Passage of the

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

SP Bill 63 (Session 4), subsequently 2016 asp 2

SPPB 224
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Foreword

Purpose of the series

The aim of this series is to bring together in a single place all the official Parliamentary documents relating to the passage of the Bill that becomes an Act of the Scottish Parliament (ASP). The list of documents included in any particular volume will depend on the nature of the Bill and the circumstances of its passage, but a typical volume will include:

- every print of the Bill (usually three – “As Introduced”, “As Amended at Stage 2” and “As Passed”);
- the accompanying documents published with the “As Introduced” print of the Bill (and any revised versions published at later Stages);
- every Marshalled List of amendments from Stages 2 and 3;
- every Groupings list from Stages 2 and 3;
- the lead Committee’s “Stage 1 report” (which itself includes reports of other committees involved in the Stage 1 process, relevant committee Minutes and extracts from the Official Report of Stage 1 proceedings);
- the Official Report of the Stage 1 and Stage 3 debates in the Parliament;
- the Official Report of Stage 2 committee consideration;
- the Minutes (or relevant extracts) of relevant Committee meetings and of the Parliament for Stages 1 and 3.

All documents included are re-printed in the original layout and format, but with minor typographical and layout errors corrected. An exception is the groupings of amendments for Stage 2 and Stage 3 (a list of amendments in debating order was included in the original documents to assist members during actual proceedings but is omitted here as the text of amendments is already contained in the relevant marshalled list).

Where documents in the volume include web-links to external sources or to documents not incorporated in this volume, these links have been checked and are correct at the time of publishing this volume. The Scottish Parliament is not responsible for the content of external Internet sites. The links in this volume will not be monitored after publication, and no guarantee can be given that all links will continue to be effective.

Documents in each volume are arranged in the order in which they relate to the passage of the Bill through its various stages, from introduction to passing. The Act itself is not included on the grounds that it is already generally available and is, in any case, not a Parliamentary publication.

Outline of the legislative process

Bills in the Scottish Parliament follow a three-stage process. The fundamentals of the process are laid down by section 36(1) of the Scotland Act 1998, and amplified by Chapter 9 of the Parliament’s Standing Orders. In outline, the process is as follows:
After a Bill is passed, three law officers and the Secretary of State have a period of four weeks within which they may challenge the Bill under sections 33 and 35 of the Scotland Act respectively. The Bill may then be submitted for Royal Assent, at which point it becomes an Act.

Standing Orders allow for some variations from the above pattern in some cases. For example, Bills may be referred back to a committee during Stage 3 for further Stage 2 consideration. In addition, the procedures vary for certain categories of Bills, such as Committee Bills or Emergency Bills. For some volumes in the series, relevant proceedings prior to introduction (such as pre-legislative scrutiny of a draft Bill) may be included.

The reader who is unfamiliar with Bill procedures, or with the terminology of legislation more generally, is advised to consult in the first instance the Guidance on Public Bills published by the Parliament. That Guidance, and the Standing Orders, are available for sale from Stationery Office bookshops or free of charge on the Parliament’s website (www.scottish.parliament.uk).

The series is produced by the Legislation Team within the Parliament’s Chamber Office. Comments on this volume or on the series as a whole may be sent to the Legislation Team at the Scottish Parliament, Edinburgh EH99 1SP.

Notes on this volume

The Bill to which this volume relates followed the standard 3 stage process described above.

The Delegated Powers and Law Reform Committee’s report at Stage 1 is included in this volume. The Delegated Powers and Law Reform Committee took oral evidence on the Bill and the extracts from the minutes and the Official Report of the relevant meeting of the Committee are, therefore, included in this volume.
Inquiries into Fatal Accidents and Sudden Deaths etc. (Scotland) Bill
[AS INTRODUCED]

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Schedule 1 — Procedure rules
Schedule 2 — Modification of enactments
Inquiries into Fatal Accidents and Sudden Deaths etc. (Scotland) Bill

[AS INTRODUCED]

An Act of the Scottish Parliament to make provision for the holding of public inquiries in respect of certain deaths.

Inquiries into certain deaths

1 Inquiries under this Act

5 (1) Where an inquiry is to be held into the death of a person in accordance with sections 2 to 7, the procurator fiscal must—

(a) investigate the circumstances of the death, and

(b) arrange for the inquiry to be held.

(2) An inquiry is to be conducted by a sheriff.

10 (3) The purpose of an inquiry is to—

(a) establish the circumstances of the death, and

(b) consider what steps (if any) might be taken to prevent other deaths in similar circumstances.

(4) But it is not the purpose of an inquiry to establish civil or criminal liability.

15 (5) In this Act, unless the context requires otherwise—

(a) “inquiry” means an inquiry held, or to be held, under this Act,

(b) references to a “sheriff” in relation to an inquiry are to a sheriff of the sheriffdom in which the inquiry is, or is to be, held.

Inquiries into deaths occurring in Scotland

2 Mandatory inquiries

20 (1) An inquiry is to be held into the death of a person which—

(a) occurred in Scotland, and

(b) is within subsection (3) or (4).
(2) Subsection (1) is subject to section 3.

(3) The death of a person is within this subsection if the death was the result of an accident which occurred—
   (a) in Scotland, and
   (b) while the person was acting in the course of the person’s employment or occupation.

(4) The death of a person is within this subsection if, at the time of death, the person was—
   (a) in legal custody, or
   (b) a child required to be kept or detained in secure accommodation.

(5) For the purposes of subsection (4)(a), a person is in legal custody if the person is—
   (a) required to be imprisoned or detained in a penal institution,
   (b) in police custody, within the meaning of section 56 of the Criminal Justice (Scotland) Act 2015,
   (c) otherwise held in custody on court premises,
   (d) required to be detained in service custody premises.

(6) For the purposes of subsections (4)(b) and (5)(a) and (d), it does not matter whether the death occurred in secure accommodation, a penal institution or, as the case may be, service custody premises.

(7) In this section—
   “penal institution” means any—
   (a) prison (including a legalised police cell within the meaning of section 14(1) of the Prisons (Scotland) Act 1989), other than a naval, military or air force prison,
   (b) remand centre, within the meaning of section 19(1)(a) of that Act,
   (c) young offenders institution, within the meaning of section 19(1)(b) of that Act,
   “secure accommodation” means accommodation provided in a residential establishment, approved in accordance with regulations made under section 78(2) of the Public Services Reform (Scotland) Act 2010, for the purpose of restricting the liberty of children,
   “service custody premises” has the meaning given by section 300(7) of the Armed Forces Act 2006.

3 Mandatory inquiries: exceptions

(1) The Lord Advocate may decide that an inquiry is not to be held into the death of a person within section 2(3) or (4) if satisfied that the circumstances of the death have been sufficiently established during the course of proceedings of a kind mentioned in subsection (2).

(2) The proceedings referred to in subsection (1) are—
   (a) criminal proceedings,
   (b) an inquiry under section 17(2) of the Gas Act 1965 (accidents),
(c) an inquiry under section 14(2A) of the Health and Safety at Work etc. Act 1974 (power of the Health and Safety Executive to direct investigations and inquiries),
(d) an inquiry under section 1 of the Inquiries Act 2005 (power to establish inquiry),
(e) an inquiry under section 85(1) of the Energy Act 2013 (inquiries).

(3) But subsection (1) does not apply if—
(a) at the time of death, the person was required to be detained in service custody premises, and
(b) the proceedings referred to in that subsection are an inquiry under section 1 of the Inquiries Act 2005.

4

Discretionary inquiries

(1) An inquiry is to be held into the death of a person which occurred in Scotland if the Lord Advocate—
   (a) considers that the death—
      (i) was sudden, suspicious or unexplained, or
      (ii) occurred in circumstances giving rise to serious public concern, and
   (b) decides that it is in the public interest for an inquiry to be held into the circumstances of the death.

(2) Subsection (1) does not apply to a death within section 2(3) or (4).

5

Certain deaths and accidents to be treated as occurring in Scotland

(1) For the purposes of sections 2 and 4, the death of a person, or an accident, is to be treated as having occurred in Scotland if it occurred—
   (a) in connection with an activity falling within section 11(2) of the Petroleum Act 1998 (application of civil law to offshore activities), and
   (b) in a relevant area.

(2) In subsection (1)(b), “relevant area” means an area in respect of which it is provided by Order in Council under section 11(1) of the Petroleum Act 1998 that questions arising out of acts or omissions taking place in the area are to be determined in accordance with the law in force in Scotland.

6

Inquiries into deaths occurring abroad

Inquiries into deaths occurring abroad: general

(1) Subsection (3) applies to the death of a person if—
   (a) the death occurred outwith the United Kingdom,
   (b) at the time of death, the person was ordinarily resident in Scotland, and
   (c) the person’s body has been brought to Scotland.

(2) But that subsection does not apply to the death of a person within section 12(2) or (3) of the Coroners and Justice Act 2009 (investigation in Scotland of deaths of service personnel abroad).
(3) An inquiry is to be held into a death to which this subsection applies if the Lord Advocate—

(a) considers that the death—

(i) was sudden, suspicious or unexplained, or

(ii) occurred in circumstances giving rise to serious public concern,

(b) considers that the circumstances of the death have not been sufficiently established in the course of an investigation in relation to the death,

(c) considers that there is a real prospect that those circumstances would be sufficiently established in an inquiry, and

(d) decides that it is in the public interest for an inquiry to be held into the circumstances of the death.

7 Inquiries into deaths occurring abroad: service personnel

(1) An inquiry is to be held into the death of a person if—

(a) the Lord Advocate is notified in relation to the death under section 12(4) or (5) of the Coroners and Justice Act 2009 (investigation in Scotland of deaths of service personnel abroad),

(b) the death is within subsection (2) or (3), and

(c) the Lord Advocate—

(i) decides that it is in the public interest for an inquiry to be held into the circumstances of the death, and

(ii) does not reverse that decision.

(2) The death of a person is within this subsection if the person was, at the time of death, in custody in circumstances analogous to legal custody (as construed by reference to section 2(5)).

(3) The death of a person is within this subsection if the Lord Advocate considers that the death—

(a) was sudden, suspicious or unexplained, or

(b) occurred in circumstances giving rise to serious public concern.

(4) But this section does not apply to a death within subsection (2) if the Lord Advocate is satisfied that the circumstances of the death have been sufficiently established in the course of any criminal proceedings against any person in respect of the death.

8 Reasons where inquiry not held

Reasons for decision not to hold an inquiry

Where it is decided that an inquiry is not to be held into the death of a person (“A”), the Lord Advocate must give reasons in writing if requested to do so by—

(a) A’s spouse or civil partner at the time of A’s death,

(b) a person living with A as if married to A at the time of A’s death, or

(c) A’s nearest known relative if, at the time of A’s death, A—

(i) did not have a spouse or civil partner, and
Inquiries into Fatal Accidents and Sudden Deaths etc. (Scotland) Bill

5 (ii) was not living with a person as if married to the person.

Procurator fiscal’s investigation

9 Citation of witnesses for precognition

(1) The procurator fiscal may cite a person to attend for precognition in connection with an investigation under section 1(1)(a).

(2) This section is sufficient warrant for such citation.

(3) Subsection (4) applies where a person cited under subsection (1)—

(a) having been given reasonable notice in the citation, and without reasonable excuse, fails to attend for precognition at the time and place mentioned in the citation, or

(b) does so attend but refuses to give information which is—

(i) within the person’s knowledge, and

(ii) relevant to the investigation.

(4) The sheriff may, on the application of the procurator fiscal, make an order requiring the person to attend for precognition or, as the case may be, give the information at a time and place specified in the order.

(5) A person who fails to comply with an order under subsection (4) commits an offence.

(6) A person who commits an offence under subsection (5) is liable on summary conviction to imprisonment for a term not exceeding 21 days or a fine not exceeding level 3 on the standard scale (or both).

Participants

10 Persons who may participate in the inquiry

(1) The following persons may participate in inquiry proceedings in relation to the death of a person (“A”—

(a) A’s spouse or civil partner at the time of A’s death,

(b) a person living with A as if married to A at the time of A’s death,

(c) A’s nearest known relative if, at the time of A’s death, A—

(i) did not have a spouse or civil partner, and

(ii) was not living with a person as if married to the person,

(d) where the death is within section 2(3)—

(i) A’s employer, if A was an employee,

(ii) an inspector appointed under section 19 of the Health and Safety at Work etc. Act 1974 (appointment of inspectors),

(e) any other person who the sheriff is satisfied has an interest in the inquiry.

(2) In this Act—

(a) “inquiry proceedings” means any proceedings under this Act in relation to an inquiry,
Inquiries into Fatal Accidents and Sudden Deaths etc. (Scotland) Bill

(b) references to a participant in an inquiry are references to a person who participates in the inquiry proceedings by virtue of subsection (1).

Location

11 Places at which inquiries may be held

5 (1) The Scottish Ministers may by regulations designate places at which a sheriff court may be held for the purposes of this Act (in addition to the places designated by virtue of the Courts Reform (Scotland) Act 2014 for the holding of sheriff courts).

(2) The Scottish Ministers may make regulations under subsection (1) only following the submission of a proposal under subsection (3).

10 (3) The Scottish Courts and Tribunals Service (“the SCTS”) may, with the agreement of the Lord President of the Court of Session, submit a proposal to the Scottish Ministers for the making of regulations under subsection (1).

(4) Before submitting a proposal to the Scottish Ministers, the SCTS must consult such persons as it considers appropriate.

15 (5) If, following the submission of a proposal, the Scottish Ministers decide to make regulations, they must have regard to the proposal in deciding what provision to make in the regulations.

(6) The Scottish Ministers may make regulations under subsection (1) only with the consent of—

(a) the Lord President, and

(b) the SCTS.

(7) Regulations under subsection (1)—

(a) may make transitional, transitory or saving provision,

(b) are subject to the affirmative procedure.

Jurisdiction in relation to inquiries

12 (1) Inquiry proceedings may be held in a sheriffdom whether or not there is a connection between the death, or any accident resulting in the death, to which the inquiry relates and the sheriffdom, and a sheriff of the sheriffdom accordingly has jurisdiction in relation to the proceedings.

30 (2) The Lord Advocate is, after consulting the Scottish Courts and Tribunals Service, to choose the sheriffdom in which proceedings are to be held.

(3) But the sheriff may make an order transferring the proceedings to a sheriff of another sheriffdom.

(4) The sheriff may make an order under subsection (3) only—

(a) after giving the procurator fiscal and the participants in the inquiry an opportunity to make representations about the proposed transfer, and

(b) with the consent of—

(i) the sheriff principal of the sheriffdom of which the sheriff is a sheriff, and

(ii) the sheriff principal of the sheriffdom to which the sheriff proposes to transfer the proceedings.
(5) The sheriff may make such an order—
   (a) on the sheriff’s own initiative, or
   (b) on the application of the procurator fiscal or a participant in the inquiry.

Inquiries into multiple deaths

13 Inquiry into more than one death

(1) A single inquiry may be held into the deaths of more than one person if it appears to the Lord Advocate that the deaths occurred—
   (a) as a result of the same accident, or
   (b) otherwise in the same or similar circumstances.

(2) Where an inquiry is held in relation to the deaths of more than one person, references in this Act to the death to which, or person to whom, the inquiry relates are references to each death to which, or person to whom, the inquiry relates.

Pre-inquiry procedure

14 Initiating the inquiry

(1) Where an inquiry is to be held into the death of a person, the procurator fiscal must give the sheriff—
   (a) notice that the inquiry is to be held,
   (b) a brief account of the circumstances of the death so far as known to the procurator fiscal, and
   (c) any other information required by an act of sederunt under section 34(1).

(2) On receiving notice under subsection (1)(a), the sheriff must make an order—
   (a) fixing—
      (i) a date and place for the holding of a preliminary hearing in accordance with section 15 (if one is to be held), and
      (ii) a date for the start of the inquiry and the place at which it is to be held, and
   (b) granting warrant for the procurator fiscal and the participants in the inquiry to cite persons to attend and give evidence at the inquiry.

(3) But the sheriff need not fix a date for the start of the inquiry (and the place at which it is to be held) in the order if—
   (a) a preliminary hearing is to be held, and
   (b) the sheriff considers that it is not appropriate to fix the date before that hearing.

(4) The sheriff may make an order varying a date or place fixed in an order under subsection (2).

(5) The sheriff must, when fixing a date for the start of the inquiry, have regard to the desirability of holding the inquiry as soon as is reasonably practicable.
15 Preliminary hearings

(1) At least one preliminary hearing is to be held before the start of an inquiry unless the sheriff dispenses with that requirement in accordance with provision made in an act of sederunt under section 34(1).

(2) Subsection (3) applies where the sheriff dispenses with the requirement to hold a preliminary hearing.

(3) The sheriff may subsequently make an order—
   (a) for the holding of such a hearing, and
   (b) fixing the date and place for it to be held.

(4) Provision is to be made in an act of sederunt under section 34(1) about—
   (a) matters to be dealt with at a preliminary hearing under this Act,
   (b) things that the procurator fiscal and the participants in the inquiry must do before such a hearing.

16 Notice of the inquiry

(1) After the sheriff makes an order under section 14(2) in relation to an inquiry, the procurator fiscal must give notice to the persons mentioned in subsection (2) of the following matters—
   (a) the fact that the inquiry is to be held, and
   (b) if fixed in the order—
      (i) the date and place for the holding of the preliminary hearing,
      (ii) the date for the start of the inquiry and the place at which it is to be held.

(2) The persons referred to in subsection (1) are—
   (a) a person appearing to the procurator fiscal to be entitled to participate in the inquiry under section 10(1)(a) to (d), and
   (b) any other person specified, or in a category of persons specified, in an act of sederunt under section 34(1).

(3) The procurator fiscal must also give public notice of the matters specified in subsection (1)(a) and (b).

(4) Subsection (5) applies where the sheriff makes an order under section 14(4).

(5) The procurator fiscal must—
   (a) give notice to the persons mentioned in subsection (2) of the new date or, as the case may be, place fixed in the order, and
   (b) give public notice of that fact.

(6) Subsection (7) applies where the sheriff makes an order under section 15(3).

(7) The procurator fiscal must—
   (a) give notice to the persons mentioned in subsection (2) of the following matters—
      (i) the fact that a preliminary hearing is to be held, and
      (ii) the date and place fixed for the holding of the hearing, and
   (b) give public notice of those matters.
17 Agreement of facts before an inquiry

(1) Provision is to be made in an act of sederunt under section 34(1) about the agreement, by the procurator fiscal and the participants in an inquiry, of any facts of a kind mentioned in subsection (2) before the start of the inquiry.

(2) The facts referred to in subsection (1) are facts—

(a) in relation to which the procurator fiscal or a participant intends to bring forward evidence at the inquiry, and

(b) which the procurator fiscal or, as the case may be, participant considers are unlikely to be disputed at the inquiry.

18 The powers of the sheriff

(1) The sheriff has all such powers in relation to inquiry proceedings as a sheriff, under the law of Scotland, inherently possesses for the purposes of the discharge of the sheriff’s jurisdiction and competence and giving full effect to the sheriff’s decisions in civil proceedings.

(2) Subsection (1) is subject to—

(a) the other provisions of this Act,

(b) provision made in an act of sederunt under section 34(1).

19 Evidence and witnesses

(1) At an inquiry—

(a) the procurator fiscal must bring forward evidence relating to the circumstances of the death to which the inquiry relates,

(b) a participant in the inquiry may bring forward such evidence.

(2) Without limiting subsection (1), the sheriff may require the procurator fiscal or a participant in the inquiry to bring forward evidence about any matter relating to the circumstances of the death.

(3) The rules of evidence which apply in relation to civil proceedings in the sheriff court (other than a simple procedure case) apply in relation to an inquiry.

(4) Subsection (3) is subject to provision made in an act of sederunt under section 34(1).

(5) The examination of a person at an inquiry does not prevent criminal proceedings being taken against the person.

(6) A person is not required at an inquiry to answer a question tending to show that the person is guilty of an offence.

(7) In subsection (3), “simple procedure case” has the same meaning as in section 72(9) of the Courts Reform (Scotland) Act 2014.

20 Inquiry to be conducted in public

(1) Inquiry proceedings are to be conducted in public.
21 Publishing restrictions in relation to children

(1) Subsection (2) applies where a child is involved in an inquiry.

