. These include:

- The sheriff may order information to be presented on a particular matter by a single expert witness. In such circumstances, participants must make reasonable effort to agree joint instructions for the expert witness.

- In proceedings with more than one expert, the sheriff can order the expert to provide a witness statement or a video recording of their evidence. Within 14 days of the video or statement being lodged, the other participants may lodge a set of questions that can be put to the expert witness. The sheriff may approve the set of questions, with appropriate modifications, and order answers to be lodged by a particular date.

- The sheriff can order expert witnesses to present information concurrently. If so, the participants must jointly prepare and lodge a note for the sheriff, setting out the areas of agreement and disagreement at least seven days before the start of the inquiry. At the hearing all expert witnesses will present information at the same time; the sheriff may direct how the information is to be presented by the expert witnesses, including the sheriff questioning the witnesses directly; inviting the witnesses to discuss a particular matter between them; or allowing questioning by participants where necessary.

Status: Superseded by the FAI rules

[56] Act of Sederunt (Fatal Accident Inquiries Rules) 2017, Part 4 Expert Witnesses.

CHAPTER 6 – COMMUNICATION WITH NEAREST RELATIVES AND INTERESTED PARTIES

Liaison with Bereaved Relatives

130. The impact of a loved one's death is traumatic and personal and the reaction of nearest relatives can vary widely. Family dynamics can be complex with different reactions from different family members; some may wish to be represented at any inquiry and others may wish privacy and choose not to engage with the procurator fiscal and want no involvement with the FAI. To retain confidence in the investigation and any subsequent FAI, communication must be timely, clear, consistent, empathetic and tailored to the bereaved relatives' needs.

Victim Information and Advice (VIA)

131. 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. At the time of our thematic review, SFIU West and HSD had a dedicated VIA Officer. 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.

132. While recognising the fluidity of staff and unpredictable absences may inevitably result in changes of personnel, given the relatively low number of FAIs, we recommended:

Recommendation 9

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

133. We also reported that, in most cases, there was no handover meeting with the nearest relatives by the procurator fiscal dealing with the criminal case and SFIU and that there was a lack of continuity of support for nearest relatives.

134. 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. Placing bereaved relatives' needs at the heart of the process, we recommended:

Recommendation 10

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

Recommendations 9 and 10

Action Taken

135. All of the geographical SFIU teams now have a dedicated VIA resource. From 23 April 2019, VIA is the point of contact for all new discretionary and mandatory FAIs. For continuity purposes, in some of the older cases, the person who has primarily dealt with the case and the nearest relatives will retain contact, with in some cases, additional support from VIA.

136. Having a VIA presence in each team provides a dedicated VIA resource throughout any criminal and FAI proceedings.

Status: Achieved

Family Liaison Charter

137. The Family Liaison Charter (the Charter) applies to any death reported or any FAI applied for on or after 1 September 2016. It sets out: how and when initial contact will be made with the nearest relatives; 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 is to be provided in a manner agreed by the nearest relatives and COPFS at the outset. Where a personal meeting takes place or 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.

138. A process map of the commitments at the various stages is provided at **Annex B**.

Case Review

139. In every case reported after 1 September 2016 a template, containing the various commitments of the charter, is added to the case directory. At the top of the template there is a section to record the manner and frequency of contact wished by the nearest relatives. There were 15 cases in our review where the death occurred after 1 September and the charter should have been applied from the outset. We examined the 15 cases to ascertain if there was compliance with the obligations set out in the charter.

Communication

140. We found that:

141. In all 15 cases there was a point of contact for the relatives whether it was VIA or a procurator fiscal dealing with the case or in some instances a combination of both.

Initial Report and Post Mortem

142. Following receipt of a death report, the nearest relative should be advised:

- if there is a post mortem
- the cause of death and any amended cause of death and
- if the results of the post mortem will take more than 12 weeks.

143. In all 15 cases, the nearest relatives were advised if there was to be a post mortem, the cause and any amended cause of deaths and if the results of the post mortem were not expected within 12 weeks.

Further Investigations

144. Where further investigation is necessary, whether by the police or another reporting agency, the procurator fiscal should:

- Contact the family no later than 12 weeks after the death has been reported, to inform them of progress made and likely timescales for the investigation. A personal meeting will be offered at this time which will take place within fourteen days unless the family indicate they do not wish a personal meeting.
- Contact the family every six weeks to advise of the progress of the investigation and ascertain if they wish a personal meeting or in accordance with their needs and wishes.
- Contact the family at any stage where there is a significant development in the investigation, unless this would be likely to prejudice any potential prosecution. A personal meeting will be offered unless the family have already indicated they do not wish to attend personal meetings.

