Justice Committee

Inquiry into the role and purpose of the Crown Office and Procurator Fiscal Service

Written submission from Action for a Safe and Accountable People’s NHS (ASAP NHS)

1. Summary
This is a short form of the original submission provided to the Justice Committee office and to individual members of the committee. ASAP-NHS is concerned with patient safety in Scotland and the protection of whistle-blowers in the NHS. The main legal issue relating to COPFS and its effectiveness is on the Health and Safety at Work etc Act 1974 (HSWA) and the Human Rights Act 1998 (HRA) on patient safety and the government’s duty to protect the ‘right to life’. The fundamental issue is the failure of the Scottish Government and its ministers to uphold the UK-wide legislation, to implement it, or to comply with it as it applies to their constitutional and statutory responsibilities. Our submission deals with the absence of law, the failure of respective bodies to notify COPFS of deaths, the failures of investigation, prosecution, and enforcement of the law. The consequence is the failure of healthcare in Scotland to learn on preventing avoidable harm, and comply with the law. By the Department of Health and the Secretary of State for Health estimates this failure will for Scotland result in about 2,000 avoidable deaths each year in healthcare and related social care. There will be many more cases of major avoidable harm, and wasted resources.

2. Background
The previous submission to the committee gave substantive evidence of the issues summarised here. The submission is also available via our website https://asapnhs.org.uk/. This is backed by the case for the public inquiry ‘Patient Safety in Scotland’. Although healthcare and social care are devolved responsibilities, the legal requirements that they are safe is reserved. As we state in our submissions the points we make would need checking but they will be proved to be correct. The evidence to back the points has been collected as in preparation for a prosecution case, there is prosecution-grade evidence available. The case for the public inquiry is currently lodged with five UK ministers, five UK select committees, and the Secretary for State for Scotland has sent it to the Scottish Government.

3. COPFS Effectiveness Issues

3.1 Lack of Independence

COPFS is not ‘Scotland’s independent prosecution service’. It is the ‘Scottish Government’s prosecution service’, it is headed by two government ministers the Lord Advocate and the Solicitor General. Prosecutions are in the name of the Lord Advocate. There is not the separation of powers between the executive and the judiciary. A majority government in Holyrood and no second chamber also means that the legislature is also synonymous. The practical result is very serious. Ministers are not disposed to take action against their colleagues, including the one who appointed them. On the ‘40 suspicious deaths at Ayrshire and Arran (A&A) NHS Board we asked the previous Lord Advocate to investigate the deaths and the
statutory responsibilities of the Scottish government and ministers on their failure to implement the law or have a policy that complies with the law.

The response of the previous Lord Advocate placed ministers and the Scottish government beyond the rule of law. COPFS has not acted on advising or ensuring compliance with the law, the rule of law, nor addressed this basic constitutional anomaly. This position is not tenable and harms the public good.

3.2 Fundamental Role of Scottish Government

The stated role of the Scottish Government and ministers is to implement the law and policy on devolved matters. The law is reserved on patient safety in healthcare and related social care. The Scottish government policy must as a minimum deliver legal compliance. The law is HSWA, the Human Rights Act 1998, and covered by the Corporate Manslaughter and Corporate Homicide Act 2007 (CMCHA) which states that it applies to the Scottish Government. The law is absent from the government’s approach to healthcare, it does not uphold the law. Of the twenty essential statutory requirements that must be in place to ensure patient safety in Scotland we have none. The consequences are seen with the very large number of avoidable deaths that can be found across healthcare in Scotland. To date we can see no evidence of COPFS using CMCHA when pro rata it almost certainly should have been. The absence of law and the failure to use the law undermines the rule of law and public safety, so allowing these many deaths. The government in effect is encouraging law-breaking by the law’s absence from the joint Health and Social Care Directorate (HSCD) and NHS Scotland, from NHS Scotland’s quality assurance bodies such as Healthcare Improvement Scotland (HIS) and Healthcare Environment Inspectorate (HEI). COPFS is not addressing these failures of acts and omissions covered by the law.

3.3 Failed Public Inquires

The recent public inquiries into healthcare are the Vale of Leven Hospital and the Penrose inquiries and both involved a great many avoidable deaths in Scotland. The risks were covered by the above legislation but the law was totally absent from the inquiries. The deaths should have been prevented so far as reasonably practicable. The law was ignored and the legally-required lessons were not identified. Similar deaths from poor infection control will continue. COPFS did not act on legal compliance or the failure of government policy on the law.

3.4 Non-Notification of Deaths

COPFS and Procurator Fiscals cannot act if they do not know about incidents, this is a particular problem with deaths, particularly avoidable ones, in healthcare and social care. The Scottish Information Commissioner has worked on NHS boards covering up incidents. This involved their judgement on A&A and their current investigation at NHS Lothian. Fiscals have long known that many mandatory notifiable deaths (e.g. sudden and unexpected) which should be notified but are not. The problem has not been addressed. ASAP-NHS has found many such cases where the deaths would not be reported. There is likely to be a very large number of deaths that go unreported for investigation within the NHS or be notified to COPFS.
This prevents learning and any necessary enforcement or prosecution. This could be a large scandal in its own right. COPFS needs to address the major failing on notification of deaths.