(2) The sheriff may order that no person may publish any material by which the child may be identified in connection with the inquiry.

(3) Such material includes (but is not limited to)—
   (a) the child’s name or address,
   (b) the name of a school attended by the child,
   (c) a picture of the child.

(4) The sheriff may make an order under subsection (2)—
   (a) on the sheriff’s own initiative, or
   (b) on the application of the procurator fiscal or a participant in the inquiry.

(5) A person who fails to comply with an order under subsection (2) commits an offence.

(6) A person who commits an offence under subsection (5) is liable on summary conviction to a fine not exceeding level 4 on the standard scale.

(7) It is a defence for a person charged with an offence under subsection (5) to show that the person did not know or have reason to believe that the publication of the material would identify the child in connection with the inquiry.

(8) In this section—
   “material” means anything that is capable of being read, looked at, watched or listened to, either directly or after conversion from data stored in another form,
   “publish” includes in particular—
   (a) to publish in a programme service, as defined by section 201 of the Broadcasting Act 1990,
   (b) to cause to be published.

22 Offences by bodies corporate etc.

(1) Subsection (2) applies where—
   (a) an offence under section 21(5) has been committed by—
      (i) a body corporate,
      (ii) a Scottish partnership, or
      (iii) an unincorporated association other than a Scottish partnership, and
   (b) it is proved that the offence was committed with the consent or connivance of, or was attributable to neglect on the part of—
(i) a relevant individual, or
(ii) an individual purporting to act in the capacity of a relevant individual.

(2) The individual (as well as the body corporate, partnership or, as the case may be, association) commits the offence and is liable to be proceeded against and punished accordingly.

(3) In subsection (1)(b), “relevant individual” means—
   (a) in relation to a body corporate (other than a limited liability partnership)—
      (i) a director, manager, secretary or similar officer of the body,
      (ii) where the affairs of the body are managed by its members, a member,
   (b) in relation to a limited liability partnership, a member,
   (c) in relation to a Scottish partnership, a partner,
   (d) in relation to an unincorporated association other than a Scottish partnership, an individual who is concerned in the management or control of the association.

Assessors

(1) The sheriff may appoint a person (an “assessor”) to assist the sheriff in an inquiry.

(2) The sheriff may appoint a person as an assessor if the sheriff considers that the person has knowledge and expertise in matters that are relevant to the inquiry.

(3) The sheriff may make an appointment under subsection (1)—
   (a) on the sheriff’s own initiative, or
   (b) on the application of the procurator fiscal or a participant in the inquiry.

Expenses

The sheriff may not make any award of expenses in relation to inquiry proceedings.

Findings and recommendations

The sheriff’s determination

(1) As soon as possible after the conclusion of the evidence and submissions in an inquiry, the sheriff must make a determination setting out—
   (a) in relation to the death to which the inquiry relates, the sheriff’s findings as to the circumstances mentioned in subsection (2), and
   (b) such recommendations (if any) as to any of the matters mentioned in subsection (4) as the sheriff considers appropriate.

(2) The circumstances referred to in subsection (1)(a) are—
   (a) when and where the death occurred,
   (b) when and where any accident resulting in the death occurred,
   (c) the cause or causes of the death,
   (d) the cause or causes of any accident resulting in the death,
   (e) any precautions which—
could reasonably have been taken, and
(ii) had they been taken, might realistically have resulted in the death, or any accident resulting in the death, being avoided,
(f) any defects in any system of working which contributed to the death or any accident resulting in the death,
(g) any other facts which are relevant to the circumstances of the death.

(3) For the purposes of subsection (2)(e) and (f), it does not matter whether it was foreseeable before the death or accident that the death or accident might occur—
(a) if the precautions were not taken, or
(b) as the case may be, as a result of the defects.

(4) The matters referred to in subsection (1)(b) are—
(a) the taking of reasonable precautions,
(b) the making of improvements to any system of working,
(c) the introduction of a system of working,
(d) the taking of any other steps,
which might realistically prevent other deaths in similar circumstances.

(5) A recommendation under subsection (1)(b) may (but need not) be addressed to—
(a) a participant in the inquiry,
(b) a body or office-holder appearing to the sheriff to have an interest in the prevention of deaths in similar circumstances.

(6) A determination is not admissible in evidence, and may not be founded on, in any judicial proceedings of any nature.

26 Dissemination of the sheriff’s determination

(1) The Scottish Courts and Tribunals Service (“the SCTS”) must—
(a) publish, in such manner as it considers appropriate, each determination made under section 25(1),
(b) give a copy of each such determination to—
(i) the Lord Advocate,
(ii) each participant in the inquiry,
(iii) each person to whom a recommendation made in the determination is addressed, and
(iv) any other person who the sheriff considers has an interest in a recommendation made in the determination.

(2) The SCTS must, on request, give the Scottish Ministers, a Minister of the Crown, a department of the Government of the United Kingdom or the Health and Safety Executive a copy of—
(a) a determination made under section 25(1),
(b) the notice given under section 14(1) in relation to the inquiry to which the determination relates,
(c) any transcript of the evidence at the inquiry,
(d) any report or documentary production used in the inquiry.

(3) The SCTS must, on payment of the specified fee, give any other person a copy of—
(a) a determination made under section 25(1),
(b) any transcript of the evidence at an inquiry, if the person—
   (i) makes a request for it within the specified period, and
   (ii) has an interest in the inquiry.


(5) The sheriff may decide in accordance with provision made in an act of sederunt under section 34(1) that part of a determination—
(a) is not to be given to a person under this section,
(b) is to be withheld from publication under this section.

(6) After the sheriff has made a determination under section 25(1), the procurator fiscal must give the following information to the Registrar General of Births, Deaths and Marriages for Scotland—
(a) the name and last known address of the person to whose death the determination relates, and
(b) the date, place and cause of the death.

27 Compliance with sheriff’s recommendations

(1) A person to whom a recommendation under section 25(1)(b) is addressed—
   (a) must, if the person was a participant in the inquiry to which the recommendation relates, give the Scottish Courts and Tribunals Service (“the SCTS”) a response in writing,
   (b) may do so in any other case.

(2) A response under subsection (1) must set out—
   (a) details of what the respondent has done or proposes to do in response to the recommendation, or
   (b) if the respondent has not done, and does not intend to do, anything in response to the recommendation, the reasons for that.

(3) A response under subsection (1)(a) must be given to the SCTS within the period of 8 weeks beginning with the day on which the respondent receives a copy of the determination in which the recommendation is made.

(4) A person who gives a response to the SCTS under subsection (1) may, at the same time, make representations to the SCTS as to the withholding of part of the response from publication under subsection (5).

(5) The SCTS must, after considering any representations made under subsection (4), publish, in such manner as it considers appropriate—
   (a) a response, or part of a response, given in accordance with subsection (1),
   (b) if no response is given in accordance with subsection (1)(a) by the end of the 8 week period mentioned in subsection (3), notice of that fact.
Further inquiry proceedings

28 Circumstances in which there may be further proceedings

(1) Where an inquiry into the death of a person has ended, further inquiry proceedings may be held in relation to the death only in accordance with subsection (2).

(2) Further inquiry proceedings are to be held in relation to the death if—

(a) there is new evidence in relation to the circumstances of the death, and

(b) the Lord Advocate—

(i) considers that it is highly likely that a finding or recommendation set out in the determination would have been materially different if the evidence had been brought forward at the inquiry, and

(ii) decides that it is in the public interest for further inquiry proceedings to be held in relation to the circumstances of the death.

(3) For the purposes of subsection (2)(a), “new evidence” is evidence which was not available, and could not with the exercise of reasonable diligence have been made available, at the inquiry.

(4) For the purposes of subsection (1), an inquiry ends when the sheriff makes a determination in the inquiry.

(5) In this section and sections 29 and 30, references to the holding of further inquiry proceedings in relation to a death are references to—

(a) the re-opening and continuation of an inquiry into the death, or

(b) the holding of a fresh inquiry into the death.

29 Precognition of witnesses

(1) Subsection (2) applies where the Lord Advocate is considering whether further inquiry proceedings should be held in relation to the death of a person.

(2) The procurator fiscal may cite a person to attend for precognition in connection with that consideration.

(3) This section is sufficient warrant for such citation.

(4) Subsection (5) applies where a person cited under subsection (2)—

(a) having been given reasonable notice in the citation, and without reasonable excuse, fails to attend for precognition at the time and place mentioned in the citation, or

(b) does so attend but refuses to give information which is—

(i) within the person’s knowledge, and

(ii) relevant to the Lord Advocate’s consideration.

(5) The sheriff may, on the application of the procurator fiscal, make an order requiring the person to attend for precognition or, as the case may be, give the information at a time and place specified in the order.

(6) A person who fails to comply with an order under subsection (5) commits an offence.
(7) A person who commits an offence under subsection (6) is liable on summary conviction to imprisonment for a term not exceeding 21 days or a fine not exceeding level 3 on the standard scale or both.

(8) In this section and section 30, references to the sheriff are references to a sheriff of the sheriffdom in which the inquiry into the person’s death was held.

30 Initiating further proceedings

(1) Where further inquiry proceedings are to be held in relation to the death of a person in accordance with section 28(2), the procurator fiscal must give the sheriff—
   (a) notice that such proceedings are to be held,
   (b) a copy of the determination made in relation to the death (“the original determination”),
   (c) a brief account of the nature of the new evidence mentioned in section 28(2)(a), and
   (d) any other information required by an act of sederunt under section 34(1).

(2) On receiving notice under subsection (1)(a), the sheriff must make an order—
   (a) setting aside the original determination, and
   (b) either—
      (i) re-opening the inquiry into the death, or
      (ii) requiring a fresh inquiry to be held into the death.

31 Re-opened inquiries

(1) Sections 14 to 17 apply in relation to a re-opened inquiry into the death of a person as they apply in relation to any other inquiry, subject to subsections (2) to (4).

(2) The sheriff must, when making the order under section 30(2) re-opening the inquiry, also make an order under section 14(2) in relation to the re-opened inquiry (and section 14(1) (which requires the procurator fiscal to notify the sheriff that an inquiry is to be held) does not apply).

(3) The procurator fiscal must give notice of the re-opened inquiry under section 16(1), in addition to the persons mentioned in section 16(2), to any person not mentioned in that section—
   (a) who was a participant in the original inquiry proceedings, or
   (b) to whom a recommendation in the determination in those proceedings was addressed by virtue of section 25(5)(b).

(4) The notice required by section 16(1) and (3) must include notice of—
   (a) the fact that the inquiry has been re-opened (and section 16(1)(a) does not apply), and
   (b) the matters to which the new evidence relates.

(5) Evidence may be brought forward at a re-opened inquiry only if it relates to a matter to which the new evidence relates.

(6) But the sheriff may—
(a) require evidence to be brought forward about any other matter relating to the circumstances of the death, or
(b) on the application of the procurator fiscal or a participant in the inquiry, allow such evidence to be brought forward.

7 In this section—
“new evidence” means the new evidence mentioned in section 28(2)(a),
“original inquiry proceedings” means the part of an inquiry held before it is re-opened under section 30(2),
“re-opened inquiry” means the part of an inquiry held after it is so re-opened.

32 Fresh inquiries

(1) This section applies where the sheriff makes an order under section 30(2) setting aside the determination in an inquiry (“the original inquiry”) and requiring a fresh inquiry to be held.

(2) The sheriff must, when making the order, also make an order under section 14(2) in relation to the fresh inquiry (and section 14(1) (which requires the procurator fiscal to notify the sheriff that an inquiry is to be held) does not apply).

(3) The procurator fiscal must give notice of the fresh inquiry under section 16(1), in addition to the persons mentioned in section 16(2), to any person not mentioned in that section—
(a) who was a participant in the original inquiry, or
(b) to whom a recommendation in the determination in that inquiry was addressed by virtue of section 25(5)(b).

(4) The fresh inquiry is to be held in the sheriffdom in which the original inquiry was held (and section 12(2) (which requires the Lord Advocate to choose where the inquiry is to be held) does not apply).

(5) Subsection (4) is subject to section 12(3).

33 Further inquiry proceedings: compliance with recommendations

(1) This section applies where—
(a) a determination (“the original determination”) made in an inquiry into the death of a person has been set aside under section 30(2)(a), and
(b) the sheriff makes a determination (“the new determination”) in the re-opened inquiry or, as the case may be, the fresh inquiry into the death.

(2) Section 27(1) does not apply in relation to a person to whom a recommendation is addressed in the new determination if a recommendation in the same terms was addressed to the person in the original determination.

(3) Subsection (4) applies where—
(a) a recommendation was addressed to a person in the original determination, but
(b) a recommendation in the same terms is not addressed to the person in the new determination.

(4) The Scottish Courts and Tribunals Service must withdraw from publication—
Inquiries into Fatal Accidents and Sudden Deaths etc. (Scotland) Bill

Inquiry procedure rules

34 Power to regulate procedure etc.

(1) The Court of Session may by act of sederunt make provision for or about—

(a) the practice and procedure to be followed in inquiry proceedings,
(b) any matter incidental or ancillary to an inquiry.

(2) Without limiting the generality of subsection (1), the power in that subsection includes power to make provision for or about—

(a) the giving of notice under section 16,
(b) the conduct and management of inquiry proceedings, including the use of technology,
(c) the form of any document to be used in, or in connection with, inquiry proceedings,
(d) the process by which a person becomes a participant in an inquiry,
(e) the representation of the procurator fiscal and participants in inquiry proceedings, including representation of participants by persons who—

(i) are neither solicitors nor advocates, or
(ii) do not have the right to conduct litigation, or a right of audience, by virtue of section 27 of the Law Reform (Miscellaneous Provisions) (Scotland) Act 1990,
(f) witnesses and evidence, including modifying the rules of evidence as they apply to an inquiry,
(g) action to be taken by the procurator fiscal and the participants before the start of an inquiry or a re-opened inquiry,
(h) the fees payable to solicitors and advocates in relation to inquiry proceedings,
(i) the expenses payable to persons attending inquiry proceedings,
(j) the appointment of assessors under section 23(1) (including their functions and the terms on which they may be appointed),
(k) the giving and publication of responses under section 27,
(l) such other matters as the Court thinks necessary or appropriate for the purposes of carrying out or giving effect to the provisions of any enactment (including this Act) relating to inquiry proceedings or matters incidental or ancillary to such proceedings.

(3) An act of sederunt under subsection (1) may make—

(a) incidental, supplemental, consequential, transitional, transitory or saving provision,
(b) provision amending, repealing, or revoking any enactment (including any provision of this Act) relating to matters with respect to which an act of sederunt may be made,
Inquiries into Fatal Accidents and Sudden Deaths etc. (Scotland) Bill

(c) different provision for different purposes.

(4) Before making an act of sederunt under subsection (1) with respect to any matter, the Court of Session must—

(a) consult the Scottish Civil Justice Council, and

(b) take into consideration any views expressed by the Council with respect to that matter.

(5) Subsection (4) does not apply in relation to an act of sederunt that embodies, with or without modifications, draft rules submitted by the Scottish Civil Justice Council to the Court of Session.

(6) Schedule 1 makes further provision (including transitional provision) in relation to the regulation of the practice and procedure to be followed in inquiry proceedings.

Specialist sheriffs and summary sheriffs

Judicial specialisation in inquiries

(1) The sheriff principal of a sheriffdom may designate one or more sheriffs or summary sheriffs of that sheriffdom as specialists in inquiries for the purposes of this Act.

(2) The sheriff principal may at any time withdraw a designation made under subsection (1).

(3) The Lord President of the Court of Session may designate one or more part-time sheriffs or part-time summary sheriffs as specialists in inquiries for the purposes of this Act.

(4) The Lord President may at any time withdraw a designation made under subsection (3).

(5) The designation of a sheriff, summary sheriff, part-time sheriff or part-time summary sheriff (a “designated judicial officer”) under subsection (1) or (3) does not affect the competence of any other member of the judiciary of the sheriffdom to conduct inquiry proceedings.

(6) Subsection (7) applies where the sheriff principal is exercising any function relating to the allocation of inquiry proceedings.

(7) The sheriff principal must have regard to the desirability of ensuring that inquiry proceedings are conducted by a designated judicial officer.

(8) In subsection (5), the reference to a member of the judiciary of the sheriffdom is to be construed in accordance with section 136(2) of the Courts Reform (Scotland) Act 2014.

Summary sheriff: competence to conduct inquiries

A summary sheriff may, in relation to inquiry proceedings, exercise the jurisdiction and powers that attach to the office of sheriff.

General

Repeal and modification of enactments

(1) The Fatal Accidents and Sudden Deaths Inquiry (Scotland) Act 1976 is repealed.

(2) Schedule 2 modifies other enactments.

Interpretation

In this Act, unless the context requires otherwise—
“advocate” means a member of the Faculty of Advocates,
“child” means a person who has not yet reached the age of 18 years,
“inquiry” has the meaning given by section 1(5),
“inquiry proceedings” has the meaning given by section 10(2)(a),
“participant” is to be construed in accordance with section 10(2)(b),
“procurator fiscal” means any procurator fiscal, assistant procurator fiscal, procurator fiscal depute or person duly authorised to execute the duties of a procurator fiscal,
“re-opened inquiry” has the meaning given by section 31(7),
“solicitor” means a solicitor enrolled in the roll of solicitors kept under section 7 of the Solicitors (Scotland) Act 1980.

39 Ancillary provision

(1) The Scottish Ministers may by regulations make such incidental, supplemental, consequential, transitional, transitory or saving provision as they consider necessary or expedient for the purposes of, in consequence of, or for giving full effect to, any provision of this Act.

(2) Regulations under subsection (1)—

(a) may—

(i) make different provision for different purposes,

(ii) modify any enactment (including this Act),

(b) are subject to—

(i) the affirmative procedure if they add to, replace or omit any part of the text of an Act,

(ii) otherwise, the negative procedure.

40 Commencement

(1) This section and sections 38, 39 and 41 come into force on the day after Royal Assent.

(2) The remaining provisions of this Act come into force on such day as the Scottish Ministers may by regulations appoint.

(3) Regulations under subsection (2) may—

(a) include transitional, transitory or saving provision,

(b) make different provision for different purposes.

41 Short title

The short title of this Act is the Inquiries into Fatal Accidents and Sudden Deaths etc. (Scotland) Act 2015.
### SCHEDULE 1

*(introduced by section 34(6))*

**PROCEDURE RULES**

#### Role of the Scottish Civil Justice Council

1. **(1)** The Scottish Civil Justice Council and Criminal Legal Assistance Act 2013 is amended in accordance with this paragraph.

2. **(2)** In subsection (1) of section 2 (functions of the Council)—
   - after paragraph (ba) insert—
     - "(bb) to review the practice and procedure followed in inquiry proceedings under the Inquiries into Fatal Accidents and Sudden Deaths etc. (Scotland) Act 2015,",
   - after paragraph (c)(ii) insert—
     - "(iii) draft inquiry procedure rules,"

3. **(3)** After subsection (7) of that section insert—
   - "(8) For the purposes of this Part, “draft inquiry procedure rules” are draft rules prepared with a view to the making by the Court of Session of an act of sederunt under section 34(1) of the Inquiries into Fatal Accidents and Sudden Deaths etc. (Scotland) Act 2015.”.

4. **(4)** In section 4 (Court of Session to consider rules)—
   - in subsection (1), for “or draft tribunal procedure rules” substitute “, draft tribunal procedure rules or draft inquiry procedure rules”,
   - in subsection (2), for “or draft tribunal procedure rules” substitute “, draft tribunal procedure rules or draft inquiry procedure rules”.

5. **(5)** In subsection (1) of section 16 (interpretation of Part 1), after the entry relating to draft civil procedure rules insert—
   - "“draft inquiry procedure rules” has the meaning given in section 2(8),”.

#### Transitional arrangements

1. **(1)** Until paragraph 1 comes into force, section 34 applies as if, instead of conferring power on the Court of Session to make provision by act of sederunt for or about the matters mentioned in paragraphs (a) and (b) of subsection (1), that subsection conferred power on the Scottish Ministers to make such provision by regulations (and subsection (3) of that section is to be read accordingly).

2. **(2)** Section 34(4) does not apply in relation to regulations made by virtue of sub-paragraph (1).

3. **(3)** Before making regulations by virtue of sub-paragraph (1), the Scottish Ministers must consult—
   - (a) the Lord President of the Court of Session,
   - (b) such other persons as they consider appropriate.