145. The difficulty in assessing compliance with this part of the charter is that in the majority of cases the relevant section at the top of the template recording the family's wishes on the type and frequency of contact was not completed. In some cases, the information was contained in the body of the template; in others there was an entry on an administration screen on the COPFS IT system and in some there was no record.

146. Of the 15 cases:

147. There was regular six weekly contact and at times of any significant development or in accordance with the specified wishes of the family in nine cases.

148. In four cases, there was no contact over a prolonged period – in one case five months and in three more than a year.

149. In two cases, there was no record of a meeting being offered to the nearest relatives. In one the initial letter had a link to the charter and within it a reference to being entitled to a meeting but this is only evident if the relative opens the link and reads the charter. To comply with the requirements of the charter the offer of a meeting should be explicitly stated in the letter advising of further inquiries or recorded in the template if discussed by telephone.

FAI

150. COPFS should:

- Inform the bereaved family when a report is to be submitted for Crown Counsel's instructions on whether or not there should be an FAI and to take into account their views in reaching a decision and in how we communicate that decision.
- Inform the bereaved family of Crown Counsel's decision on whether or not there should be an FAI in relation to the death within fourteen days of this decision being made.
- Offer a meeting if Crown Counsel decides that there should not be an FAI to explain the reasons for this decision. These reasons will also be confirmed in writing unless the family have indicated they do not wish to be provided with these.
- Explain what happens if Crown Counsel decide that an FAI should be held and meet with the family to discuss this process if the family wishes.

151. We found that the obligations at this stage were complied with in all cases.

Conclusion of Court Proceedings

152. COPFS should:

- Offer to meet with the bereaved family at the conclusion of any criminal proceedings or FAI and after the determination has been issued to explain the outcome and to discuss any issues arising.

153. We found that the obligations at this stage were complied with in all cases.

> **New Recommendation**
>
> In order to assess compliance with the Family Liaison Charter a record of the wishes of the family should be recorded on the charter template.

154. This would provide a record of the nearest relatives' preferences where contact has to be made with the bereaved relatives by another person where there are staff absences due to illness or leave.

Nearest Relatives and Interested Parties

155. In our thematic review 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 that were not relevant to establishing the circumstances and cause of the death. To assist nearest relatives families, grieving following the sudden death of a loved one, we recommended:

Recommendation 11

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

Recommendation 11

Action Taken

156. This recommendation was superseded by the 2017 FAI rules that specify the type information that must be provided in the first notice.[57] It includes:

- A brief account of the circumstances of the death, so far as known to the procurator fiscal;
- The identity of the deceased;
- Any issues identified by the procurator fiscal which it is anticipated the inquiry should address;
- Whether the procurator fiscal considers that a preliminary hearing is unnecessary and, if so, the reasons for that view;
- The type of inquiry – mandatory or discretionary and if mandatory, the category of mandatory inquiry; and
- The identity of any person who the procurator fiscal considers might have an interest in the inquiry.

Status: Superseded by FAI Rules

[57] Rule 3.1.

CHAPTER 7 – ROLE OF OTHER REGULATORY AND INVESTIGATIVE BODIES

157. There is a wide range of other organisations and agencies that have a duty to investigate certain types of deaths including Healthcare Improvement Scotland (HIS),[58] the Mental Welfare Commission for Scotland,[59] the Care Inspectorate,[60] Local Authorities,[61] Child Protection Committees and the SPS. In many cases, the death will also be reported to the procurator fiscal. Whilst the nature and extent of such investigations vary, the common objective is 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.

Primacy of Investigation

158. In the thematic report we reported that organisations who have responsibility to investigate certain types of deaths would welcome greater clarity on whether it is appropriate to carry out internal investigations where criminal proceedings and/or an FAI are in contemplation. Many advised that internal investigation was often put on hold until the conclusion of any criminal investigation and proceedings. Conversely we found that SFIU often delays progressing FAIs to await the outcome of internal investigations.

159. The need to ensure that evidence in criminal proceedings is not prejudiced 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.