3.5 Scottish Work-Related Deaths Protocol (WRDP)

This protocol requires close joint-working by Police Scotland, the Health and Safety Executive (HSE) and COPFS. It applies to both the deaths of workers and the public in relation to work activities. It will usually be followed for workers but it is generally not for the deaths of the public. This looks like a widespread failure. It is not followed for deaths in healthcare not even for the very few that have eventually resulted in convictions. It was not followed with the Police-involved deaths of Lamara Bell in the M9 crash or Sheku Bayou. It was not followed in the Glasgow bin lorry disaster leading to the law that would have prevented it not being used. There are a multitude of consequences from failures to use it, including loss of evidence. COPFS, HSE and Police Scotland need to make sure that WRDP is understood and applied.

3.6 Glasgow Bin Lorry Disaster

This was a catalogue of errors in the investigations, the absence of law, and the COPFS decision-making process. Neither Glasgow City Council nor the driver’s HSWA responsibilities were investigated by HSE. COPFS did not understand the law. COPFS gave an ‘amnesty’ to the council on HSWA but not the driver, he can still be prosecuted under HSWA section 7. The failings of COPFS are covered extensively elsewhere, regrettably it reads as a case study of how not to run a justice system. The understanding of the law was two hundred years out of date.

3.7 Forty Suspicious Deaths at Ayrshire and Arran NHS Board (Dr Shipman Investigation Errors)

These deaths were not notified to COPFS despite them often being sudden or unexpected. All involve likely serious breaches of HSWA section 3(1) as it applies to patient safety. Independently two requests were made for their investigation using different routes. In effect they became tests of the system for investigating deaths in healthcare as well as getting the specific cases investigated and standards improved. These have still not been independently investigated. The two police ‘investigations’ failed every test of a criminal law investigation, e.g. they relied on the sole evidence of the main suspect. COPFS and the previous Lord Advocate based their decision of ‘no action’ on the basis of no investigation. This is now with the Police Investigation Review Commissioner (PIRC) and the Chief Inspector of Constabulary Scotland (HMICS). The Lord Advocate and COPFS need to reopen the investigation into these deaths (and subsequent incidents) and to address both the NHS failings and those of government and ministers on their statutory responsibilities.

As it stands Police Scotland, COPFS and HSE have repeated the errors of the first investigation into the mass serial killer Dr Shipman. For details, very strong criticisms, and recommendations see report 2 of the public inquiry, the Shipman Inquiry. That investigation failed very badly. There was no system for handling
potentially suspicious deaths in healthcare, they did not know what to look for, and they did not have the competent staff to undertake the investigation. The failure allowed Dr Shipman to continue to kill more patients. That was intentional, here we are dealing with criminal negligence. The failures to investigate at Ayrshire and Arran have allowed many times the number of deaths associated with the failure with Dr Shipman. Generally across Scotland, the failure to uphold and comply with the law on patient safety results in vastly more deaths than Shipman's work activities. COPFS, Police Scotland and HSE do not have the corporate learning from the Shipman Inquiry.

3.8 Understanding and Application of the Law

It can be seen in the Glasgow bin lorry, the A&A deaths, and from our dealings with COPFS that there is not the understanding of HSWA. This is also referenced in the submission to the committee from ORR. The cases are not straightforward, they need a thorough understanding of specialist law, the principles on prevention, and the detailed precautions required by law. That is why in the rest of the UK HM Inspectors made the decisions and took the cases. The COPFS's Health and Safety Unit does not have the competences and resources to make decisions on HSWA cases.

3.9 Absence of Enforcement, Learning, Compliance and Prevention

With the lack of understanding of the law or the use of WRDP, a large number of deaths go without being investigated. They are often not reported by NHS or in social care. The deaths are fudged as to their cause, their preventability is not recognised, families are not given the information on what happened and why. HSWA is about prevention, making sure that effective precautions are in place. The law is primarily not about prosecution. Prosecution is a sign of failure by the main duty-holders but also by the government and of regulation. Here the Scottish government abolished the healthcare regulator in 2010. There is no chance of legal compliance or the prevention of these avoidable deaths without one. Currently there is not the learning, or the enforcement to make sure that standards are improved. NHS Scotland relies on weak, legally non-compliant guidance. The non-compliance with the law continues and the deaths continue. COPFS needs to end its role of being complicit. Currently COPFS with its inaction on healthcare is giving the ‘green-light’ to law-breaking on a massive scale. It is part of the failure of the Scottish government to protect the ‘right to life’ of the Human Rights Act 1998. This position should not be tenable.

3.10 Conclusion

Deaths associated with non-compliance with HSWA amount to about forty times the number of ‘conventional’ homicides. COPFS and the justice system may be geared to dealing with the latter but are not equipped to deal with the former.

There needs to be a major systematic review of COPFS and what is required to address these many avoidable deaths. This is not our call, but the matters found by ASAP-NHS should be of major public concern, ones that will affect all of us in Scotland in some serious way. COPFS failings meet the criterion of a public inquiry.
The deaths are still happening, there are lessons to be learnt and acted on. The law is not being upheld or complied with. It reads that under the Public Inquiries Act 2005 any minister be it Scottish or UK, including the Lord Advocate or the Solicitor General, could call such an inquiry. It is of course a requirement of being in office that all ministers and MSPs uphold the law and comply with it. The law must particularly be upheld in this case.

In the specifics and in the wider context, this has the characteristics of being part of the worst error in Scottish and UK legal history.

Action for a Safe and Accountable People’s NHS
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