4. **(4)** Regulations by virtue of sub-paragraph (1) are subject to the negative procedure.
# SCHEDULE 2
*(introduced by section 37(2))*

## MODIFICATION OF ENACTMENTS

### Gas Act 1965

<table>
<thead>
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<th>No.</th>
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<tr>
<td>5</td>
<td>In the Gas Act 1965, section 17(4) (accidents) is repealed.</td>
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### Health and Safety at Work etc. Act 1974

<table>
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<td>In the Health and Safety at Work etc. Act 1974, section 14(7) (power of the Health and Safety Executive to direct investigations and inquiries) is repealed.</td>
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### Energy Act 2013

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<th>No.</th>
<th>Amendment</th>
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<tbody>
<tr>
<td>10</td>
<td>In section 85 of the Energy Act 2013 (inquiries), subsections (7) and (8) are repealed.</td>
</tr>
</tbody>
</table>
Inquiries into Fatal Accidents and Sudden Deaths etc.
(Scotland) Bill
[AS INTRODUCED]

An Act of the Scottish Parliament to make provision for the holding of public inquiries in respect of certain deaths.

Introduced by: Michael Matheson
Supported by: Paul Wheelhouse
On: 19 March 2015
Bill type: Government Bill
INQUIRIES INTO FATAL ACCIDENTS AND SUDDEN DEATHS ETC. (SCOTLAND) BILL

EXPLANATORY NOTES

(CONTENTS)

As required under Rule 9.3 of the Parliament’s Standing Orders, the following documents are published to accompany the Inquiries into Fatal Accidents and Sudden Deaths etc. (Scotland) Bill introduced in the Scottish Parliament on 19 March 2015:

- Explanatory Notes;
- a Financial Memorandum;
- a Scottish Government statement on legislative competence; and
- the Presiding Officer’s statement on legislative competence.

A Policy Memorandum is published separately as SP Bill 63–PM.
INTRODUCTION

1. These Explanatory Notes have been prepared by the Scottish Government in order to assist the reader of the Bill and to help inform debate on it. They do not form part of the Bill and have not been endorsed by the Parliament.

2. The Notes should be read in conjunction with the Bill. They are not, and are not meant to be, a comprehensive description of the Bill. So where a section or schedule, or a part of a section or schedule, does not seem to require any explanation or comment, none is given.

THE BILL

3. The Bill seeks to modernise the legislative framework for Fatal Accident Inquiries (FAIs) in Scotland. The provisions in the Bill take forward many of the recommendations requiring primary legislation from Lord Cullen’s Review of the operation of the Fatal Accidents and Sudden Deaths Inquiry (Scotland) Act 1976 (“the 1976 Act”), which reported in 2009. The Scottish Government issued its response to the review in 2011, accepting the majority of Lord Cullen’s 36 recommendations.

4. The recommendations from Lord Cullen which were addressed to the Crown Office and Procurator Fiscal Service (COPFS) have already been taken forward by the establishment of the Scottish Fatalities Investigation Unit (SFIU).

5. The Bill will implement the remaining recommendations that the Government accepted in its response in 2011. A public consultation on the proposals of the Bill was carried out from 1 July to 9 September 2014 and responses published on 15 October 2014.

6. The Bill will repeal the 1976 Act and enact new provisions to govern the system of FAIs in Scotland. The Bill does not attempt to legislate for all of the recommendations made by Lord Cullen that were accepted by the Government. Some of the changes recommended will be implemented by the Lord President and the Scottish Courts and Tribunal Service (SCTS). Other changes will be implemented through FAI Rules to govern the procedure. The Bill seeks to set out the framework within which the rules will add the necessary detail.

7. For the purposes of this document, the term FAI will be used to describe an inquiry under the 1976 Act and this Bill.

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3. Consultation on proposals to reform Fatal Accident Inquiries legislation: http://www.scotland.gov.uk/Publications/2014/07/6772
4. Responses to the consultation on proposals to reform Fatal Accident Inquiries legislation: http://www.scotland.gov.uk/Publications/2014/10/8764
8. The Bill is in 41 sections and 2 schedules.

9. Section 1 sets out the nature and purpose of an inquiry under the Bill, with sections 2 to 7 describing the situations where an inquiry must or may be held.

10. Section 8 provides for the Lord Advocate on request to explain to close relatives and partners why an inquiry is not to be held.

11. Sections 9 to 13 make general provision, firstly, relative to the procurator fiscal’s investigation (section 9), then for who may participate in an inquiry (section 10), thirdly, for the location of the inquiry and the jurisdiction of the sheriff (sections 11 and 12), and lastly for inquiries into multiple deaths (section 13).

12. Sections 14 to 17 provide for the procedure that precedes the inquiry proper. This includes the procedure for initiating the inquiry (section 14) and for giving notice of it (section 16), provision for preliminary hearings (section 15), and provision for the agreement of undisputed facts between the procurator fiscal and the participants (section 17).

13. Sections 18 to 24 provide for the inquiry itself. This includes provision relating to the powers of the sheriff (section 18), provision about evidence and witnesses (section 19), a requirement that the inquiry be held in public (section 20), and publishing restrictions and offences relating to those restrictions in relation to the identification of children (sections 21 and 22). Section 23 permits a sheriff to appoint a person (known as an assessor) to assist him/her. Finally, section 24 prohibits the sheriff from awarding expenses in relation to the proceedings.

14. Sections 25 to 27 provide for the sheriff’s findings, dissemination of his/her determination, and compliance with any recommendations.

15. Sections 28 to 33 make provision for the circumstances in which there might be further proceedings and the procedures for those. Section 31 makes provision where these further proceedings are to be a re-opening of the original inquiry and section 32 where they are to be a fresh inquiry.

16. Section 34 provides for the Court of Session to make rules relating to procedure, schedule 1 (which is introduced by subsection (6)) makes provision in relation to the functions of the Scottish Civil Justice Council and sets out transitional provisions relating to the making of rules. Section 35 makes provision for the designation of specialist judicial officers in relation to FAIs.

17. Finally, sections 37 to 41 make general provision in relation to the Bill and schedule 2 lists modifications of existing legislation.
COMMENTARY ON SECTIONS

Inquiries into certain deaths

Section 1- Inquiries under this Act

18. Subsection (1) provides that where an FAI is to be held into a death, it is the duty of the procurator fiscal to investigate the death, and arrange for an FAI to be held into it. Subsection (2) provides that the FAI is to be conducted by a sheriff (this may include a sheriff principal) as defined in subsection (5)(b). Subsection (3) makes it clear that the purpose of an FAI is to establish the circumstances of the death and to consider whether any precautions could be taken which may prevent other deaths in similar circumstances. Subsection (4) makes it clear that it is not the purpose of FAIs to establish civil or criminal liability. They are not adversarial hearings and are not designed to be like civil litigation. Nor have they any connection to criminal proceedings. The definition of sheriff in subsection (5)(b) means that when the Bill refers to sheriff it is referring to a sheriff of the sheriffdom in which the FAI is, or is to be, held. Section 12 makes provision about where the FAI is to be held. The powers of the sheriff can also be exercised by a summary sheriff, given the effect of section 36 of the Bill, and the reference to sheriff also includes the sheriff principal given the effect of section 134(2) of the Courts Reform (Scotland) Act 2014.

Inquiries into deaths occurring in Scotland

Section 2 - Mandatory inquiries

19. Section 2 sets out the circumstances in which an FAI is mandatory. Under subsection (3) an FAI is mandatory if the person died in Scotland as a result of an accident in Scotland, in the course of the person’s employment or occupation. This replicates the effect of section 1(1)(a)(i) of the 1976 Act.

20. Under subsection (4) an FAI is mandatory if the person has died in Scotland and was in legal custody, or was a child required to be kept or detained in secure accommodation. A person being in legal custody or secure accommodation is defined by the status of that person regardless of the person’s physical location at the time of the death. Accordingly if a person dies in hospital who is at the time of death still serving a custodial sentence, an FAI must be carried out. The effect is the same as that in section 1(1)(a)(ii) and (4) of the 1976 Act.

21. Subsection (5) defines “legal custody”. This includes being imprisoned or detained in a penal institution, being in police custody, being held in custody on court premises or being detained in service custody premises. The definition of police custody takes its meaning from the Criminal Justice (Scotland) Bill currently at stage 2 before the Parliament. The reference to court custody includes the death of any person in the court cells or the court building, which may be separate from police custody or occur after the end of police custody. A death of a person required to be detained in premises used by the armed forces as service custody premises continues to be included as before restating reserved law in this regard.

22. The inclusion of a death of a child required to be kept or detained in secure accommodation is an addition to the mandatory categories in the 1976 Act. “Child” is defined in section 38 as a person who has not yet reached the age of 18 and secure accommodation takes its definition from regulations made under the Public Services Reform (Scotland) Act 2010, thus
These documents relate to the Inquiries into Fatal Accidents and Sudden Deaths etc. (Scotland) Bill (SP Bill 63) as introduced in the Scottish Parliament on 19 March 2015

keeping pace with any change to the meaning of such accommodation which may occur from time to time.

23. By providing that an FAI is to be held in these circumstances, the effect of this section is to require the procurator fiscal to investigate the circumstances of the death and arrange for a FAI to be held.

Section 3 – Mandatory inquiries: exceptions

24. This section allows the Lord Advocate to decide that an FAI is not to be held into a death which falls within the categories of death set out in section 2 (mandatory inquiries). The Lord Advocate can exercise this discretion only if satisfied that the circumstances of the death have been sufficiently established in the course of certain other proceedings.

25. The other proceedings which the Lord Advocate is permitted to rely upon are criminal proceedings, an inquiry under section 17(2) of the Gas Act 1965, an inquiry under section 14(2A) of the Health and Safety at Work etc. Act 1974, an inquiry under section 85(1) of the Energy Act 2013 and, except in the case of a death of a person required to be detained in service custody premises, an inquiry under section 1 of the Inquiries Act 2005. Inquiries under the 2005 Act are public inquiries into events that have caused or have potential to cause public concern, examples include inquiries into a particular event (eg Dunblane inquiry 1996) or a series of events (eg BSE inquiry 1997). They are held at the instigation of UK or Scottish Government Ministers with the aim of helping to restore public confidence in systems or services by investigating the facts, which may include why matters may have been dealt with in a particular way over the course of many years and making recommendations to prevent recurrence, not to establish liability or to punish anyone. By comparison, FAIs provide a local inquiry into the circumstances of a death and consider what steps might be taken to prevent deaths in similar circumstances.

26. Currently, section 1(2) of the 1976 Act makes provision for the interaction between deaths that are subject to a mandatory inquiry and criminal proceedings. In relation to other inquiries, currently separate provision is made in section 17(4) of the Gas Act 1965, section 14(7) of the Health and Safety at Work etc. Act 1974 and section 85(7) and (8) of the Energy Act 2013, which state that an FAI is not be held where a death has already been investigated in an inquiry under those Acts, unless the Lord Advocate directs otherwise. In relation to the Inquiries Act 2005, there is currently no provision which allows the Lord Advocate to take into account that the circumstances of the death requiring a mandatory FAI have been established during the course of an inquiry under the 2005 Act. For inquiries under the various statutory provisions noted above, the Bill therefore shifts the emphasis from there being no FAI unless the Lord Advocate directs otherwise. In relation to the Inquiries Act 2005, there is currently no provision which allows the Lord Advocate to take into account that the circumstances of the death requiring a mandatory FAI have been established during the course of an inquiry under the 2005 Act. For inquiries under the various statutory provisions noted above, the Bill therefore shifts the emphasis from there being no FAI unless the Lord Advocate directs, to the Lord Advocate having discretion to direct that there will be no FAI. So if the discretion is not exercised the result under the Bill is that (if the circumstances are within section 2(3) or (4)) there will be an FAI. The Bill also brings the relevant interactions with mandatory inquiries and other inquiries within fatal accident legislation, making it easier to access. Insofar as these provisions modify the law on reserved matters they effect a restatement (see also the Explanatory Note to schedule 2).

27. In summary, this section permits the Lord Advocate to decide that the circumstances of the death have been sufficiently established in certain specified proceedings and therefore no FAI is necessary. If the circumstances have not been established then an inquiry must be held. But
the Bill also permits the Lord Advocate to decide that even where the circumstances have been established, an inquiry could still be held. There may be deaths where the Lord Advocate may conclude that even though the circumstances have been established, the public interest demands that a sheriff should consider whether recommendations should be made in the public interest as to how deaths in similar circumstances might be avoided in the future.

Section 4 – Discretionary inquiries

28. Section 4 reproduces the effect of section 1(1)(b) of the 1976 Act to give the Lord Advocate discretion to require an inquiry to be held into a death in Scotland if they consider that the death was sudden, suspicious or unexplained or occurred in circumstances which give rise to serious public concern, and that it is in the public interest to do so. Subsection (2) provides that the power to hold discretionary inquiries does not apply to a death where a mandatory inquiry is required.

Section 5 – Certain deaths and accidents to be treated as occurring in Scotland

29. Section 5 reproduces the effect of section 9 of the 1976 Act as a restatement of reserved law. Section 5 operates to ensure that a death or accident is to be treated as having occurred in Scotland if it was connected to certain activities related to the offshore oil and gas industry and took place within the area of sea adjacent to Scotland which is treated as being subject to Scottish civil law. The Bill does this by defining the activities and areas regulated by reference to section 11(2) of the Petroleum Act 1998, with the effect that those activities and that area subject to section 11(2) are also covered by the Bill.

Inquiries into deaths occurring abroad

Section 6 – Inquiries into deaths occurring abroad: general

30. Section 6 permits an FAI to be held into a death of a person ordinarily resident in Scotland, if it occurs outwith the United Kingdom and the body is repatriated to Scotland (subsection (1)). Until now it has only been possible to hold an FAI into a death which occurred in Scotland (other than the deaths of service personnel). Section 6 does not apply to deaths in England, Wales and Northern Ireland as such deaths will continue to be subject to the system of coroners’ inquests in those countries (see the use of the words “outwith the United Kingdom” in subsection (1)(a)). The effect of subsection (2) is that this section does not apply to deaths of service personnel abroad, which are dealt with in in section 7.

31. Subsection (3) sets out the criteria for the Lord Advocate’s discretion to decide if an FAI should be held into such a death. As for other discretionary FAIs, the Lord Advocate will consider whether the death was either sudden, suspicious or unexplained, or occurred in circumstances giving rise to serious public concern. The Lord Advocate must also consider whether the circumstances of the death have already been established in the course of an investigation by the appropriate authorities in the country where the death occurred, and whether there is a real prospect that those circumstances would be sufficiently established in a FAI. The FAI will only be held if the Lord Advocate decides that it is in the public interest to investigate the circumstances of the death. An FAI into a death within this section will proceed in the same way as any other FAI under the Bill.
Section 7 – Inquiries into deaths occurring abroad: service personnel

32. Section 7 re-enacts section 1A of the 1976 Act which was inserted by section 12 of the Coroners and Justice Act 2009. Those provisions were inserted following a Legislative Consent Resolution passed by the Scottish Parliament on 21 May 2009 and accordingly the Scottish Government’s position is that elements of section 7 restate reserved law. Section 12 permits the Secretary of State or the Chief Coroner to notify the Lord Advocate if it is considered that it is appropriate for the death abroad of armed forces service personnel, or of a civilian subject to service discipline who was accompanying service personnel who were engaged in active service, to be the subject of an FAI rather than a coroner’s inquest. This will normally be where the deceased was domiciled in Scotland.

33. Section 7 of the Bill makes provision for an FAI to be held into such a death if it occurs while the person is in legal custody, or is sudden, suspicious or unexplained, or occurs in circumstances giving rise to serious public concern. This includes a death abroad whilst detained abroad in premises analogous to service custody premises as defined under the Armed Forces Act 2006.

34. An FAI will be held if the Lord Advocate decides that it will be in the public interest so to do. Subsection (4) means that no inquiry can be held if the Lord Advocate is satisfied that the circumstances of the death have been sufficiently established in criminal proceedings. An FAI into a death within this section will proceed in the same way as any other FAI under the Bill.

Reasons where inquiry not held

Section 8 – Reasons for decision not to hold an inquiry

35. Under section 8, where it is decided that an FAI is not to be held, the Lord Advocate must give reasons (in writing) for that decision. This duty only applies where the request is made by the spouse or partner (civil or cohabiting) or nearest relative of the deceased and the Lord Advocate is only required to respond to these persons. This reflects COPFS’ current practice and would cover situations such as when the Lord Advocate decides that an FAI should not be held in terms of section 4. Paragraph (b) includes a same sex couple living together.

Procurator fiscal’s investigation

Section 9 – Citation of witnesses for precognition

36. It will sometimes be necessary for the procurator fiscal to precognosce witnesses as part of a death investigation prior to determining whether there are to be further proceedings. Section 9 replicates section 2 of the 1976 Act to enable the citation of witnesses for precognition as part of that death investigation. Subsection (5) makes it an offence to fail to comply with an order made by the sheriff requiring a person to attend for precognition and subsection (6) sets out the penalty if convicted of that offence.

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Participants

Section 10 – Persons who may participate in the inquiry

37. Section 10 specifies the people who may participate in an FAI in addition to the procurator fiscal. The provisions in this section have been updated to capture modern relationships as the 1976 Act does not include civil or cohabiting partners. There may be circumstances where the deceased may not have been living with a spouse or civil partner at the time of death and may instead have been cohabiting with another person. This provision gives a cohabitee in such circumstances the right to participate in the FAI. The Bill’s description in section 10(1)(b) of a person living with A as if married to A at the time of A’s death will include a same sex couple living together.

38. The provisions preserve the effect of section 4(2) of the 1976 Act providing that, where the inquiry concerns a death at work, an inspector appointed under section 19 (appointment of inspectors) of the Health and Safety at Work etc. Act 1974 may also be a participant if he or she so chooses. In that limited regard, the Bill restates reserved law.

Location

Section 11 – Places at which inquiries may be held

39. The Scottish Ministers will be able to make regulations under section 11 to designate places at which a sheriff court may be held for the purposes of holding an FAI. Subsection (1) makes it clear that these places will be additional to the places already designated for the holding of sheriff courts under the Courts Reform (Scotland) Act 2014. “Places” in this sense means the towns and cities where sheriff courts are held – it does not mean specific sheriff court buildings as FAIs have already been held in other buildings.

40. An FAI may be held at a sheriff court building, but it may also be held in another building in a place designated under the 2014 Act or section 11 of the Bill. This allows the current practice of holding FAIs in buildings not usually used for court purposes (e.g. locations such as the Council Chamber in, for example, Aberdeen City Chambers and the Maryhill Community Centre in Glasgow, or in places where there is no sheriff court (e.g. Motherwell)).

41. Since the SCTS has the statutory responsibility for providing property for the Scottish courts under section 61(1) of the Judiciary and Courts (Scotland) Act 2008, the Scottish Ministers will only make regulations under subsection (1) following the submission of a proposal by SCTS – with the agreement of the Lord President – for the designation of a place for the holding of FAIs under subsections (2) and (3). However, this procedure will be subject to consultation with appropriate persons under subsection (4).

42. In making the regulations, the Scottish Ministers are to have regard to the SCTS proposal under subsection (5). Given the statutory responsibility which the Lord President has for the efficient disposal of business in Scotland’s courts under section 2(2) of the 2008 Act, and the equivalent responsibility of the SCTS set out above, the Scottish Ministers must obtain the consent of both the Lord President and the SCTS under subsection (6) before making those regulations. This power is subject to affirmative procedure.
Section 12 – Jurisdiction in relation to inquiries

43. Section 12(1) provides that an FAI may be held in any sheriffdom in Scotland regardless of the place of the death or (if applicable) any accident causing the death. This removes the requirement of a close connection between the place most closely connected with the circumstances of the death and the procurator fiscal for the sheriff court district relating to that place that is provided by section 1 of the 1976 Act. This will allow greater flexibility in the system of FAIs which may allow inquiries to be held more quickly if they can be accommodated in alternative accommodation. This flexibility still permits an FAI to be heard locally in relation to the circumstances of the death, however, and indeed it is expected that the majority of FAIs will be held in the same sheriffdom as the place of death.