160. To provide reassurance and clarity to other investigative agencies on the roles and responsibility of each agency, the primacy of investigations and likely timescales, we recommended:

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.

[58] Healthcare Improvement Scotland has an active role in reviewing deaths from suicide and promoting any lessons learned across the NHS.
[59] 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.
[60] 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.
[61] Local authorities have systems in place to review some deaths, through a critical incident review or multi-agency review type process.

Recommendation 12

Action Taken

161. While there has been some preliminary discussion with some agencies, no MoUs have yet been agreed.

Status: Not achieved.

CHAPTER 8 – DEATHS OF YOUNG PEOPLE IN CUSTODY

162. Following the tragic deaths of two young people in custody at HMYOI Polmont in 2018, the Cabinet Secretary for Justice commissioned an independent expert review of mental health and well-being services for young people in custody. The review was conducted by HM Chief Inspector of Prisons and published in May 2019.[62] An action group, including relevant officials from across the Scottish Government, SPS and NHS, has been established to oversee progress across the recommendations.

163. In addition, we were asked to consider, as part of the follow-up report on FAIs, the merits of prioritising the investigation following the death in custody of a young person and, where appropriate, to establish whether there is scope within the current system to prioritise this category of case.

164. We identified eight cases over the last five years involving the death of a young person – aged under 21 years – while in custody. There are four cases where a mandatory FAI has still to be conducted and four cases where a mandatory FAI has been concluded, two of which fell within our case review sample.

165. In seven, the young person had or appears to have committed suicide. The other death involved apparent drug intoxication and occurred whilst in police custody. No standard prosecution report (SPR) was submitted to COPFS. The circumstances are very different to the other deaths which all occurred in prison or in a HMYOI and where a SPR had been submitted.

Why the Young People were in Custody

166. Three of the seven young people reported to COPFS were on remand at the time of their death, the remaining four were either serving a sentence or were awaiting sentence having pled guilty.

167. Four had been prosecuted under solemn procedure and three under summary procedure. The offences for two of those prosecuted under summary procedure involved the use of weapons.

[62] HMIPS, Report on an expert review of the provision of mental health services, for young people entering and in custody at HMP YOI Polmont, May 2019.

Provision of Information

168. In six of the seven cases it was clear from the subsequent death report that the young person had vulnerabilities either due to Adverse Childhood Experiences (ACEs),[63] family background or a history of mental health difficulties and/or self-harming. All six had been a looked after child at some time and for five there was a documented history of mental health problems. In the remaining case such vulnerabilities were not evident. Despite this, only one SPR submitted by the police provided information relating to the family background, ACEs and vulnerabilities of the young person.

169. Of note, in one case involving an extremely vulnerable young person who had an extensive history of self-harming and involvement with mental health services, although there was no such background information provided in the SPR, an earlier SPR had contained this information indicating a lack of consistency in the information provided by the police.

170. The lack of information accords with our findings in the thematic report on the Prosecution of Young People[64] where we recommended that COPFS should liaise with Police Scotland to standardise the provision of information on any known vulnerabilities or family circumstances that may have a bearing on the appropriate prosecutorial action. In addition to informing the appropriate action in each case, as an officer of the court, the procurator fiscal has a responsibility to make the court and prison authorities aware of any known vulnerabilities for risk assessment purposes.

Delay/Time taken

171. We examined the time taken in the eight cases.

172. In the four cases where an FAI was concluded the average time between date of death and the first notice was two years and four months and between date of death and the FAI two years and nine months.

173. All four took longer than 12 months from date of death to lodging the first notice. We examined these cases to ascertain the reasons for the time taken:

- In one there were significant delays in the police or other agencies providing additional information, documentation or statements requested. This was compounded by time taken to explore and obtain expert reports. There was evidence it had not been possible to progress this case more quickly due to workload.
- In one there were difficulties obtaining a statement from an essential witness and delays in instructing additional inquires to address concerns raised by nearest relatives. A number of preliminary hearings were also necessary before the FAI commenced.

[63] The 10 most commonly measured Adverse Childhood Experiences (ACEs)**; Abuse** – physical, verbal and sexual, **Household Adversities –** mental illness, incarcerated relative, domestic violence, parental separation, substance abuse, **Neglect –** physical and emotional.
[64] IPS, Thematic report on the prosecution of young people in the Sheriff and Justice of Peace courts, 27 November 2018.