44. Subsection (2) allows the Lord Advocate to choose in which sheriffdom the FAI is to be held, after consulting with the SCTS. It does not allow the Lord Advocate to choose the place or building within the sheriffdom where the FAI will be held, which will be a matter for discussion between the Lord Advocate (who will have been in contact with any relatives of the deceased), the sheriff principal and the SCTS. Ultimately the decision is for the sheriff principal under his or her powers relative to the efficient disposal of business contained in the Courts Reform (Scotland) Act 2014.

45. Subsections (3) and (5) allow the sheriff to transfer the FAI to another sheriffdom, but only after the procurator fiscal and the participants have been given an opportunity to make representations about such a transfer and only with the consent of the sheriff principal for that sheriffdom and the sheriffdom to which the FAI is to transfer. The transfer order may be made at the sheriff’s own initiative or at the instigation of the procurator fiscal or one of the participants at the FAI.

Inquiries into multiple deaths

Section 13 - Inquiry into more than one death

46. Section 13 permits a single FAI to be held into multiple deaths if they are as a result of the same accident or occur in the same or similar circumstances. The 1976 Act only allows inquiries into multiple deaths that occur in the same sheriffdom. This provision, along with section 12, means that one FAI may take place into multiple deaths regardless of the place where the deaths took place.

Pre-inquiry procedure

Section 14 - Initiating the inquiry

47. An inquiry is only to be held where the Lord Advocate makes a decision to that effect or where the Bill requires one to be held on a mandatory basis. Section 14 provides that where an inquiry is to be held, the procurator fiscal is to give notice to the sheriff of that fact. The procurator fiscal is also required to give the sheriff a brief account of the circumstances of the death so far as they are then known to the procurator fiscal, together with any other information which may be set out as required in FAI rules made by act of sederunt under section 34(1) of the Bill. Under subsection (2), the sheriff will set out in an order the date and place for the preliminary hearing to the FAI if one is to be held, and for the FAI itself, which need not be held at the same place. The sheriff will also grant warrant for the procurator fiscal and participants to cite witnesses.
48. Subsection (3) provides flexibility for the sheriff to not fix a date and place for the hearing, but only if a preliminary hearing is to be held and the sheriff considers it appropriate not to fix such a date. It is left to the discretion of the sheriff as to the circumstances in which it is not appropriate to fix a date; it may be that at this early stage the sheriff is unsure as to the scope of the FAI and may wish to hear submissions prior to fixing the date.

49. Subsection (4) allows the sheriff to vary a date and place fixed for the holding of a preliminary hearing or inquiry.

50. Subsection (5) makes it clear that, in deciding the date for the holding of the FAI, the sheriff must have regard to the desirability of holding the inquiry as soon as is reasonably practicable. This means that the sheriff must bear in mind the need to hold the inquiry soon, and while the inquiry need not be held immediately, that only practical aspects which require a delay be taken into account (such as available accommodation and reasonable time for participants to prepare) when choosing a date.

Section 15 – Preliminary hearings

51. Section 15 requires a preliminary hearing to be held before every FAI unless the sheriff dispenses with that requirement in accordance with rules made in an act of sederunt under section 34(1). The sheriff is given further power to reverse a decision not to hold a preliminary inquiry.

52. Further provision is to be made with regard to the content and purpose of preliminary hearings in rules made in an act of sederunt under section 34(1). The purpose of a preliminary hearing for an FAI is to consider the likely length of the proceedings, the state of preparedness of participants and the procurator fiscal, the amount of evidence and any areas for agreement of uncontroversial facts, and anything else that needs to be addressed before the inquiry proceedings can begin.

Section 16 – Notice of the inquiry

53. Once the date and location of the preliminary hearing and/or FAI hearing is fixed (in accordance with the sheriff’s powers under section 14), then section 16 places a duty on the procurator fiscal to notify those persons who the procurator fiscal considers to be persons who are entitled to participate in the FAI. Those who are entitled to be participants are set out in section 10. In addition, the procurator fiscal is also required to notify any person specified in FAI rules or in a category of person specified in FAI rules made in an act of sederunt under section 34(1). Subsection (3) provides that the procurator fiscal will also have to provide public notice of the FAI, the date and place of any preliminary hearing, and the date and place of the FAI.

54. The procurator fiscal is under a continuing duty to notify and publicise changes to the place or date of these matters, including notification of a preliminary hearing where the sheriff has reversed his or her decision not to hold one. For the avoidance of doubt, the procurator fiscal only has to notify directly those who appear to the procurator fiscal to be entitled to participate or whom he or she has to notify under FAI rules.
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Section 17 – Agreement of facts before an inquiry

55. Section 17 provides that FAI rules will make provision about the agreement, before the start of the inquiry, by the procurator fiscal and the participants in an inquiry of uncontroversial facts which are unlikely to be disputed. This is to avoid the need for evidence to be led at the FAI about issues which are not in doubt and thus contribute to shortening the FAI. FAI rules are likely to set out the process by which agreement is to be reached, and include a duty to seek agreement.

The inquiry

Section 18 - The powers of the sheriff

56. Section 18 makes it clear that sheriffs have all of the inherent powers that they have as a judge in civil proceedings in relation to an FAI. This does not make an FAI a form of civil proceedings. Such inherent powers are, however, subject to the other provisions in the Bill or provision made by FAI rules by virtue of subsection (2).

Section 19 – Evidence and witnesses

57. Section 19 sets out that the procurator fiscal must bring forward evidence relating to the circumstances of the death at the inquiry and that participants may also bring forward such evidence. The Bill does not regulate the procedure to be followed or the way in which evidence is led and further details on that may be provided in rules. In addition, subsection (2) enables the sheriff to instruct a participant in the FAI or the procurator fiscal to lead evidence on any matter relating to the circumstances of the death. The sheriff is not, therefore, dependent upon the procurator fiscal nor the participants with regard to what evidence is led. An FAI is an inquisitorial judicial inquiry held in the public interest and empowering the sheriff in this way is in keeping with the aims of the process.

58. Subsection (3) applies the rules of evidence that apply in civil proceedings to FAIs. This continues the approach in section 4(7) of the 1976 Act and, accordingly, evidence that has not been corroborated and hearsay evidence are both admissible in FAI proceedings (as set out in sections 1, 2, and 9(c) of the Civil Evidence (Scotland) Act 1988). It follows that the evidential standard for facts to be proven for FAIs is the civil standard of proof – the balance of probabilities.

59. Subsection (4) makes it clear that subsection (3) is subject to any provision made in rules in an act of sederunt under section 34(1).

60. Subsections (5) and (6) restate section 5 of the 1976 Act. These subsections make clear that, where a witness is questioned, that does not mean that subsequent criminal proceedings may not then be taken against that person. Further, if a question is put to a witness the answer to which could show the witness was guilty of an offence, that witness is not required to answer that question.

Section 20 – Inquiry to be conducted in public

61. Section 20 provides that an FAI should normally be open to the public. However subsection (2) allows the sheriff to order that an inquiry, or part of it, is to be held in private.
The sheriff can make this order if the procurator fiscal or one of the participants applies for it, or may do so on his or her own initiative. The circumstances in which an FAI may be held in private have been left to the discretion of the sheriff, as the reasons may range widely from issues of national security to the need to protect children or other vulnerable persons.

Section 21 – Publishing restrictions in relation to children

62. Section 21 allows the sheriff to prohibit publication of material that could identify a child involved in an FAI. “Child” now means a person who has yet to reach the age of 18 years. The prohibited material which may lead to identification of the child includes, but is not limited to, the items listed in subsection (3). Under subsection (4), the sheriff may make such an order on his or her own initiative or on the application of the procurator fiscal or a participant in the FAI. Failure to comply with the sheriff’s order will constitute an offence under subsection (5), the penalty for which is set out in paragraph (6). The Bill recognises that some of those involved in the process of publishing, such as a newspaper distributor or retailer, may not be aware that the content of the publication is in breach of such an order and provides for a defence. The definitions of “publish” and “material” in subsection (8) are wide and include material published online. The Scottish Government proposes that the Order under section 104 of the Scotland Act 1998 referred to in the Policy Memorandum will extend the effect of publishing restrictions to England and Wales and Northern Ireland.

Section 22 – Offences by bodies corporate etc.

63. Section 22 applies where the publication offence in section 21(5) is committed by bodies such as companies, partnerships and unincorporated associations (e.g. a club). This provision allows for natural persons who have an element of control over such bodies (e.g. a director or partner (as set out in subsection (3)) also to be held criminally liable and to be fined in certain circumstances.

Section 23 – Assessors

64. Under section 23, the sheriff can appoint an assessor to provide assistance to the sheriff in relation to that FAI based on the assessor’s specialist knowledge or expertise.

Section 24 – Expenses

65. This provision expressly removes any power of the court to award legal expenses in an FAI. The effect of this section is unconnected with the payment of the expenses of witnesses etc. about which rules may be made in an act of sederunt under section 34(1).

66. The decision to hold an FAI is taken by the Lord Advocate acting in the public interest. The rule making power in the Bill will permit rules to be made to give sheriffs sufficient case management powers to be able to deal with vexatious behaviour as it arises without the need to award expenses. For example, FAI rules will greatly empower the sheriff to control proceedings through the use of minutes of agreed evidence, powers to regulate the conduct and management of proceedings and the regulation of witnesses and evidence.
Findings and recommendations

Section 25 – The sheriff’s determination

67. Section 25 provides for the determination made by the sheriff at the end of an FAI. Subsection (1) modernises what is currently set out in section 6(1) of the 1976 Act as recommended by Lord Cullen. The sheriff must make findings in relation to the circumstances of the death as set out in subsection (2), and has discretion as he or she considers appropriate, whether to make recommendations about steps which might realistically prevent deaths in similar circumstances in the future (as set out in subsection (4)).

68. Subsection (2) specifies the circumstances of the death or facts which must be set out in the determination, i.e. it looks back at what happened in the particular case. Subsection (2)(a) to (d) replicates section 6(1)(a) and (b) of the 1976 Act.

69. Subsection (2)(e) requires the determination to set out any precautions which were not taken before the death which is the subject of the FAI, but that could reasonably have been taken and might realistically have prevented the death. The precautions that the sheriff identifies at this point relate to the death which is the subject of the FAI and might not be the same as those recommended to prevent other deaths in the future under subsection (4)(a). In subsection (2)(e)(i), “reasonably” relates to the reasonableness of taking the precautions rather than the foreseeability of the death or accident. A precaution might realistically have prevented a death if there is a real or likely possibility, rather than a remote chance, that it might have so done.

70. Subsection (2)(f) is based on section 6(1)(d) in the 1976 Act. It allows the sheriff to make findings about any defects in a system of working which contributed to the death or an accident resulting in the death.

71. Subsection (2)(g) allows the sheriff to make findings about any other facts which are relevant to the circumstances of the death.

72. Subsection (3) provides that, for the purpose of identifying precautions that might have been taken, it does not matter whether it was foreseeable before the death or accident that the death or accident might occur if the precautions were not taken. Subsection (3) also provides that it does not matter, for the purpose of identifying defects in a system of working, whether or not if it was foreseeable that the death or accident might have occurred as a result of those defects. This makes it clear that the sheriff may employ hindsight when considering these findings, and further distinguishes an FAI from civil litigation.

73. Subsection (4) sets out the matters about which the sheriff may make recommendations, i.e. it looks forward to the prevention of similar deaths in the future. These matters are the taking of reasonable precautions, the making of improvements to, or introduction of, a system of working, or the taking of any other steps that might realistically prevent future deaths in similar circumstances. Again, there must be a real or likely possibility that the matters recommended may prevent other deaths in similar circumstances, rather than a remote chance that a similar death in the future might be prevented.
74. Subsection (5) allows the sheriff to address a recommendation to a participant or a body or office-holder with an interest in the prevention of deaths in similar circumstances to those in which the death occurred.

75. Subsection (6) provides that an FAI determination is inadmissible in evidence and cannot be founded on in other judicial proceedings. This reproduces the effect of section 6(3) of the 1976 Act. This is an essential element of the distinction between, on the one hand, the fact-finding inquisitorial nature of the FAI with the sheriff empowered to make recommendations and on the other, the fault-finding, adversarial nature of civil proceedings. It is not the purpose of the FAI to establish liability. If liability arises from the death, then a civil case is the forum in which such matters are to be examined.

Section 26 - Dissemination of the sheriff’s determination

76. Section 26 confers duties on SCTS to publish and disseminate an FAI determination once it has been made by the sheriff.

77. Subsection (1)(a) requires the SCTS to publish all FAI determinations in such manner as it considers appropriate, but it is expected that this will be done by posting on the SCTS website. Subsection (1)(b) requires SCTS to issue a copy of the determination to the Lord Advocate, participants at the FAI, any person to whom a recommendation has been addressed and anyone else who may have an interest in any recommendation made.

78. Subsections (2) and (3) replicate the effect sections 6(4)(a) and (5) of the 1976 Act respectively. Subsection (2) obliges SCTS on request to send to the people and bodies listed there: a copy of the determination, the notice given by the procurator fiscal which initiated the FAI, any transcript of the evidence which was taken and any report or documentary production used in the FAI. Subsection (3) obliges SCTS to give to any other person, if requested and on payment of a fee to be set out in the FAI rules, a copy of the determination, or, if the person has an interest in the inquiry and makes the request within a timeframe set out in rules, any transcript of the evidence at the inquiry.

79. There may, however, be cases where persons should not receive all the details (for example cases involving children where identities may be irrelevant to the recipients). Subsection (5) provides that the sheriff may decide that part of the determination should not be published or should not be given to a person. It is expected that the determination will be treated in the same way as any other sensitive court judgement. The subsection gives the sheriff flexibility to redact where he or she thinks fit and in line with SCTS policy, but only in accordance with provision made in the FAI rules.

80. Subsection (6) provides that the procurator fiscal must, after the determination has been issued, advise the Registrar General of Births, Deaths and Marriages for Scotland of the date, place and cause death and the deceased’s name and last known address. This replicates the effect of section 6(4)(b) of the 1976 Act.
Section 27 – Compliance with sheriff’s recommendations

81. Subsection (1) obliges a person to whom a sheriff has made a recommendation to provide SCTS with a written response to that recommendation if he or she was a participant in the inquiry. In any other case, the person may choose to respond.

82. Under subsection (2) the respondent must state—
   • what the respondent has done or proposes to do in response to the sheriff’s recommendation; or
   • if the respondent has not done and does not intend to do anything in response to the recommendation, their reasons for that.

83. Under subsection (3), the respondent should reply within eight weeks of receipt of a copy of the determination. If the person does not respond to the determination with that period, there will be no sanction as such – the incentive for parties to respond would be that a lack of response or lack of good reasons for not implementing the recommendation would become public knowledge, thus promoting accountability and transparency. A person responding will have the opportunity to make representations to SCTS that part of the response should be withheld (subsection (4)).

84. SCTS will publish the response alongside the original determination, subject to such redaction as considered appropriate taking into account any representations from the respondent and any other reason (such as data protection law). If no response is received, SCTS will publish a note to that effect alongside the original determination (subsection (5)(b)).

Further inquiry proceedings

Section 28 – Circumstances in which there may be further proceedings

85. Section 28 makes provision for the circumstances in which there may be further proceedings under the Bill in relation to a death. This is a new power conferred on the Lord Advocate, which was not provided for in the 1976 Act.

86. Subsection (1) provides that, after an inquiry has ended, there may only be further inquiry proceedings in accordance with subsection (2).

87. Subsection (2) sets out the test for holding further FAI proceedings. The Lord Advocate may decide that there are to be further proceedings if there is new evidence in relation to the circumstances of the death, and the Lord Advocate considers that it is highly likely that any of the sheriff’s findings and/or recommendations would have been materially different if the new evidence had been available at the original FAI (rather than the determination as a whole being materially different), and the Lord Advocate decides that it is in the public interest for further proceedings to be held.

88. The definition of “new evidence” in subsection (3) is based on section 4(7)(b) of the Double Jeopardy (Scotland) Act 2011. It means evidence which was not available, and could not reasonably have been made available, at the original inquiry into the death.
89. Further inquiry proceedings can take one of two forms, either the re-opening and continuation of the original inquiry, or a completely new (fresh) inquiry being held into a death which was the subject of the original inquiry. The making of a determination by the sheriff is treated as the end of the original FAI in subsection (4). The sheriff will decide if further proceedings should be in the form of re-opening the original FAI or in the form of holding a fresh FAI (see section 30).

Section 29 – Precognition of witnesses

90. Section 29 allows the procurator fiscal to cite witnesses for precognition prior to any further proceedings. It is based on section 9 of the Bill and, if a person fails to comply when cited, the person is subject to the same level of sanction.

Section 30 – Initiating further proceedings

91. Section 30(1) requires the procurator fiscal to notify the sheriff that there are to be further proceedings in relation to the death and to provide a copy of the original determination as well as a brief account of the new evidence which has come to light. The sheriff to be notified is a sheriff of the sheriffdom within which the original proceedings were held (section 29(8)). Under subsection (2), the sheriff must set aside the determination made at the original inquiry and decide whether there is to be a fresh FAI or whether the original FAI is to be re-opened, and then make an appropriate order. This is not a matter for the Lord Advocate, nor is the location of the fresh or re-opened FAI.

92. Irrespective of whether the sheriff decides to re-open or hold a fresh FAI, the whole determination in the original proceedings must be set aside under subsection (2)(a). This is because, even if the only change to a determination is to record the new evidence led at a re-opened FAI, there will be another determination at the end of the further proceedings.

Section 31 – Re-opened inquiries

93. Subsection (1) applies sections 14 to 17 of the Bill (which provide for pre-inquiry procedure) to a re-opened inquiry in the same way as to the original inquiry. Subsections (2) to (4) modify the application of those sections to take into account that this is a re-opening of the original inquiry. Accordingly, as the procurator fiscal has already notified the sheriff that there are to be further proceedings, the notification procedure on the procurator fiscal in section 14(1) is disapplied by subsection (2). This subsection also provides that the sheriff is to make an order under section 14(2) at the same time as he or she makes the order under section 30(2). An order under section 14(2) is one fixing a date and place for the holding of a preliminary hearing and the inquiry.

94. Subsection (3) requires notice of the re-opened inquiry under section 16 to be given to the participants at the original FAI and persons to whom recommendations were originally addressed.

95. Subsection (4)(b) requires notice to include the nature of the new evidence which was provided to the sheriff by the procurator fiscal. The purpose of this is to focus the minds of participants as to why the FAI has been re-opened and help them to prepare the relevant submissions and evidence they may wish to lead and any relevant background evidence which was led at the original FAI and which is required in order to set the context of the new evidence.
96. Subsection (5) restricts the evidence that is to be led to evidence about the matters to which the new evidence relates. However subsection (6) permits any evidence to be led if the sheriff either requires or allows it to be led. Taken together, the intention is that there is to be strong presumption that the re-opened inquiry will consider only those matters related to the new evidence. However, there is a recognition that it may not be foreseeable where that new evidence will lead, permitting the sheriff to widen the scope of the inquiry as required.

97. As a continuation of the original proceedings, the re-opened inquiry is to be held in the same sheriffdom as the original proceedings (but may be transferred by the sheriff to a different sheriffdom under section 12(3)).

Section 32 – Fresh inquiries

98. Section 32 makes provision about fresh inquiries.

99. Subsection (2) requires the sheriff to make an order under section 14(2) (fixing the date and place for the holding of a preliminary hearing and the inquiry) at the same time as making the order requiring it to be held.

100. Subsection (3) requires the procurator fiscal to notify all participants in the original FAI about the fresh FAI.

101. Subsections (4) and (5) provide that the fresh inquiry is to be held in the same sheriffdom as the original inquiry, unless transferred by the sheriff to a different sheriffdom under section 12(3).

Section 33 – Further proceedings: compliance with recommendations

102. Under section 30(2)(a), a sheriff will set aside the original determination made after the original proceedings. The sheriff will therefore issue a new determination at the conclusion of a re-opened or fresh FAI even if the only change to the original determination is to record the new evidence led at that FAI. Section 33(2) makes provision about the application of section 27 (compliance with the sheriff’s recommendations) where there is a new determination.

103. Under subsection (2), the requirement on a participant to respond to a sheriff’s recommendation under section 27 will not apply anew if the recommendation is the same as that already made in the original determination from the original FAI. This removal of a requirement to respond again to the same point does not affect any published response or published note of a lack of response made by SCTS in relation to the original FAI.

104. Under subsections (3) and (4), if a recommendation was addressed to a person in the original determination, but that recommendation is not made again in the new determination, the SCTS will be obliged to withdraw from publication any response made to the recommendation or any notice that no response has been given.
Inquiry procedure rules

Section 34 – Power to regulate procedure etc.

105. Section 34 gives the Court of Session a broad power to make acts of sederunt concerning the procedure and practice to be followed in FAI proceedings.

106. Subsection (1) contains a broad general power to make provision regarding practice and procedure. Subsection (2) contains some specific illustrative examples of the sort of matters about which provision may be made. For example, rules can be made in relation to witnesses and evidence (which may be used to further empower the sheriff to focus the evidence led on matters of concern to the inquiry having regard to its purpose), the conduct and management of FAI proceedings, the forms of documents used, and action to be taken before the FAI commences. However, this does not limit the broad power in subsection (1), which is a substantial widening of the power to regulate practice and procedure in FAIs.

107. Subsections (4) and (5) require the Court of Session to consult with the Scottish Civil Justice Council when making acts of sederunt which were not prepared in draft by the Council. The power to make rules under this section will be subject to transitional provisions set out in schedule 1 to the Bill as explained below.

Specialist sheriffs and summary sheriffs

Section 35 – Judicial specialisation in inquiries

108. Section 35 makes provision for sheriffs, part-time sheriffs, summary sheriffs and part-time summary sheriffs to be designated as specialist sheriffs in FAIs. Subsection (1) allows the sheriff principal to designate sheriffs and summary sheriffs within the sheriffdom, with section (3) allowing the Lord President of the Court of Session to designate part-time sheriffs and part-time summary sheriffs, who are not assigned to any particular sheriffdom, as specialists.

109. Subsection (5) makes it clear that it is still competent for a sheriff, part-time sheriff, summary sheriff, or part-time summary sheriff who is not designated as a specialist in FAIs to conduct an FAI. This may be inevitable owing to pressure of other casework. Under subsection (7), however, the sheriff principal must have to have regard to the desirability of allocating an FAI to a specialist.

Section 36 – Summary sheriff: competence to conduct inquiries

110. Section 36 gives summary sheriffs the same competence as sheriffs to conduct FAIs.

Section 37 – Repeal and modification of enactments

111. Section 37(1) repeals the 1976 Act in consequence of its re-enactment in the form of the Bill. For the most part the 1976 Act only extends to Scots law, however section 4(4) and (5) which are the precursor provisions for section 21 (publishing restrictions) extend to the law of England and Wales and Northern Ireland. The Scottish Government proposes that the full repeal of these provisions be progressed via the Order under section 104 of the Scotland Act 1998, as a natural consequence of extending the effect of section 21 to those jurisdictions. Section 37(2) introduces schedule 2 which is more fully described below. Insofar as any of the repeal modifies
the law on reserved matters this in the context of repealing provisions which are spent as a consequence of restatement in the Bill

General

Section 38 – Interpretation

112. Section 38 sets out the definitions that apply throughout the Bill unless the context requires otherwise.

Schedule 1 – Procedure rules

Role of the Scottish Civil Justice Council

113. Paragraph 1 of schedule 1 amends the Scottish Civil Justice Council and Criminal Legal Assistance (Scotland) Act 2013, bringing the practice and procedure of FAIs and the making of FAI rules under the ambit of the Scottish Civil Justice Council.

Transitional arrangements

114. Paragraph 2 of schedule 1 sets out the transitional arrangement affecting section 34. It will initially be the role of the Scottish Ministers, by regulations, to make FAI rules until such time as the provisions conferring responsibility on the Scottish Civil Justice Council and the Court of Session for the making of FAI rules are commenced. It is made clear that section 34(4), which requires consultation with the Scottish Civil Justice Council prior to the making of rules, will not apply during this transitional period. However, the Scottish Ministers must instead consult the Lord President and such other persons as are considered appropriate before making any such regulations.

Schedule 2 – Modification of enactments

115. Schedule 2 repeals certain provisions in the Acts of Parliament referred to in section 3(2)(b), (c) and (e). The provisions being repealed have the same effect as section 3.

116. As mentioned, this also effects a restatement of reserved law. The provisions repealed in Scots law extend to the law of England and Wales and, except in the case of the Gas Act 1965, extend to Northern Ireland. The Scottish Government proposes that the full repeal of the provisions be progressed via the Order under section 104 of the Scotland Act 1998.
INTRODUCTION

1. This document relates to the Inquiries into Fatal Accidents and Sudden Deaths etc. (Scotland) Bill (“the Bill”) introduced in the Scottish Parliament on 19 March 2015. It has been prepared by the Scottish Government to satisfy Rule 9.3.2 of the Parliament’s Standing Orders. It does not form part of the Bill and has not been endorsed by the Parliament.

2. The Policy Memorandum, which is published separately, explains in detail the background to the Bill and the policy intention behind the Bill. The purpose of this Financial Memorandum is to set out the costs associated with the measures introduced by the Bill, and as such it should be read in conjunction with the Bill and the other accompanying documents.

3. The Bill takes forward many of the recommendations made by Lord Cullen in his 2009 Review of the Fatal Accident Inquiry (FAI) Legislation that require primary legislation. Some of Lord Cullen’s recommendations were addressed to the Crown Office and Procurator Fiscal Service (COPFS) and have already been implemented, principally by the establishment of the Scottish Fatalities Investigation Unit. That Unit now oversees death investigations across Scotland and provides advice, support and expertise to procurators fiscal in order to ensure that policy and practice in the investigation of deaths is applied consistently.

4. The Bill provides an enabling framework and many of the detailed changes will be delivered through secondary legislation as FAI Rules. The Bill will repeal and re-enact the current legislation on FAIs to bring this area of law up-to-date.

5. The Scottish Government carried out a public consultation in the summer of 2014 on the proposals to implement Lord Cullen’s recommendations and other measures to modernise the FAI system. The consultation provided organisations and individuals the opportunity to comment on the potential impacts of the proposals. Further details of the consultation can be found in the Policy Memorandum.

6. The Financial Memorandum gives an overview of the impact on the Scottish Government, COPFS, Scottish Court and Tribunal Service (SCTS), and the other affected bodies as a result of the provisions in the Bill. However, many of the provisions will have no impact or financial element as they are a restatement (in modern drafting style) of the current provisions.

7. The estimates of costs and impacts contained in this Memorandum are compiled from information provided by those bodies affected by the Bill. It is estimated that there will be some impacts as a result of the Bill, however at this stage they are expected to be limited. The figures provided are the best estimates available.

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1 Consultation paper: [http://www.scotland.gov.uk/Publications/2014/07/6772](http://www.scotland.gov.uk/Publications/2014/07/6772)
OVERVIEW

8. Currently the number of FAIs held each year are relatively small. The table below outlines the total number of FAIs commenced each year over the last four years. By way of comparison, there were 77,453 civil litigation cases in Scotland in 2012-13. The table also shows the volatility of FAI numbers due to the unpredictable nature of deaths requiring investigation and inquiry.

Table 1: Number of FAIs commenced each financial year

<table>
<thead>
<tr>
<th>Financial year</th>
<th>Number of mandatory FAIs commenced</th>
<th>Number of discretionary FAIs commenced</th>
<th>Total number of FAIs commenced that year</th>
</tr>
</thead>
<tbody>
<tr>
<td>2011/12</td>
<td>46</td>
<td>17</td>
<td>63</td>
</tr>
<tr>
<td>2012/13</td>
<td>35</td>
<td>11</td>
<td>46</td>
</tr>
<tr>
<td>2013/14</td>
<td>30</td>
<td>3</td>
<td>33</td>
</tr>
<tr>
<td>2014/15</td>
<td>54</td>
<td>5</td>
<td>59</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>165</strong></td>
<td><strong>36</strong></td>
<td><strong>201</strong></td>
</tr>
</tbody>
</table>

9. The existing costs of an FAI will not change as a result of the Bill. The Bill will not affect or change the long-standing common law duty of procurators fiscal to investigate sudden, suspicious or unexplained deaths in Scotland. Table 2 gives an overview of the average costs of three different lengths of FAIs. Obviously it is impossible to predict the number and length of FAIs in any given year and any additional FAIs provided for by this Bill will fall into one of these categories depending on the case itself.

Table 2: Estimated cost to COPFS and SCTS of preparing and conducting an FAI

<table>
<thead>
<tr>
<th></th>
<th>1 day FAI</th>
<th>1 week FAI</th>
<th>Lengthy FAI</th>
</tr>
</thead>
<tbody>
<tr>
<td>COPFS</td>
<td>£9,494</td>
<td>£13,122</td>
<td>£94,701</td>
</tr>
<tr>
<td>SCTS</td>
<td>£2,000</td>
<td>£10,000</td>
<td>£90,000</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>£11,494</strong></td>
<td><strong>£23,122</strong></td>
<td><strong>£184,701</strong></td>
</tr>
</tbody>
</table>

10. The one-day FAI is based on a straightforward mandatory FAI into a death in custody heard over one day or less. The one week FAI is based on a week-long mandatory FAI into a death as a result of a work-place accident. The lengthy FAI is based on a discretionary FAI involving complex medical evidence (the length of 45 days has been used for the SCTS cost as an example). The impact on SCTS relates to the accommodation, services, staff and judiciary it provides for the purposes of FAIs.

11. The following assumptions were made in estimating the existing costs in table 2. The costs for SCTS are based on the actual court sitting days for the hearing and, as such, do not include preparation work, including preliminary hearings. They also exclude any additional costs if the FAI is held outwith a sheriff court room. Details of the costs of using alternative accommodation are available at paragraph 58. The estimates for COPFS for the one-day FAI

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3 Figures as at 31/1/15
4 Includes administrative, precognition, Victim Information & Advice (VIA), legal, pathology and witness costs.
5 Based on the basic approximate cost of an FAI sitting in a sheriff court, which includes judicial and staff costs as well as running costs.
and the one-week FAI assume that administrative and legal staff costs were mid-range; the legal costs for COPFS for the lengthy FAI were, however, calculated at the equivalent of the Civil Service Grade 6 level (£53,060 - £64,733).

12. The figures in tables 1 and 2 show that the numbers and costs of FAIs vary each year and depend on the nature and circumstances of the death. There were markedly fewer FAIs held in 2013/14 compared to other years. Furthermore, no practical change is being made in the Bill to the law in relation to the categories that currently result in the most FAIs (work place accidents and deaths in prison). Therefore, it is not expected that any changes provided for by this Bill will have a substantial effect on the numbers of FAIs held each year. As noted later in this document, there may be an additional one or two FAIs per year due to the change in definition for mandatory categories of FAIs and also the addition of discretionary FAIs into deaths abroad.

13. Table 3 below, outlines the costs for COPFS’ role in investigating deaths, which put the amount of business and resource for death investigations (of which FAIs are only a part) into context.

**Table 3: COPFS expenditure and staff**

<table>
<thead>
<tr>
<th></th>
<th>2011/12</th>
<th>2012/13</th>
<th>2013/14</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total expenditure in £000s</td>
<td>£105,604</td>
<td>£104,456</td>
<td>£106,095</td>
</tr>
<tr>
<td>Death investigation expenditure in £000s</td>
<td>£4,153</td>
<td>£4,107</td>
<td>£4,172</td>
</tr>
<tr>
<td>Total permanently employed staff</td>
<td>1,526</td>
<td>1,436</td>
<td>1,379</td>
</tr>
<tr>
<td>Staff employed on death investigations</td>
<td>43</td>
<td>40</td>
<td>45</td>
</tr>
</tbody>
</table>

**BILL PROVISIONS**

14. There are very few provisions within the Bill which are expected to commit the Scottish Administration to additional spending.

15. The Bill will:

- amend the categories of death in which it is mandatory to hold a fatal accident inquiry to ensure that all deaths in police custody and deaths of children in secure accommodation are covered;
- permit FAIs at the discretion of the Lord Advocate into deaths of Scots abroad where the body is repatriated and where there is a realistic prospect that the inquiry will yield significant findings;
- build on recommendations implemented by the Crown Office to make the system more efficient;
- provide flexibility for the location and accommodation for FAIs; and
- place a requirement on those to whom sheriffs direct recommendations at the conclusion of the inquiry to respond to indicate what, if any, action they have taken.

6 Figures taken from COPFS annual reports and accounts, available at: [http://www.copfs.gov.uk/publications/finance](http://www.copfs.gov.uk/publications/finance). This expenditure is for the net operating costs only

7 The average number of whole-time equivalent persons employed permanently on death investigations.
COSTS ON THE SCOTTISH ADMINISTRATION

16. The Bill’s provisions are not expected to have cost implications for the Scottish Government. As part of the legislative provision to reform the FAI system, new FAI Rules will be required. The Rules will be made by the Scottish Ministers as a transitional arrangement before the rule-making power is conferred on the Court of Session, advised by the Scottish Civil Justice Council (SCJC).

17. There will be no new provisions for enforcement or sanction (e.g. sanction for not giving evidence) in the Bill or subsequent FAI Rules. This is an enabling Bill to provide the statutory framework to implement Lord Cullen’s recommendations, and to enable COPFS, SCTS and Lord President to make the system more efficient and provide appropriate flexibility. The provisions to make the FAI system more efficient are expected to have a positive impact on the implementing bodies and the public, although the impact is not measurable in financial savings.

18. The parts of the Scottish Administration affected by the proposals will mainly be COPFS and SCTS, with the Scottish Prison Service and Police Scotland also having an interest. The impact on each body is set out below under the impact of each of the main provisions. The staff involved in the FAI process are salaried and there will be no additional cost for staff or administration within the current business profile.

19. Overall, looking at the provisions in the Bill there will be an additional cost to COPFS for investigating any deaths abroad each year. This is expected to be around 50 cases each year and COPFS estimate this will cost around £157,350.

20. As stated above there may also be up to an additional two FAIs each year due to the provisions in the Bill. It is impossible to predict the expected length of any additional FAI, however, based on a mid-length FAI then this would cost an estimated £26,000 to COPFS and £20,000 to SCTS (based on the averages set out in Table 2).

COSTS ON LOCAL AUTHORITIES

21. Extending the mandatory categories of FAI to include deaths of children in secure accommodation will be of interest to local authorities as they provide secure accommodation approved in accordance with regulations made under section 78(2) of the Public Services Reform (Scotland) Act 2010. However, there are not expected to be additional costs to local authorities as a result of this measure because an increase in the number of FAIs as a result of this provision is unlikely, as set out in paragraphs 37-39.

22. The majority of local authorities which responded to the Government’s consultation indicated support for the above provision and the proposal for a response to sheriffs’ recommendations. Most local authorities stated that the proposal for sheriffs’ recommendations would not impact on them negatively based on their existing practices.
COSTS ON OTHER BODIES, INDIVIDUALS AND BUSINESSES

23. Responses to the consultation and meetings with stakeholders indicate that the proposals will have only a minimal financial impact on organisations. The proposal regarding responding to sheriffs’ recommendations is supported by regulatory bodies such as the Health and Safety Executive and the Care Inspectorate which already react to recommendations they are aware of and note their decisions.

24. Business or consumer groups did not respond to the consultation despite being sent a notification. It is assumed that they consider that they will not be affected by the Bill. Some responses were received by insurance firms, but no concerns over financial impact were raised. A Business and Regulatory Impact Assessment (BRIA) is not necessary because changes in the Bill to the current system will not affect businesses except in the very exceptional circumstance that they may be obliged to respond to a sheriff’s recommendation. Any additional costs for public sector organisations will also only relate to responding to sheriffs’ recommendations.

Scottish Legal Aid Board

25. The proposals do not intend to change the provision of legal aid for FAIs. There may be a very slight increase in the number of FAIs arising from the provisions for mandatory FAIs into deaths of children in secure accommodation and discretionary FAIs into deaths abroad, which may lead to a similarly slight increase in applications for legal aid. However, it is impossible to determine which FAIs could lead to a legal aid application and, as noted in table 1, the numbers of FAIs vary every year. As table 4 below shows, the average cost for funding an FAI varies significantly.

26. The current upper limit for disposable income for civil legal aid is £26,239 per annum. The disposable income limit is such that it is estimated that around 75% of the Scottish population qualify for civil legal aid (which includes FAIs) based on their disposable income. According to the SLAB, the cost of an FAI can vary considerably. For example, representation for the Rosepark Care Home FAI cost around £1.1 million in 2009/10. These are part of the natural variations in the total costs of FAIs and, as such, are not expected to be impacted by the proposals in this Bill.

27. There are two main types of legal aid help: advice and assistance (for all matters of Scots law) and legal aid (for legal representation in court). Together these are called legal assistance. The figures provided by SLAB at table 4 below for certificate payments are for legal aid only, which represent the most significant element of these costs to SLAB.
Table 4: Legal assistance for FAIs

<table>
<thead>
<tr>
<th></th>
<th>2009/10</th>
<th>2010/11</th>
<th>2011/12</th>
<th>2012/13</th>
<th>2013/14</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of legal assistance</td>
<td>33</td>
<td>38</td>
<td>16</td>
<td>10</td>
<td>18</td>
</tr>
<tr>
<td>applications for FAIs</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Number of legal aid</td>
<td>27</td>
<td>25</td>
<td>10</td>
<td>8</td>
<td>8</td>
</tr>
<tr>
<td>certificates paid for FAIs</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Average payment per</td>
<td>£88,950</td>
<td>£36,970</td>
<td>£18,124</td>
<td>£4,405</td>
<td>£16,966</td>
</tr>
<tr>
<td>certificate</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Range of certificate</td>
<td>£1,470 to £389,581</td>
<td>£197 to £166,103</td>
<td>£161 to £110,891</td>
<td>£823 to £9,411</td>
<td>£1,764 to £82,894</td>
</tr>
<tr>
<td>payments</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total paid from Fund for</td>
<td>£2,401,661</td>
<td>£924,261</td>
<td>£181,236</td>
<td>£35,239</td>
<td>£135,727</td>
</tr>
<tr>
<td>FAIs</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

28. There are a number of caveats for the figures provided by SLAB and what can be estimated from them. There is a level of unpredictability of the cost per legal aid certificate for each individual and then that unpredictability is increased as FAIs can involve more than one legally-aided person per case. Given the length of these cases, and the fact that they can often span several years, it is likely that SLAB will make part payments on these cases, thereby spreading the costs of the cases across multiple years and limiting the assumptions that can be made regarding average costs.

29. Based on an additional two FAIs each year due to provisions in this Bill it is impossible to predict whether those involved will require or be eligible for legal aid. Therefore, there may be a slight increase to the charge on the Legal Aid Fund as a result of the Bill but this will have no substantial effect to the general variation of FAI costs across the years.

NHS Scotland

30. NHS Scotland is involved in FAIs when inquiries are held at the discretion of the Lord Advocate into deaths in hospitals or some other form of health care setting. Doctors, nurses and other healthcare workers often give evidence and “medical” inquiries can be among the most complex and long-running FAIs. The provisions of the Bill will not affect the number or length of such medical inquiries. It is essential that, if the circumstances of a death have caused serious public concern, there should be a proper and thorough investigation. There should be no additional costs for NHS Scotland as a result of the Bill. There may be some administrative and legal costs incurred in responding to recommendations, however the numbers of these are expected to be minimal as sheriffs only make recommendations in fewer than 20 FAIs per annum and few of these will relate to medical inquiries. In such cases, remedial action is likely to have been taken by the time the sheriff makes recommendations and a response will simply explain what action has been taken. NHS bodies will normally be represented at FAIs by their

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8 Number of certificates paid out so far each year. Some cases that have been granted legal aid have yet to be concluded so this figure is subject to change

9 This excludes any nil payments for legal aid certificates. This is not the average cost of an FAI case as there could be multiple certificates for one FAI. An example is the Rosepark FAI which resulted in a total of £2.1 million paid across 6 parties
These documents relate to the Inquiries into Fatal Accidents and Sudden Deaths etc. (Scotland) Bill (SP Bill 63) as introduced in the Scottish Parliament on 19 March 2015

own legal representatives and the response to a recommendation addressed to such a body will be dealt with by those legal representatives. Therefore, any additional cost as a result of this Bill relates only to the drafting and issuing of a written response, which will not be substantial.

BILL PROVISIONS: CATEGORIES OF INQUIRIES

Existing mandatory categories

31. FAIs are currently mandatory for deaths that occur as a result of an accident in the course of employment or which occur in legal custody. It is not proposed to change the existing mandatory categories.