- In one there was significant delay obtaining the necessary statements by the procurator fiscal. Thereafter extensive and legitimate investigations had to be conducted into an allegation, subsequently established to be unfounded, that prison officers had conducted an inappropriate interview with the young person prior to his death.
- In one a period of time was taken to consider whether it was appropriate to conjoin the FAI with the death of another young person that were closely connected in time although ultimately it was determined that the circumstances were too different.

174. In three cases the FAI has yet to commence although in one dates have been identified. The average time between the date of death to the present date[65] for each case is 14 months, 10 months and two years and six months. In the remaining case which involved apparent drug intoxication, the time between the date of death to present date[66] is just over five years.

175. We have found that SFIU teams often delay commencing the FAI until all other inquiries undertaken by SPS and other bodies are completed resulting in delays between the death and the FAI. Whilst it is paramount that investigations into such deaths are thorough they should also be concluded as expeditiously as possible. Where there is a long delay the FAI is often advised that measures specific to the circumstances of the death have been implemented, resulting in few recommendations. Such an approach risks devaluing the purpose of the FAI and has been criticised by the judiciary. In relation to an inquiry where over four and a half years had elapsed since the death, the sheriff stated:

> "The effectiveness of holding an inquiry must be questioned, evidenced in this case where no recommendations are made, not because there were no defects or precautions that could have been taken, but because necessary changes have already been made by those involved. This does not even begin to take into account the distress which in many cases will be occasioned to families in re-opening the circumstances around the painful loss of a loved one so long after the event."[67]

176. The FAI should be the primary forum to explore the circumstances of the death, while it is fresh in the minds of all those involved, and not a vehicle to summarise outcomes of other reports.

177. Provisions introduced by the 2016 Act provides that any recommendations directed to a person or body or organisation have to respond to advise what action they are taking or provide reasons where they are not taking action, providing an element of accountability.

178. With that in mind it is essential that SFIU ensures such deaths are investigated both thoroughly and expeditiously to reduce the likelihood of similar deaths recurring and applies a holistic approach when considering the merits of conjoining inquiries where similar themes are identified. While there may be subtle differences in issues/circumstances an FAI looking at the circumstances of more than one death

[65] As at 19/07/19.
[66] As at 19/07/19.
[67] Determination of William Hume.

could provide a more in-depth analysis of a variety of factors with a view to identifying precautions that may be taken to avoid similar deaths.

179. To expedite the investigation into such deaths, the proposed MoU with SPS and NHS to receive the all required documentation within a specified time period should be progressed as a priority, enabling the investigation to be progressed more quickly. The additional resource and the introduction of dedicated teams to deal solely with FAIs should also assist in reducing timelines.

Findings

180. It is extremely concerning that these young people have died whilst in the care of the state. While recognising it is not possible to eradicate the risk of self-harm and mental health issues that affect many young people and that it can be very difficult to identify those who might or intend to take their own life and prevent suicides, it must remain the aspiration.

181. The function of the FAI is to identify failings/defects and to make recommendations to prevent deaths recurring in similar circumstances. Any death where there are apparent defects or reasonable precautions that may prevent deaths in similar circumstances should be prioritised.

182. Due to the heightened sensitivities around the death of any young person who by their age alone are vulnerable and as seen in our cohort often have a number of other vulnerabilities, it is right to demand that when such deaths occur, whilst they are in the care of the state, that they should be prioritised and, if appropriate, conjoined to learn lessons and make recommendations to minimise the reoccurrence of deaths in similar circumstances.

183. It is also timely following the 2018 review by HM Chief Inspector of Prisons resulting in the introduction of new measures that the court maintains an oversight on the impact of measures dealing with the well-being of young people and adjudicates on whether there is scope for further improvements.

184. To fulfil this role, the inquiry must be held in relative proximity to the death and as such COPFS should aspire to ensure that the first notice is lodged within 12 months to comply with the new COPFS KPI. We recommend:

New Recommendation

SFIU should prioritise the FAI of any young person in legal custody.

185. For clarification, there are some deaths that are attributable to natural causes or may be the result of a tragic accident where the circumstances do not suggest any system issues. In such circumstances the FAI should be dealt with timeously but would not require to be prioritised over other death investigations.