Costs on the Scottish Administration

32. These categories will be re-enacted and, therefore, there will be no financial impact on the Scottish Administration or those involved in FAIs.

Deaths when under police arrest or detention

33. The Bill implements Lord Cullen’s recommendation to make FAIs mandatory for deaths in all types of legal custody irrespective of the place of death. It offers the same level of protection for everyone under police care and legal custody. In requiring a mandatory FAI for deaths of people under police arrest irrespective of the location, the Bill provisions clarify the circumstances in which a mandatory FAI should be held for a death in police custody.

Costs on the Scottish Administration

34. COPFS interprets the term “detention” in section 1(4) of the Fatal Accidents and Sudden Deaths (Scotland) Act 1976 in the plain English usage and does not differentiate between a person “detained” in terms of a statutory provision or under “arrest”. The key question is whether the person’s liberty is deprived at the point of "detention" — all such inquiries are held in terms of section 1(1)(a)(ii) of the 1976 Act. As a mandatory FAI would be held for any death during police arrest under the existing legislation, it is not expected that this provision will increase the number of FAIs, and is not, therefore, expected to give rise to extra costs to Police Scotland, COPFS, or SCTS.

Costs on other bodies, individuals and businesses

35. An increase in the number of FAIs due to this provision is not expected, therefore there should not be an increase in the number of legal aid claims as a result.

36. SLAB’s existing guidance in relation to applications for representation at an FAI indicates that it is considered that the reasonableness test for civil legal aid is met where a death arises while an individual is in custody. In practical terms SLAB treats "in custody" as covering deaths in prison, at police stations, or in other care institutions and it provides funding to otherwise eligible individuals if the death occurred while the deceased was arrested or detained by the police. This, along with COPFS’ interpretation of police custody, means that there will be no change to the costs for SLAB as a result of this provision.
Deaths of children in secure accommodation

37. The Bill will extend the mandatory categories of FAIs to cover all deaths of children in secure accommodation as per Lord Cullen’s recommendation.

Costs on the Scottish Administration

38. There has been no death of a child in secure accommodation in the last five years. An FAI would usually be held on a discretionary basis for any deaths of children in secure accommodation under the current legislation unless the bereaved relatives were strongly opposed. It is, therefore, thought that having this as a mandatory category could result in no more than an additional one or two FAIs every few years. Given the minimal numbers, these additional FAIs are expected to be managed as part of the natural flux of death investigations and FAIs.

Costs on local authorities

39. Given the small numbers, it is not anticipated that this proposal will have a significant impact on local authorities. Even if it results in one additional FAI per year, which would be unlikely given the figure above, this could be managed from existing resources as part of duties regarding looked-after children. The local authorities that responded to the consultation agreed with this proposal and did not raise any resource concerns.

Discretionary FAIs

40. The provision in the 1976 Act for the Lord Advocate to hold a discretionary FAI will be re-enacted in the Bill so that a discretionary FAI can be held when:

- the death was sudden, suspicious or unexplained, or it occurred in circumstances which would give rise to serious public concern; and
- it appears to the Lord Advocate to be in the public interest that a FAI be held.

41. If the Lord Advocate decides against holding a discretionary inquiry, the Lord Advocate will have to provide reasons in writing to the bereaved family if requested so to do. This simply reflects existing COPFS practice. COPFS also writes to bereaved families, if requested to do so, in order to explain why an FAI is not to be held if a death falls within one of the mandatory categories, but the Lord Advocate takes the view that the circumstances of the death have been sufficiently established in other proceedings such as a criminal trial.

Investigations and inquiries into deaths abroad

42. Lord Cullen recommended that the Lord Advocate should have discretion to hold an FAI into the death abroad of a person ordinarily resident in Scotland whose body has been repatriated to Scotland. The provision will largely bring Scottish legislation in line with that in England and Wales where an inquest must be held into the death of everybody repatriated to a coroner’s area where the cause of death is unnatural, violent, or unknown.
43. Lord Cullen indicated that he thought that this power would be used very rarely out of respect for the investigating authority in the country concerned. There is, moreover, no intention that COPFS or Police Scotland should travel to the country where the death took place to conduct investigations. Rather, investigations will be conducted in the same way as is done by coroners in England and Wales.

**System of Coroner’s Inquests in England and Wales**

44. Since the decision of the Court of Appeal in 1983 in *R v West Yorkshire Coroner, ex parte Smith* [1983] QB 335 (the case of Helen Smith), coroners in England and Wales must hold an inquest into a death overseas if the body is returned to the coroner’s district and the circumstances are such that an inquest would have been held if the death had occurred in England and Wales.

45. As the provision in Scotland will be discretionary rather than mandatory, it will be less costly to implement than in England and Wales. Unlike the provision in the Bill, coroners must investigate a death irrespective of whether the deceased was a British national and/or was ordinarily resident in England and Wales. For illustrative purposes, the cost of such an inquest is estimated to be less than £3,400, based on a post-mortem costing in the region of £300, translation costs of up to £3,000, and the cost of reports from foreign jurisdictions.

46. Around 6,000 Britons die abroad each year. However, the vast majority of these will be expatriates and not those ordinarily resident in the United Kingdom. There are no accurate statistics available on the number of bodies repatriated to the UK as they do not have to be registered. The Foreign and Commonwealth Office (FCO) is not informed of every death.

**Repatriations to Scotland**

47. There are currently no accurate statistics kept on deaths of domiciled Scots abroad as there is no requirement to report them to the procurator fiscal or to register the death with the National Records of Scotland (NRS). NRS has a record of only 25 deaths of domiciled Scots abroad in 2013 but the figure is likely to be higher. The number of bodies repatriated to Scotland each year to be cremated is approximately 100. Figures are not readily available for the numbers of bodies repatriated for burial as they do not have to be registered with the authorities. However, there are likely to be at least the same number per year as for cremations. There is no way of working out which of these people were domiciled Scots to estimate the number of potential investigations and FAIs as a result of this provision.

**Costs on the Scottish Administration**

48. Of the cases of domiciled Scots deaths abroad where the body is repatriated to Scotland, the overwhelming majority will be natural cause or expected deaths with no unexplained circumstances and very few may require further investigation. For those that do, the investigation will be akin to a liaison exercise rather than a full detailed investigation due to the lack of powers to cite witnesses or obtain documents from abroad. Put into context, of approximately 11,000 deaths reported to COPFS, there are only around 50-60 FAIs held per annum. It is, therefore, reasonable to expect very limited additional inquiries as a result of this provision.
49. There will be no power for COPFS to cite witnesses from abroad, therefore any inquiry will be based on documentary evidence provided, as is the case for coroners’ inquests. Correspondence (the cost of which is in table 5 below) is expected even when no investigation or FAI will take place as the families will have questions and expectations as a result of the provision being available. Therefore, it will be important to manage the expectations of bereaved families to mitigate the impact of unnecessary correspondence.

50. In Scotland, there are not expected to be additional post-mortem costs as: (a) pathologists’ costs are provided in terms of contractual arrangements rather than being fee-paid for each post mortem in Scotland, and (b) they cannot be carried out if the body has been embalmed as is usually the case when a body is prepared for repatriation. Post mortem reports from the foreign authorities can be used instead.

Table 5: estimated potential costs for investigating deaths abroad

<table>
<thead>
<tr>
<th></th>
<th>Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>Translation costs</td>
<td>£1,207</td>
</tr>
<tr>
<td>Staff costs - Liaison with nearest relatives and general correspondence</td>
<td>£440</td>
</tr>
<tr>
<td>Staff costs – Liaison with authorities in foreign jurisdiction</td>
<td>£1,500</td>
</tr>
<tr>
<td>Total cost</td>
<td>£3,147</td>
</tr>
</tbody>
</table>

51. In arriving at this figure, COPFS made the following assumptions:

- The documentation that will require to be translated will include any police report, post mortem and/or toxicology report and witness statements;
- The number of witness statements will be the same as a current case involving an FAI of one week’s duration, namely 21 witness statements; and
- The level of liaison and correspondence will equate to a current case involving an FAI of one week’s duration.

52. For coroners’ inquests in England and Wales, the FCO seeks documentation from the local competent legal authorities and then provides this to the coroner’s office for investigation. If the same arrangement can be made, which is a reasonable assumption given that FCO already supports Scottish residents abroad as British nationals and their relatives if there is an accident or death, then this will result in less costs for COPFS directly. As FCO already provides consular support for the deaths of Scots abroad that it is aware of, this should not result in a significant increase in its costs. Furthermore, documents, such as a death certificate and any post-mortem and toxicology report, should be provided with the body as part of repatriation. Therefore, it is likely to be police reports and witness statements that will be sought for investigation and any potential FAI.

53. It is difficult to predict how many deaths abroad will be reported to COPFS and could require investigation each year. If a burial or cremation has taken place abroad, or a body is not found, then this would not require investigation for an FAI. Based on estimates of bodies repatriated to Scotland being around 200 per year, the number requiring investigation will be much less as not all of the deceased will be ordinarily resident in Scotland. COPFS has estimated that there are likely to be no more than 50 investigations of deaths abroad each year at a total cost of approximately £157,350, which takes account of the fact that some of the liaison
should be done by FCO. Based on this level of investigations, COPFS estimates that there will be no more than one FAI per year into a death abroad, which would only be held if it is in the public interest to do so according to specific criteria set out by the Bill. This is broadly in line with the number of FAIs held as a proportion of death investigations carried out by COPFS. The cost of an FAI into a death abroad should not cost any more than an FAI into a death that occurred in Scotland as the additional costs resulting from liaison and translation will be part of the investigation costs in table 5. Therefore, depending on the complexity and therefore the length of any inquiry, the expected average cost would be as set out in Table 2 (e.g. £13,000 cost to COPFS and £10,000 cost to SCTS for a mid-length inquiry).

Costs on other bodies, individuals and businesses

54. As noted above, there is not expected to be any more than one FAI of this type each year. In some of these cases there may be an additional claim on the Legal Aid Fund. Table 4 sets out the average and range of costs for Legal Aid and it would be assumed this would be the same for any FAIs of this type.

INCREASING EFFICIENCY AND FLEXIBILITY FOR FAIS

Location of FAIs

55. An inquiry will be capable of being held in any place where there is a sheriff court and can be transferred from one court or sheriffdom to another. Other venues can also be used as currently happens for some longer running FAIs. This will allow greater flexible use of the existing court and tribunals estate as well as greater opportunity to use ad hoc non-court accommodation, which will support the efficient disposal of business and Lord Cullen’s recommendation that FAI should be held outwith a courtroom accommodation wherever possible. The provisions for jurisdiction and accommodation in the Bill do not require SCTS to hold FAIs outwith courts, but merely enables that option.

Costs on the Scottish Administration

56. It is anticipated that these enabling provisions will have a positive impact on SCTS as it will permit it to use any sheriff court or extend its practice of allocating an FAI to ad hoc premises. The main advantage will be to allow flexibility in programming and to reduce any delays in the allocation of dates for hearings. Arrangements for accommodation for FAIs is an operational matter for SCTS which is an independent, judicially led body. If it decides to extend the use of ad hoc non-court accommodation, the costs are set out below.

57. The SCTS has to date made use of ad hoc non-court premises in Glasgow, Motherwell and Aberdeen, which have already been configured to provide appropriate IT and accommodation for court use, allowing them to be used at relatively short notice (within six-eight weeks). The ongoing cost of setting up these premises is approximately £4000 per FAI depending on provision of services required. This does not include the cost of renting the premises. The cost of running an FAI in total, including rent and other costs in such ad hoc premises, can be significant, ranging between £100,000-150,000 (with a recent six-week inquiry costing over £112,000). The SCTS considers there are operational advantages to using such premises earmarked for the hearing of FAIs to support the overall management of the FAI and court programme but the cost of using these premises requires appropriate budget support.
58. The SCTS has a long-term vision for justice centres, dependent on the appropriate budget provision, and is looking initially at Fife, Lanarkshire and Inverness. Such centres will provide a full range of specialist support services which will complement the high quality courts which exist in many of Scotland’s cities and could include FAIs. The SCTS will work up feasibility studies into the three areas identified for justice centres. The SCTS believes that, with the relevant funding in place, justice centres can be progressed in the next three to five years. It is possible that bespoke accommodation for FAIs might be made available with such centres if they are set up.

Costs on other bodies, individuals and businesses

59. It is anticipated that the benefit of having the flexibility for FAIs to be held in any court or other appropriate accommodation will balance the potential inconvenience and cost of participants to an inquiry having to attend further away than expected or to change location if the inquiry is transferred. The choice of sheriffdom will be made by the Lord Advocate in consultation with SCTS, and the choice of court or non-court premises will be a decision for the sheriff principal. These choices will take into account the needs and location of the participants. The sheriff will determine if a case is to be transferred in consultation with the sheriff principal of the other sheriffdom. This will allow the efficient disposal of business with the needs of the bereaved families also being considered.

Preliminary hearings

60. The Bill provides for preliminary hearings to be held for every FAI, unless the sheriff decides to dispense with such a hearing, which follows the successful practice in Glasgow and Edinburgh. FAI Rules will govern that decision as well as the purpose of a preliminary hearing. The purpose of the preliminary hearing is to try to establish how much evidence needs to be heard at the FAI hearing itself and is thus intended to facilitate an estimate of how much court time will be required.

61. It is proposed that preliminary hearings may be held by conference call, video-link or in chambers, rather than having to convene a full court and the FAI Rules will allow for this.

Costs on the Scottish Administration

62. This provision will simply provide a statutory basis for what largely happens in practice in many areas allowing greater judicial case management at the discretion of the sheriff. Therefore, this provision will have no additional costs and will be met within existing resources of COPFS and SCTS.

Agreement of facts

63. The Bill makes it clear that agreed statements on matters which are uncontroversial can be submitted before the FAI hearing.
Costs on the Scottish Administration

64. Joint statements of agreed facts are currently used in some FAIs and this provision merely clarifies and encourages their use.

65. Providing for agreement of facts may have a beneficial impact on the duration and, therefore, the costs of the FAI, though this is impossible to quantify. The Act will encourage the fiscal and each of the participants at the inquiry to take reasonable steps to reach agreement about any facts in relation to which the fiscal or participant intends to bring forward evidence and which the fiscal or as the case may be participant considers unlikely to be disputed by the other participants.

Benefits

66. The benefit of front-loading the process using the above provisions will free up time for the actual inquiry and give it focus with increased judicial case management. This is expected to benefit all involved in an FAI. An example of some of these provisions working can be found at Glasgow Sheriff Court where a pilot has been operating with regular preliminary hearings, increased judicial case management, front-loading of resources and agreement of uncontroversial facts. This has helped clear the backlog of FAIs waiting to be heard at Glasgow Sheriff Court.

SHERIFFS’ DETERMINATIONS

67. The proposal that parties to whom sheriffs make recommendations in their determinations should respond will encourage compliance and accountability and bring the system in relation to sheriffs’ recommendations more into line with what happens in relation to coroners’ reports in England and Wales. The greater dissemination of recommendations and public record of responses will hopefully lead to lessons being learned and deaths in similar circumstances being avoided in the future. A model for a similar scheme can be found in section 29 of the Coroners (Investigations) Regulations 2013.10

68. All sheriffs’ determinations at the conclusion of FAIs will be published on the SCTS website. At present some determinations which are thought to be of legal or other interest have been posted on the SCS website at the decision of the sheriff, so this proposal is merely an extension of existing practice. The most recent 50 determinations online are listed and all published determinations since 1999 are searchable. This provision will mean that all sheriffs’ recommendations will be available for the public and organisations to see and search online, providing a useful resource.

69. Sheriffs will have a power to disseminate determinations not only to participants of an FAI, but also to bodies which did not participate, such as regulatory bodies that can apply recommendations that are agreed. Sheriffs already send copies of their determinations to participants in an FAI. The proposal will hopefully lead to more transparency and lessons being learned from the circumstances of a death. This is a non-mandatory power for sheriffs to use at their own discretion.

70. It is proposed that parties to whom sheriffs’ recommendations are addressed will be obliged to respond to the SCTS indicating:

- what steps the person has taken or proposes to take to comply with recommendations addressed to it; and
- if there are any aspects of the recommendations which the person does not intend to comply with, their reasons for not complying with them.

71. Although those participants would not be obliged to comply with the sheriff’s recommendations, they would be obliged to explain the reasons why they have not complied if they do not intend to comply. Representations can also be made by the respondent to indicate why the response, or part of it, should not be published. A copy of the response will be published on the SCTS website with the original determination, or a note if no response has been received within eight weeks. There is to be no penalty should a person fail to respond. This provision will ensure there is a public record of any follow up action in response to sheriffs’ recommendations, which will increase transparency, compliance and accountability. This would be a proportionate and practical way of ensuring that sheriffs’ recommendations are considered by those to whom they are addressed.

Costs on the Scottish Administration

72. There are 50-60 FAIs per annum on average (with only 33 commenced in 2013) and sheriffs make recommendations in only around a third of these. In the year to 31 January 2015, 36 determinations were published by SCTS on the instruction of the presiding sheriff. This means that almost all FAI determinations are currently published. Any minor administrative costs in the duty to publish all FAI determinations can be managed by SCTS using existing resources as it is an extension of current practice. The cost of disseminating recommendations to other bodies is part of the overall cost of SCTS supporting the sheriff at an FAI, and is also an extension of existing practice, so can be managed. This is a power rather than a duty for the presiding sheriff and so no costs are being imposed as a result of this provision.

73. Receiving, checking and publishing responses is not expected to be too onerous given the low volume of determinations in which recommendations are made (fewer than 20 per year). More than one participant may have to respond. However, not all responses will require full legal examination to ensure they comply with data protection and defamation laws. The role will be similar to checking responses to consultations before publication. In England and Wales, the Chief Coroner’s Office simply removes names when redacting. That Office also informs that no responses received have contained defamatory material, so the likelihood in Scotland is very low, particularly given that many responses will come from public bodies. Allowing representations to be made will mean that participants can have a say in what should be published.

74. The Scottish Government and SCTS are developing the costs for this work. However, it is expected that these costs will not be significant. The cost of actual publication will be

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11 This is based on FAI determinations visible on the SCTS website at https://www.scotcourts.gov.uk/search-judgments/fatal-accident-inquiries
minimal as the IT provisions are already in place. The result of lessons being learned from sheriffs’ recommendations is a long-term benefit and purpose of the FAI system.

**Costs on local authorities**

75. Most local authorities and public bodies already have a review process in place to deal with recommendations. There may be some administrative and legal costs incurred in responding to recommendations but these were not specified in consultation responses. Regulatory bodies and local authorities that responded to the consultation supported this proposal and did not raise any concerns. Only one local authority indicated that there could be financial and policy considerations and no standard costs can be provided as they will depend on the nature and extent of the recommendations.

76. As there will be no penalty for non-compliance, the provision will not have a direct financial impact on bodies. Furthermore, only bodies that participated in the FAI will be obliged to respond, so responding to recommendations will become part of the overall costs of being involved in an FAI.

**FURTHER INQUIRY PROCEEDINGS**

77. Lord Cullen suggested that that there could be a basis for re-opening an FAI if new evidence becomes available which could affect the FAI findings and any recommendations in the determination. In these cases, the Lord Advocate will decide if further proceedings are appropriate (i.e. if it is in the public interest and it is likely that the new evidence will materially affect the original determination). The sheriff is to have the discretion to determine whether the original FAI is to be re-opened, or whether a fresh FAI into the same death or deaths is appropriate. The sheriff’s decision is likely to be based on how much of his or her original determination would be affected by the new evidence which has come to light.

78. This power will only be used in the public interest with a high test for the definition of new evidence, therefore it is expected to be used rarely. The costs of any additional proceedings will be managed as part of the flux of FAIs. Those affected by this provision are likely to be those involved in the original inquiry.

**Costs on the Scottish Administration**

79. COPFS will be responsible for preparing the evidence for any further inquiry proceedings; therefore, this provision will impact on them the most. The power will be at the Lord Advocate’s discretion and it will be a matter for COPFS to resource it appropriately.

80. The reopened inquiry will cover matters affected by the new evidence and it should, therefore, not be as long or cost as much as the original inquiry. As noted above, this power will be used very rarely due to the stringent tests and the low likelihood of new evidence coming to light.

81. SCTS will incur costs for any additional proceedings but, as these are expected to only occur rarely, these will be managed within the current fluctuations in numbers of FAIs.
JUDICIARY

Judicial specialisation

82. The Bill will allow for sheriffs principal to designate sheriffs as specialists in relation to FAIs and decide if an FAI should be allocated to a specialist sheriff.

Costs on the Scottish Administration

83. If the power to designate specialist FAI sheriffs is used, the Lord President may decide to require such sheriffs to undertake judicial training for FAIs. Training in FAIs is already provided by the Judicial Institute for Scotland (JIS), which is part of the Judicial Office for Scotland, and the content will need to be revised to cover changes to legislation. Training costs will be handled as per current budgets, as the training will be based on what is currently used for sheriffs and is part of the Lord President’s function.

84. The JIS entirely endorses Lord Cullen’s recommendation 3 in respect of judicial training, namely that JIS should include the law and practice of FAIs in its seminars, and sheriffs should be encouraged to take advantage of attending them. JIS has confirmed that there has been a clear focus for such training in its programmes over the years. Furthermore, the JIS will continue to train in this important area and monitor developments with new legislation which will present more need and focus for this kind of specialist training.

Summary sheriffs

85. It is proposed that the new summary sheriffs introduced by the Courts Reform (Scotland) Act 2014 will have competence to preside over FAIs. Under the 2014 Act, summary sheriffs will have jurisdiction to deal with summary criminal business and civil business not exceeding £5000 in value as well as some family cases and any other specialisations required, with the aim of having the right cases heard by the right level of judiciary. The establishment of a third tier of judiciary, summary sheriffs, to deal with such business means that sheriffs will be freed up to devote more time to more complex casework. This principle applies equally to FAIs as it does to civil and criminal business in the sheriff court.

Costs on the Scottish Administration

86. The use of summary sheriffs will have no cost implications for SCTS as it will be a redeployment of resources across sheriff court business.

FAI RULES

87. The Bill amends the Scottish Civil Justice Council and Criminal Legal Assistance Act 2013 to provide the Scottish Civil Justice Council (SCJC) with the power to propose rules of

12 The Judicial Office is a separate part of the SCTS established to provide support to the Lord President in his role as head of the Scottish judiciary with responsibility for the training, welfare, deployment, guidance and conduct of judges and the efficient disposal of business in the courts.
These documents relate to the Inquiries into Fatal Accidents and Sudden Deaths etc. (Scotland) Bill (SP Bill 63) as introduced in the Scottish Parliament on 19 March 2015

procedure for public inquiries into certain deaths (referred to as Fatal Accident Inquiries or FAIs).

88. FAI Rules are currently made by the Scottish Ministers under rule-making powers in the 1976 Act as amended by subsequent secondary legislation. The SCJC will be unable to assume responsibility for FAI rule-making for some time as it will be concentrating on court reform following the enactment of the Courts Reform (Scotland) Act 2014.

Costs on the Scottish Administration

89. It is proposed that the SCJC will take on work on FAI Rules when it is ready so to do. Until that time, the Scottish Ministers would continue to make rules for FAIs, as is currently the practice. The new FAI Rules will be drafted in consultation with the Lord President, SCTS, COPFS and other appropriate persons. As FAI Rules will be written by the Scottish Ministers, it is not expected for there to be a substantial workload for the SCJC to undertake. Its role will mainly be to review the FAI Rules, which is estimated to commence in 2018.

90. The SCJC can accommodate this function under existing resources as the work on courts reform will have reduced by 2018 with staff working on other areas, including Tribunals and FAI Rules.

IMPLEMENTATION

91. It is anticipated that COPFS will record FAI cases and maintain statistics so that there can be an assessment of the reforms.
SCOTTISH GOVERNMENT STATEMENT ON LEGISLATIVE COMPETENCE

On 19 March 2015, the Cabinet Secretary for Justice (Michael Matheson MSP) made the following statement:

“In my view, the provisions of the Inquiries into Fatal Accidents and Sudden Deaths etc. (Scotland) Bill would be within the legislative competence of the Scottish Parliament.”

PRESIDING OFFICER’S STATEMENT ON LEGISLATIVE COMPETENCE

On 19 March 2015, the Presiding Officer (Rt Hon Tricia Marwick MSP) made the following statement:

“In my view, the provisions of the Inquiries into Fatal Accidents and Sudden Deaths etc. (Scotland) Bill would be within the legislative competence of the Scottish Parliament.”
INTRODUCTION

1. This document relates to the Health (Tobacco, Nicotine etc. and Care) (Scotland) Bill introduced in the Scottish Parliament on 4 June 2015. It has been prepared by the Scottish Government to satisfy Rule 9.3.3 of the Parliament’s Standing Orders. The contents are entirely the responsibility of the Scottish Government and have not been endorsed by the Parliament.

2. Explanatory Notes and other accompanying documents are published separately as SP Bill 73-EN.

BACKGROUND AND BILL OVERVIEW

3. The Bill covers three distinct policy areas: controlling non-medical nicotine vapour products (NVPs), tobacco control and smoking on NHS hospital grounds; ill-treatment and wilful neglect; and duty of candour. This document sets out the details of consultation, policy objectives, and alternative approaches for each element of the Bill as follows:

- Minimum age of 18 for the sale of NVPs,
- Prohibition of sales of NVPs from vending machines,
- The purchase of NVPs on behalf of an under 18 - ‘proxy purchase’,
- Mandatory registration for the sale of NVPs,
- Banning certain forms of domestic advertising and promotion of NVPs,
- An age verification policy for sales of tobacco products and NVPs,
- Banning unauthorised sales of tobacco and NVPs by under 18s,
- A smoke-free perimeter around buildings on NHS hospital sites,
- An offence of ill-treatment and wilful neglect, and
- An organisational duty of candour.

References to NVPs throughout this document refer to non-medical NVPs, e-liquids and other substances intended to be used in them (including items containing such substances).
4. The Bill also introduces other measures associated with these policies, for example, changes to banning orders and the introduction of a statutory due diligence defence.

5. Alongside the Scottish Government’s latest Tobacco Control Strategy, this Bill supports the Scottish Government’s objective to support longer healthier lives and to tackle the significant inequalities in Scottish society. It will do this in the main by restricting the accessibility of NVPs to young people; reducing their visibility and appeal to young people and non-smokers; reinforcing the age restriction on tobacco products to further protect young people; and introducing statutory smoke-free perimeters around buildings on NHS hospital sites.

6. The effects of the Bill on equal opportunities, human rights, island communities, local government, sustainable development etc. are summarised in paragraphs at the end of each part.

PART 1: SMOKING, TOBACCO AND NICOTINE VAPOUR PRODUCTS

POLICY OBJECTIVES: BACKGROUND

7. In March 2013, the Scottish Government launched its latest tobacco control strategy, Creating a Tobacco-Free Generation\(^2\). The strategy sets a target to reduce smoking prevalence rates to 5% or less by 2034. The majority of adults who smoke took up smoking before the age of 18\(^3\). The ambitious target can only be achieved by focussing heavily on preventing the initiation of tobacco use.

8. The strategy builds on existing legislation. Scotland increased the minimum age of sale for tobacco products from 16 to 18 in 2007. Tobacco sales from self-service vending machines were banned in April 2013, alongside the introduction of a tobacco display ban in large shops, which is the most robust display ban legislation in the UK. April 2015 saw the end of tobacco displays in smaller retail premises. The Scottish Government also continues to invest in NHS cessation services, including free Nicotine Replacement Therapy on prescription, which have helped many smokers break the cycle of addiction. Alongside this, mass media campaigns such as the Scottish Government’s recent Take it Right Outside campaign continue to improve public awareness and support behaviour change. While adult smoking rates in Scotland have fallen from 31% in 1999 to 23% in 2013, in order to achieve a tobacco-free generation additional legislation and policy measures are necessary. This Bill forms part of the wider tobacco control policy approach while addressing the new and expanding area of NVPs.

9. The Scottish Government is legislating for the first time on NVPs, which pose both potential challenges and opportunities for public health, internationally and within Scotland. NVPs can come in two forms: those which deliver nicotine to the user and those which do not. The Scottish Government’s approach to NVPs is in part precautionary, in that it aims to limit the likelihood of potential future negative impacts on the health of individuals, for population health and for tobacco control. This is based on concerns which have been articulated in ongoing

\(^2\) [www.gov.scot/tobaccofreegeneration](http://www.gov.scot/tobaccofreegeneration)
debates amongst experts internationally. There is also a public interest in preventing and reducing addiction to nicotine in society, to make smoking behaviours (and behaviours which mimic smoking) less appealing and in particular, to protect children from “playing at smoking”. Yet the Scottish Government recognises the potential health benefits which NVPs may have for smokers in reducing smoking rates. This has particularly shaped the proposal on domestic advertising and promotion and informed consideration of other policy options which the Scottish Government has chosen not to adopt at this stage (e.g. creating restrictions on their use in public spaces and standardised packaging). Whilst the Scottish Government recognises that NVPs are likely to be less harmful than conventional cigarettes, they cannot be regarded as risk free\textsuperscript{4}. The control of NVPs which can contain nicotine and those which don’t is inextricably linked given their resemblance and operational similarity. There is a need to control both kinds of NVP in the same way to ensure effective enforcement of the measures introduced by the Bill and to help prevent public confusion which could have a consequential health impact.

What are nicotine vapour products?

10. NVPs as defined by the Bill are non-medicinal consumer products which deliver a vapour for inhalation by an individual. NVPs are sometimes referred to as ENDS (electronic nicotine delivery systems) or vapourisers and a variety of types have alternative names either for the whole device or parts of the device (e.g. ‘tanks’, e-shisha, cigalikes, vapes). Cigalike products or “e-cigarettes” were the first to appear on the market and these remain popular. Most disposable NVPs are cigalikes. Rechargeable NVPs with a tank or cartomiser, which is manually filled with e-liquid by the user, are now available in an increasing array of models with a wide variety of liquid capacity and battery power. NVPs normally contain a carrier liquid of propylene glycol and vegetable glycerine, either on their own in combination; nicotine is included in the majority of products (but not all) in different concentrations; and most products contain flavouring.

11. The Bill provides that an NVP is:

(a) a device which is intended to enable the inhalation of nicotine-containing vapour by an individual,

(b) a device which is intended to enable the inhalation of other vapour by an individual but is intended to resemble and be operated in a similar way to a device within paragraph (a),

(c) an item which is intended to form part of a device within paragraph (a) or (b),

(d) a substance which is intended to be vaporised by a device within paragraph (a) or (b) (and any item containing such a substance).

12. The Bill expressly excludes medical products and devices, and tobacco and smoking related products. The Bill does not cover nicotine in other forms as it is already regulated by the Poisons Act 1972; poisons are not substances intended for human inhalation and nicotine at poisonous levels should not be available in NVPs.

This document relates to the Health (Tobacco, Nicotine etc. and Care) (Scotland) Bill (SP Bill 73) as introduced in the Scottish Parliament on 4 June 2015

13. The term NVP is intended to include all devices known as electronic cigarettes. The Bill includes related products, such as refills, liquids, chargers and other components, within the meaning of “nicotine vapour product”. Related products are those which are intended to form part of a device used to inhale vapour or are a substance (either containing nicotine or not) intended to be vaporised by such a device. The Bill’s provisions will cover all non-medicinal NVPs, whether they contain nicotine, could contain nicotine or could never contain nicotine. The Bill will also apply to any substance which is intended to be vaporised by these devices such as e-liquids or e-juice, whether they contain nicotine or not.

14. The decision to include products which do not contain nicotine is on the basis of three main factors. One is that it would be extremely impracticable for enforcement authorities to take action against users and test individual products. This approach provides a clear and consistent framework for all products. It provides for general and simple rules under the Bill which can be easily understood, applied and managed. Without such an approach rules in respect of nicotine containing NVPs might be readily undermined and circumvented. Secondly, products which may or may not contain nicotine are still used in a way which resembles smoking and, so, pose the risk of confusion and a potential risk for the re-normalisation of smoking. Thirdly, many products have refillable tanks: they may be sold and initially used with a liquid which does not contain nicotine but could later be used with nicotine-carrying fluids.

15. In response to the Scottish Government’s consultation Electronic Cigarettes and Strengthening Tobacco Control in Scotland, a large majority of respondents (80% of respondents to the question) agreed that the age of sale regulations should apply to NVPs regardless of whether they contain or are capable of containing nicotine. Those who supported the proposal suggested it would be difficult to formulate clear definitions which distinguished between nicotine and non-nicotine NVPs and which would take account of possible future product developments. It was also suggested that the risks of devices and liquids, regardless of whether or not they contain nicotine, are not yet fully understood and that NVPs (with or without nicotine) could possibly re-normalise or model smoking behaviour. This was highlighted with particular reference to devices with a cigarette-like appearance.

Current regulation of nicotine vapour products

16. NVPs are currently subject to general consumer regulations. The EU Tobacco Products Directive (TPD) will extend and strengthen this by creating a consistent regulatory regime for nicotine containing NVPs and e-liquids across EU Member States. The TPD has to be transposed into domestic law and implemented by 20 May 2016. The TPD includes a number of provisions regarding NVPs:

- Products containing more than 20 mg/ml of nicotine or which make smoking cessation claims will be prohibited unless they are licensed as medicines.

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5 E.g. tests have shown that many liquids which claim on their packaging not to contain nicotine actually do and that labelled levels of nicotine are often incorrect. See Goniewicz ML, et al. (2015) Nicotine levels in electronic cigarette refill solutions: A comparative analysis of products from the US, Korea, and Poland. International Journal of Drug Policy. 2015. doi: 10.1016/j.drugpo.2015.01.020
6 These are described in the draft PAS produced by the British Standards Institute: http://www.pdf-archive.com/2014/11/07/pas-54115-draft-2-3-for-pr/preview/page/5/
• Products which contain less than 20 mg/ml of nicotine and have not opted into medicinal licensing (and therefore cannot make claims relating to smoking cessation), will be subject to the TPD. These will be regulated as consumer products and be subject to the following restrictions:
  o Products must be child and tamper-proof,
  o Health warnings, instructions for use, information on addictiveness and toxicity must appear on the packaging and accompanying information leaflet,
  o There can be no promotional elements on packaging,
  o All ingredients and the nicotine content must be listed,
  o Existing rules for the cross-border marketing of tobacco products will apply to electronic cigarettes, in effect banning any advertising which has a cross-border effect. The TPD leaves it to Member States to decide whether to regulate domestic advertising,
  o Manufacturers must inform Member States before placing a product on the market and must report annually to Member States, and
  o There will be new size limits on products: 10ml for e-liquids for dedicated refill containers and 2ml for electronic cigarette cartridges and tanks.

17. NVPs cannot be sold in the UK as a smoking cessation aid unless licensed as a medicine by the UK Government’s Medicine and Healthcare Regulatory Authority (MHRA) and, to date, none have been. The proposals in the Bill apply only to non-medical, unlicensed NVPs. The Bill does not regulate medicinal NVPs as they are regulated at the UK level by the MHRA. NVPs which in the future are licensed as medicines will be subject to specific regulatory rules which cover advertising, product presentation, to whom the medicines can be supplied (and whether over-the-counter or on prescription) and other requirements relating to the sale and supply of medicines.

18. Recitals 47, 48 and 53 to 55 of the TPD make clear that the TPD does not harmonise rules on certain matters which it leaves to member states, namely: smoke-free environments, domestic sales arrangements, domestic advertising, flavourings and age restrictions. Nor does it harmonise rules on NVPs which do not contain nicotine.

POLICY OBJECTIVES – SPECIFICS

Introduction

Nicotine vapour products and health

19. NVPs are new products which involve the repeated inhalation of a vapour containing a combination of chemicals. There are a number of public health issues to be examined in considering what action should be taken. NVP policies are required which balance concerns about the risks to children and adult non-smokers with potential benefits for smoking cessation and harm reduction. In short, current evidence indicates that:
they appear to be considerably safer than conventional smoked tobacco products, but there is a lack of data on the long-term impacts of use,8

the inhalation of chemicals in a vapour (whether or not there is nicotine present) is not risk-free, especially for young people or for those with certain pre-existing conditions.

20. A huge number of different products are on sale, with different chemical components, and scientific understanding of both the short and long-term effects of vaping is only just emerging and so far inconclusive. This uncertainty justifies taking a precautionary public health approach to these products:

- the positive impacts and benefits (e.g. for smoking cessation or tobacco harm reduction) NVPs may offer for individuals and for public health are not fully understood and cannot be quantified,
- the negative impacts and risks (e.g. a possible ‘gateway effect’; and direct and indirect effects on health) NVPs present for individuals using them and for bystanders, are not fully understood and cannot be quantified, although products which mimic smoking clearly contribute to some degree to normalising smoking behaviour, and
- the positive and negative impacts NVPs may have on achieving the outcomes of tobacco control policy are not fully understood.

21. NVPs may prove to be a useful cessation tool for some smokers but there is not the weight of evidence from good quality clinical trials and longitudinal data which would allow the public health community to advocate their use, or to advise on how they can be used, in an attempt to quit.9 A Cochrane Review10 assessed the evidence for their use in cessation and confirmed that there is a shortage of conclusive trials.11 It is unclear what proportion of people who have stopped smoking with an NVP will remain abstinent over the long term and the effectiveness of their use in quit attempts compared to other methods. Policies are needed which do not prevent the public health opportunities from NVPs from being realised. A delicate balance needs to be struck.

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9 Internationally, there are a number of trials of NVPs effectiveness but it will be some time before there is a sufficient accumulation of evidence for judgements to be made about the benefits versus the risks of NVPs. The expected licensing of NVP devices by the MHRA in 2016 may act as a spur to further research into their potential role in cessation.

10 Cochrane Reviews are systematic reviews of primary research in health care and health policy, and internationally recognised as the highest standard in evidence-based health care. They investigate the effects of interventions for prevention, treatment and rehabilitation. They are published online in *The Cochrane Library*.

22. The use of NVPs imitates the act of smoking. There is on-going debate internationally, and within Scotland, amongst some public health stakeholders about the potential for confusion, about the extent to which their visibility undermines efforts to de-normalise smoking and whether their use could act as a potential gateway to nicotine addiction and subsequently smoking.

23. The role of tobacco companies raises concern for public health policy. Initially, the industry consisted of small independent companies but in the past couple of years some tobacco companies have acquired NVP businesses. It seems likely that as the market matures there will be consolidation, with many mainstream brands wholly or partly owned by large tobacco companies.\(^\text{12}\) There is a legitimate public health concern about the potential for tobacco companies to become involved in discussions about cessation, tobacco harm reduction and public health policies. Article 5.3 of the World Health Organisation Framework Convention on Tobacco Control (FCTC)\(^\text{13}\) arose from a need to prevent the tobacco industry from seeking to influence public health policy, as it had done in the past. Article 5.3 enshrines a principle for public health departments and agencies in countries which are parties to the FCTC: “In setting and implementing their public health policies with respect to tobacco control, Parties shall act to protect these policies from commercial and other vested interests of the tobacco industry in accordance with national law.”.

24. The precautionary public health grounds for controlling NVPs cannot be ignored. The Scottish Government believes that the protection of public health is of paramount concern. However, it is not only precautionary public health grounds which underpin the justification for the measures to be introduced by the Bill. Nicotine addiction can directly harm health. Nicotine, as a result of NVP use, could potentially act as a gateway to tobacco use and it is also known that nicotine can have negative impacts on the development of the adolescent brain.

**Nicotine**

25. Nicotine is highly addictive and can be toxic. It is present in most NVPs which are in use. Long-term nicotine addiction is not in the interest of public health in Scotland and the Scottish Government does not believe there is any reason for using NVPs apart from their potential to support an attempt to stop smoking or to prevent or reduce tobacco use.

26. There are hundreds of brands of NVPs and e-liquids which contain nicotine. Many brands may not be independently tested for safety or effectiveness and until the regulatory framework introduced through the TPD is well established there is reason to be concerned about the mislabelling of products, including their nicotine content.

27. Nicotine affects the cardiovascular system and the nervous system. It has particular health implications for certain groups, including young people and children and unborn babies. NRT products which are licensed for medical use, and are available over the counter or on prescription, may be used in pregnancy, although abrupt cessation is the preferred approach for


\(^\text{13}\) [http://www.who.int/fctc/text_download/en/](http://www.who.int/fctc/text_download/en/)
pregnant women. The World Health Organisation has expressed concerns about the differential effects for these groups.