OVERVIEW

186. The thematic report was published in August 2016. We made 12 recommendations.

Recommendation 1: SFIU National should introduce a streamlined reporting/notification process for FAIs.
Status: In progress
Recommendation 2: SFIU should implement monthly reconciliations of all active deaths investigations between SFIU National and the SFIU Divisions.
Status: Achieved
Recommendation 3: SFIU National should review, update and centralise all guidance and policies on the investigation of deaths.
Status: In progress
Recommendation 4: COPFS should introduce an internal target for progressing mandatory FAIs.
Status: Achieved
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.
Status: In progress
Recommendation 6: COPFS should ensure that all operational case related emails are recorded and imported into the case directory.
Status: In progress
Recommendation 7: 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.
Status: Achieved
Recommendation 8: 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.
Status: Superseded by the FAI Rules
Recommendation 9: COPFS should provide a single point of contact for the nearest relatives in all FAIs.
Status: Achieved

Recommendation 10: There should be a single point of contact for the nearest relatives throughout the criminal proceedings and any subsequent FAI.
Status: Achieved
Recommendation 11: SFIU should provide written notification to all participants on the issues COPFS intends to raise at the inquiry.
Status: Superseded by the FAI Rules
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.
Status: Not achieved

187. Given it is almost three years since the thematic report was published, the lack of progress in many areas is disappointing.

188. While COPFS continues to meet the published targets for deaths requiring investigation and routine deaths, there has been little progress in shortening the time line for mandatory FAIs with the first notice lodged within 12 months in only 37% of cases in our case review.

189. While the number of outstanding FAIs over 12 months is decreasing there are still 20 over three years old.

190. Undoubtedly resourcing has been an issue for SFIU and it is not yet at full complement following the additional resource that was secured in 2018. We are aware that efforts are ongoing to accelerate back filling vacancies and increasing the SFIU complement.

191. On a positive note the aims/objectives of the modernisation project should improve the effectiveness of the processes and procedures and ring-fencing a dedicated resource to tackle the backlog of older FAIs should address some of the concerns highlighted in this report.

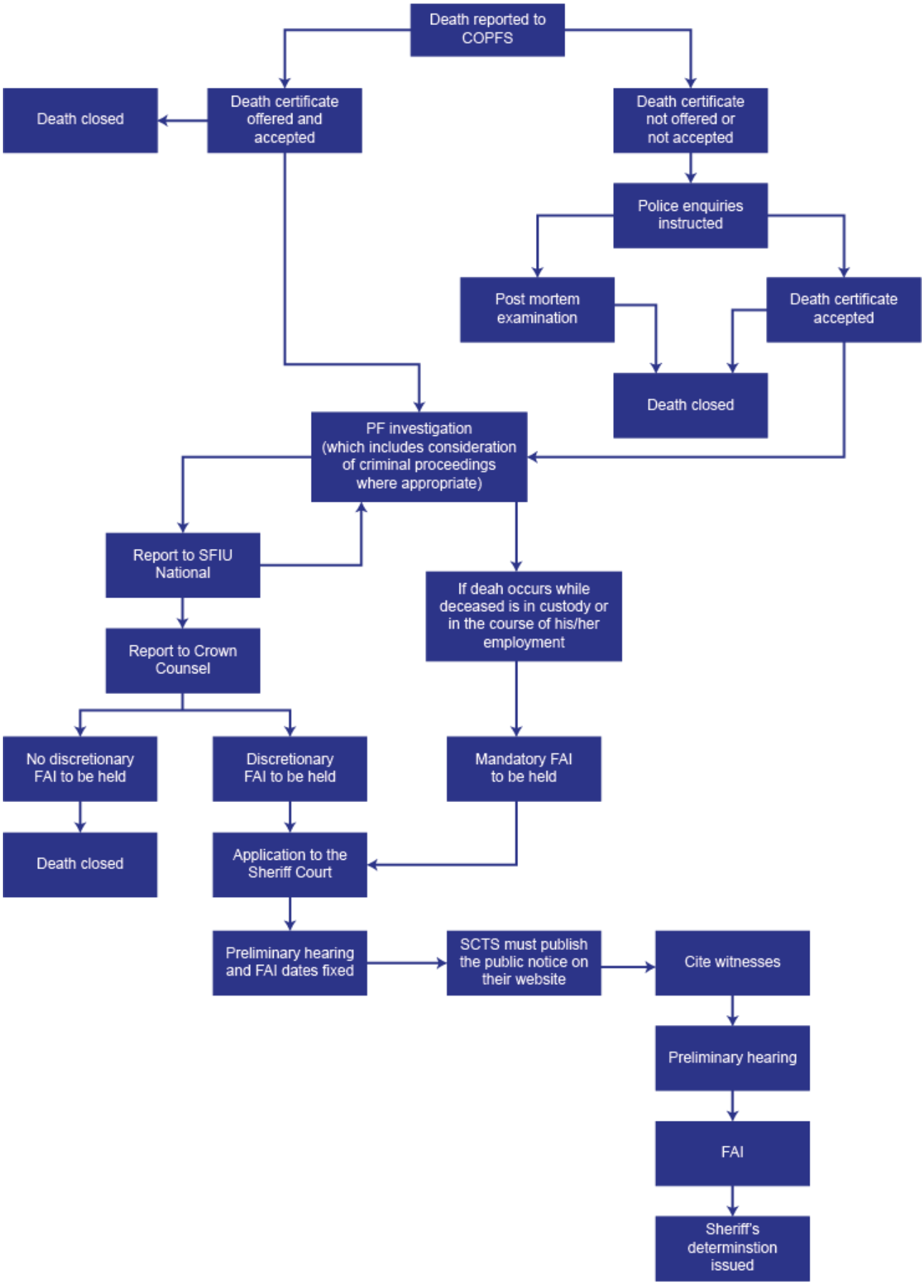
192. We have made three new recommendations.

New Recommendations

- To provide a clear audit trail in each case the work stream to record all information in the case directory should be prioritised and documents should be recorded and named in a structured manner.
- In order to assess compliance with the Family Liaison Charter a record of the wishes of the family should be recorded on the charter template.
- SFIU should prioritise the FAI of any death of a young person in legal custody.

193. Given the number of recommendations that remain in progress, continuing delays in dealing with mandatory FAIs, the proposed completion of the modernisation project by the end of 2019 and the three new recommendations, it is appropriate for the Inspectorate to re-visit the investigation of FAIs in a further follow-up report next year.

Annex A – COPFS FAI Process Flowchart



Annex B – Family Liaison Charter

Initial Report and Post Mortem

- On receipt of initial report ensure that family are informed whether post mortem is necessary and when it is likely to take place
- Contact family on receiving initial cause of death to confirm if they can proceed with funeral arrangements
- If further investigations are required and PF is unable to release the body advise family as soon as possible and provide reasons
- If final post mortem report is not available within 12 weeks provide family with an update on expected timescales
- Contact family within 14 days of receipt of final post mortem report if any change to cause of death and answer any questions

Further Investigation

- Contact family no later than 12 weeks after the date of death to inform of progress and offer a personal meeting which will take place within 14 days. If the family does not wish a meeting, COPFS will communicate according to their wishes
- Contact family every 6 weeks thereafter to advise of progress and arrange personal meeting if requested
- In all instances: If at any stage there is a significant development contact family immediately, unless it may prejudice any potential prosecution, and offer a personal meeting unless family have indicated they do not wish to attend such meetings

Criminal Proceedings

- If reported to Crown Counsel regarding possibility of criminal proceedings contact family within 14 days of Crown Counsel's decision to advise whether or not there are to be criminal proceedings
- If the family are unhappy about any decision not to prosecute they have the right to review the decision and should refer to the COPFS Right to Review Policy
- If there are to be criminal proceedings VIA will continue to provide updates to the family
- At conclusion of criminal proceedings offer to meet family to explain the outcome and answer any questions

Fatal Accident Inquiry

- If reported to Crown Counsel on whether there should be a FAI the family will be given an opportunity to say whether they wish an inquiry. Their views will be taken account of in reaching a decision and on how they wish the decision to be communicated
- Inform family of Crown Counsel's decision within 14 days of the decision being made
- If FAI has not to be held offer family a meeting within 14 days to explain reasons and these reasons to be confirmed in writing
- If FAI has to be held offer a meeting with family to explain what happens next
- PF to make an application to court within 2 months of Crown Counsel's decision being made
- If the family are unhappy about the decision to hold or not hold an FAI they may ask for the decision to be reviewed
- At conclusion of FAI offer family a meeting to explain outcome and any issues arising
- After the determination has been issued offer family a meeting to discuss any issues arising

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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 is 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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