28. There are many studies of the health harms of nicotine which distinguish these harms from the harms of tobacco use. In particular, nicotine impacts on brain development which continues into a person’s twenties. Exposure to nicotine during adolescence may affect brain activity, producing enhanced vulnerability to nicotine addiction, increased impulsivity, and mood disorders, and it is also likely to adversely affect cognitive function and development with long-term consequences. A report in 2014 by the United States Surgeon General, which reviewed half a century of tobacco control policy and research, included the following conclusions: there is sufficient evidence to infer that at high-enough doses nicotine has acute toxicity, nicotine activates multiple biological pathways through which smoking increases risk for disease, nicotine exposure during foetal development has lasting adverse consequences for brain development and nicotine adversely affects maternal and foetal health during pregnancy, contributing to multiple adverse outcomes such as preterm delivery and stillbirth. It noted that evidence suggests that nicotine exposure during adolescence may have lasting adverse consequences for brain development.

29. It is also well established that young people are particularly vulnerable to nicotine addiction and more likely to take health risks and discount future consequences of their behaviours. Prevalence data and scientific studies provide a substantial body of evidence showing that the younger a person experiments with tobacco, the more susceptible that person is to nicotine addiction and to habitual tobacco smoking, and the longer the addiction is likely to last, and the higher the levels of their tobacco use in adulthood. Some young people can become addicted to tobacco within a day or two of the first cigarette smoked. In the UK, two-thirds of smokers start before the age of 18. The evidence on this is summarised in a report

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16 For example, see the work done by the Developmental Cognitive Neuroscience Group at University College London - [https://sites.google.com/site/blakemorelab/research](https://sites.google.com/site/blakemorelab/research). Also: [https://www.tes.co.uk/article.aspx?storycode=6430098](https://www.tes.co.uk/article.aspx?storycode=6430098)


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from 2006 by the Smoking Prevention Working Group\textsuperscript{22} and a report from 2008 by the Scottish Public Health Observatory\textsuperscript{23} (a group led by NHS Health Scotland), documents which are at the heart of the Scottish Government’s thinking on efforts to prevent young people experimenting with smoking.

**Smoking de-normalisation and modelling behaviours**

30. At this stage, there is insufficient evidence to assess the likelihood and magnitude of re-normalising or modelling effects of NVPs, but the Scottish Government considers that this risk should be addressed. There is concern that the widespread use and visibility of NVPs in everyday life could ‘re-normalise’ smoking-like behaviours. This is both relevant for NVPs which do, and those which do not, contain nicotine as they are often identical in resemblance and in the way that they operate. The word “de-normalisation” refers to the effect of shifting the public’s perception of smoking as normal and socially acceptable into a less acceptable, or unacceptable, activity.\textsuperscript{24, 25} Smoking was once normal across much of society. It is now increasingly uncommon and adult smoking rates declined between 1995 and 2013 from 35% to 23%.\textsuperscript{26}

31. The fact that NVPs, both those which contain nicotine and those which do not, can replicate or resemble some of the sensorial, behavioural and social aspects of tobacco smoking is part of their additional appeal for some smokers over other forms of nicotine delivery. The similarity of the hand-to-mouth action contributes to how NVPs may prove to be effective tools for harm reduction and cessation in addicted smokers (the habitual, repeated action has a profound psychological importance for some smokers). This same similarity of NVPs to tobacco cigarettes and of the vaping action to smoking has also prompted concerns that their use could make tobacco smoking more socially acceptable than it has become. Increased exposure to others’ use of NVPs could function as a modelling of smoking behaviours for young people and children. Behavioural modelling has an important influence on individuals’ choices, attitudes and habits. The potential for confusion between NVPs and conventional tobacco cigarettes, and the increasing visibility of NVPs, may undermine efforts to de-normalise smoking behaviour. It is known from prevalence data that children who are exposed to smoking behaviour in the home and in their social and family networks, as an acceptable habit, are much more likely to become


\textsuperscript{24}De-normalisation strategies seek “to change the broad social norms around using tobacco – to push tobacco use out of the charmed circle of normal, desirable practice to being an abnormal practice”: Chapman, S and Freeman, B. (2008) ‘Markers of the denormalisation of smoking and the tobacco industry’, Tobacco Control 2008;17:25-31 (http://tobaccocontrol.bmj.com/content/17/1/25.long).

\textsuperscript{25} See British Medical Association (BMA Board of Science) (2008) Forever cool: the influence of smoking imagery on young people. The BMA reviewed the role of modelling in encouraging young people to smoke and highlighted the importance of action to ‘de-normalise’ and ‘de-glamourise’ smoking: the more visible it is, the more acceptable it seems to those who smoke and those who do not.

smokers themselves. The Scottish Government considers that it is wrong for children to be able to “play at smoking” with NVPs.

The ‘gateway effect’ theory

32. At this time there is insufficient evidence to show whether a “gateway effect” (i.e. people moving from using NVPs into conventional smoking) is being realised in increased rates of tobacco use which appear to be relatively stable. So far use is almost entirely confined to current smokers and recent ex-smokers so any gateway effect would currently be very small. However, this may change over time and will need to be monitored. Given what is known about nicotine addiction, there are concerns that NVP use could, at least potentially, act as a gateway to smoking tobacco for those who do not smoke tobacco (non-smokers, including children, and ex-smokers). This concern is more relevant to those which contain nicotine but may also apply to those which do not as it is known that, although nicotine is the main cause of addiction to cigarette use, there are also environmental and social factors which encourage habituation. The Scottish Government is also mindful that NVPs may serve for some smokers as gateway out of combustible tobacco use.

33. The risks of smoking de-normalisation, the effects of modelling behaviours and the gateway effect, cannot be ignored. The Scottish Government advocates a precautionary approach. The need on precautionary grounds to protect against these risks further supports the rationale for controlling NVPs. There is a particularly strong public interest in protecting children from these risks, which forms part of a wider strategy to protect the population of Scotland. The strategy recognises, however, the potential benefits of NVPs to smokers and the need for controls to strike a balance.

Age restriction for nicotine vapour products

34. The Bill includes a prohibition on the sale of NVPs to under-18s and several other proposals primarily designed to support the implementation and enforcement of this policy. There is currently no statutory restriction on the age at which a young person can be sold an NVP in Scotland. The Scottish Government is clear that there is no good reason for persons under the age of 18 to use NVPs and there are particular risks associated with nicotine for young people and children discussed in more detail at paragraphs 23-27. There is industry support for a mandatory age restriction. Many suppliers and retailers of NVPs voluntarily sell NVPs to persons aged 18 or over only. The Electronic Cigarette Industry Trade Association (ECITA) also requires that its members do not sell to minors or target minors in their marketing and has called for the government to legislate to introduce an age restriction. Many manufacturers mark their products with warnings that they should not be sold to under-18s and guidance from ECITA states that it is good practice to check proof of age before selling an NVP to someone who appears to be under 25.

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35. The Bill will make it an offence to sell a NVP to a person under the age of 18. It allows fixed penalty notices to be issued by enforcement officers. Local authorities will primarily enforce the measure. This largely replicates the measures already in place restricting the age of sale of tobacco products. It is intended that the same defence be available that currently exist for tobacco in that the person selling believed the young person to be aged 18 or over and obtained proof of their age. The Bill also introduces a statutory due diligence defence. The forms of identification deemed acceptable also remain the same (passport, EU driving licence or other prescribed document). The person who sells can be the employee or the employer and in either case the enforcement action could count towards an application to the court for a tobacco and NVP banning order.

36. The Bill differs slightly from the measures in place for tobacco and alcohol in that the offence will not apply to an under 18 who attempts to purchase an NVP nor is there any provision to have NVPs confiscated by the police. This difference will avoid the criminalisation of under-18 year olds who attempt to purchase or who purchase a product which is less hazardous, based on the evidence available, than tobacco. It is also possible that in the future, some NVPs could be licensed as medicines and available to young people either by prescription or over the counter. If this were the case, it would not be appropriate to confiscate such NVPs and, in the course of enforcement, it would not be straightforward to distinguish NVPs which had been licensed as medicines from ones which are not.

37. The Bill provides for a due diligence defence against the offence of selling NVPs, to an underage person. That means it is a defence for an accused to prove that the accused (or any employee or agent of that person) took all reasonable precautions and exercised all due diligence to prevent the offence being committed. The Bill also makes this defence available to a person accused of selling tobacco to an underage person, providing consistency between tobacco and NVPs.

38. Most users of NVPs are adults who smoke or used to smoke tobacco. ASH has estimated that around 2.1 million adults in Great Britain use NVPs, up from an estimated 700,000 users in 2012. UK surveys showed a rise in use by smokers from 2.7% in 2010, to 6.7% in 2012, to 11% in 2013, up to 18% in early 2014. So far studies have consistently shown extremely low levels of experimentation in non-smokers (0.1 - 3.8%). In Scotland, the Scottish...
Government’s annual Scottish Health Survey introduced a question about adult use of NVPs in 2014 which will be reported on in autumn 2015.

39. Survey evidence shows that under-18s are buying or otherwise accessing NVPs, which suggests that NVPs are attractive to some under-18s and that voluntary sales measures are insufficient. Use amongst young people currently appears to be largely limited to those who already smoke tobacco, mirroring adult use. However, it is not known whether this will continue to be the case. Evidence from the USA and across the UK suggests that rates of children and young people trying and using NVPs are continuing to increase.

40. The Scottish Schools Adolescent Lifestyle and Substance Use Survey (SALSUS) collected data on NVP use amongst 13 and 15 year olds in Scotland in 2013.\(^{36}\) Survey findings included:

- Pupils who had tried smoking, used to smoke or are current smokers were more likely to have tried NVPs,
- 6% of regular and 2% of occasional smokers used NVPs weekly,
- 17% of 15 year olds and 7% of 13 year olds reported ever trying or using NVPs,
- 4% who had never smoked had ever used an NVP (3% tried them once; 1% had tried a few times),
- 24% of those who have tried smoking had ever used an NVP,
- 66% of regular smokers and 46% of occasional smokers had used NVPs, however most had only tried them once or a few times (48% of regular and 38% of occasional smokers).

41. It is not just survey data which demonstrate that the industry’s voluntary restriction on sale is not working. Test-purchasing in England found that, of 574 visits made by under-18s in March 2014, successful purchases were made by a child on 227 occasions (40%), despite 80% of the products purchased carrying an age-restriction warning.\(^{37}\) Young people were able to buy NVPs most easily from market stalls and car boot sales, specialist NVPs retailers and independent pharmacies; sales were less frequent from national newsagents and large retailers.

42. In response to the Scottish Government’s consultation *Electronic Cigarettes and Strengthening Tobacco Control in Scotland*, a large majority of respondents (88% of those who responded to the question) agreed that the minimum age for sale of NVP devices and refills should be set at 18. Those who supported the proposal most commonly suggested that possible health risks and the addictive properties of nicotine provided a rationale for preventing under-18s from accessing NVPs.

\(^{36}\) Scottish Schools Adolescent Lifestyle and Substance Use Survey (SALSUS), Smoking Among 13 and 15 year olds in Scotland 2013. \(\text{http://www.isdscotland.org/Health-Topics/Public-Health/SALSUS/Latest-Report/}\)

43. The Institute of Tobacco Control reviewed 123 countries for regulations on NVPs and found that ‘Sixteen countries have minimum ages for NVP purchase that mirror those of traditional cigarettes in their country’. Sales of NVPs are banned in 27 countries and 21 countries have restrictions on the sale of NVPs including restricting/prohibiting the sale or requiring authorisation for products containing nicotine.38

44. In brief, due to the addictive nature of nicotine, the detrimental effects of nicotine on adolescent brain development, the precautionary health grounds noted above and the risk of promoting smoking behaviours to young people (explored in more detail in paragraphs 25-33), the Scottish Government is committed to introducing legislation to prevent the sale of NVPs to children and young people aged under 18.

Prohibition of sales of nicotine vapour products from vending machines

45. The Tobacco and Primary Medical Services (Scotland) Act 2010 banned the sale of tobacco from vending machines. This was because the sale of tobacco to a person under the age of 18 is prohibited and self-service vending machines cannot satisfactorily include a process for the vendor to verify age. It is not generally accepted for age-restricted goods to be sold through vending machines. The simple and workable solution was a complete ban for tobacco sales from vending machines. Responses to the Scottish Government consultation did not identify any instances where NVPs are currently being sold from vending machines in Scotland. However, it is possible that such businesses may appear in future if no action is taken to prevent the opportunity.

46. In response to the Scottish Government’s consultation Electronic Cigarettes and Strengthening Tobacco Control in Scotland, a large majority of respondents (79% of those who responded to the question) agreed that the sales of NVPs and refills (e-liquids) from self-service vending machines should be banned. Those who supported the proposal most commonly referred to difficulties in ensuring robust age verification for such sales.

47. The Bill contains a power to also prohibit the sale of NVPs from vending machines. As with tobacco, this will support the prohibition of sales of NVPs to those under 18 years of age. It also forms part of a wider strategy to reduce smoking behaviours (and mimicking behaviours) across the population. A majority of respondents to the written consultation agreed that the sale of NVP devices and liquids from self-service vending machines should be banned. Similar to the ban on tobacco vending machines, those who supported a ban on NVP vending machines most commonly referred to difficulties in ensuring robust age verification for vending machine sales.

Proxy purchase of nicotine vapour products

48. To support the prohibition of sales of NVPs to those under 18 years of age, the Bill will prohibit ‘proxy purchase’. This is where someone aged 18 or over purchases NVPs for, or on behalf of, a person under 18. These measures will bring the sale of NVPs into line with other age-restricted products, such as tobacco and alcohol. In response to the Scottish Government’s consultation Electronic Cigarettes and Strengthening Tobacco Control in Scotland, a majority of

respondents (78% of respondents to the question) agreed that the Scottish Government should legislate to make it an offence to proxy purchase NVPs.

**Mandatory registration for nicotine vapour products**

49. There is currently no system for identifying the many businesses which sell NVPs. The Tobacco and Primary Medical Services (Scotland) Act 2010 means that all retailers of tobacco products must register their business on the Scottish Tobacco Retailers Register. The Register is not a licensing scheme but allows legitimate businesses to be easily identified. The Register is a valuable tool, which enables local authority officers to provide advice and support to aid responsible retailing and also take enforcement action where necessary.

50. While many retailers who sell tobacco will also sell NVPs, there are many retailers – including specialist shops, pharmacies and pop-up kiosks – which sell NVPs but not tobacco. If measures are introduced to regulate NVP sales, it will be necessary for local authority officers to identify these retailers in order to assist with advice and enforcement functions in relation to the NVP related offences. This will mean that retailers who are already registered to sell tobacco products would be required to update their registration, if they also sell NVPs. Other NVP retailers would be required to register their premises for the first time.

51. There are various offences attached to the existing Register, including selling tobacco without a registration and not notifying changes of details. The Bill will attach these offences in relation to NVP retailer registration. As a result, if a retailer commits three or more tobacco or NVP related offences (such as selling these products to persons under 18) within a 2 year period, a local authority can apply to the Sheriff for a retail banning order (now called a “tobacco and nicotine vapour product banning order”). The order prevents a retailer from selling both NVPs and tobacco for up to 2 years and results in the retailer being removed from the Register. Retailers will also be required to declare whether they sell tobacco, NVPs or both.

52. A majority of respondents (65% of those who responded to the question) to the consultation on these measures were in favour of introducing a requirement that all retailers of NVPs should be registered and with making it an offence to sell such products without registration. A majority also agreed that the offences and penalties for selling NVPs without registration should mirror existing ones for the Register and tobacco sales. Views were mixed amongst individual respondents, NVP industry and tobacco sector representatives were both split, and most pharmacy respondents were opposed to registration.

**Domestic advertising and promotion of nicotine vapour products**

53. There are a range of existing legislative measures designed to protect children and young people, and the wider public, from exposure to tobacco advertising and promotion. Tobacco advertising was largely banned by the Tobacco Advertising and Promotion Act 2002 (TAPA); the Tobacco and Primary Medical Services (Scotland) Act 2010 banned retail displays of tobacco, and the Standardised Packaging of Tobacco Products Regulations 2015 ban any brand markings on cigarette and hand-rolling tobacco. These measures were based on a well-established evidence base on the role of advertising, promotion and displays in the take-up of tobacco use and normalisation of smoking and the difficulty of creating marketing which would only be accessed by, and attractive to, adults who smoke.
54. Marketing of NVPs is extensive and uses a wide variety of channels. The TPD, which will be implemented by May 2016, requires EU member states to implement a ban on cross-border advertising and promotion of nicotine containing e-cigarettes to protect primarily young people, citing concerns that these products could re-normalise smoking behaviour. The forms of advertising and promotion which will be banned by the TPD include:

- Television broadcasting;
- Radio broadcasting;
- Information society services;
- Most publications (e.g. newspapers);
- Sponsorship with a cross-border effect (e.g. televised sporting events).

55. The TPD does not cover domestic advertising, although it encourages member states to consider regulation within their own jurisdiction (see recital 48 of the TPD). Point-of-sale, billboards, posters, brand-stretching, nominal pricing and free distribution are powerful marketing tools which are not covered by the TPD. To date, no action has been taken in other parts of the UK to regulate domestic advertising and promotion of NVPs.

56. The Institute of Tobacco Control reviewed 123 countries for regulations on NVPs and found that of the 47 countries that have bans or restrictions on sale of NVPs, 33 prohibit or restrict the advertising, promotion or sponsorship of NVPs in their policies.

57. In November 2014, the UK Committee of Advertising Practice (CAP) and the Broadcast Committee of Advertising Practice (BCAP) published a new statutory code to ensure that NVPs are promoted responsibly. The CAP/BCAP explained that they “consider that electronic cigarettes’ particular characteristics, their potential for harm, for addiction and their relationship with tobacco, carry a reasonable expectation of specific regulatory protection in relation to how they may be advertised”. The rules are enforced by the Advertising Standards Authority (ASA). The CAP/BCAP rules require that adverts should not target children, but experience with tobacco and other products (e.g. alcohol and junk food) show that it is not possible to create a regime where children are not exposed to advertising aimed at adults and it is very difficult to design and deliver marketing in such a way that it only reaches a small targeted subset of the population. It is extremely difficult to ensure that marketing is designed in such a way that will only reach and appeal to a defined age group or very specific target audience. Spillover is inevitable and it is known that adolescents and children look to their elders as role models and are influenced by, and aspire to the socio-cultural context and habits of older age groups. In

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40 Tobacco Products Directive (2014/40/EU)
addition, the rules set by the CAP/BCAP codes require interpretation in some circumstances as to what might or might not target or appeal to young people.\textsuperscript{43}

58. The Scottish Government welcomes the current CAP/BCAP rules but does not believe that these rules are sufficient; there is no statutory offence attached to them and they are too open to interpretation. The Scottish Government believes a stronger legislative footing is necessary which is similar (but not necessarily identical) to the restrictions on tobacco advertising and promotion contained in TAPA. As the TPD will ban cross-border advertising it is reasonable to assume that companies will respond by diverting resources into domestic advertising in response to this. It is also worth noting that the TPD will not ban advertising of NVPs which do not contain nicotine. The Scottish Government believes that a comprehensive ban on all NVP domestic advertising and promotion is required to complement the TPD, but allowances should be made for advertising at point of sale where NVPs are sold. A display of NVPs, the purpose or effect of which is not to promote a NVP, should not be regarded as an advert or promotion, and therefore should not be prohibited. The Scottish Government considers that allowing advertising at the point of sale and certain displays balances the need to protect non-smokers, especially children and young people, whilst recognising the harm reduction potential of NVPs for smokers who might benefit from being made aware of NVP availability. The Scottish Government will monitor compliance with a ban and commit to reviewing the policy.

59. The Bill contains powers which will enable the Scottish Ministers to make regulations prohibiting or restricting domestic advertising and promotion in Scotland, principally:

- Published advertising, including adverts on billboards, bus stops, vehicles, posters, leaflets, banners and certain published material (e.g. brochures and booklets), product displays whose purpose or effect is to promote NVPs and certain audio-visual media (e.g. publically exhibited moving-picture advertisements),
- Free distribution and in support of that, nominal pricing,
- Domestic sponsorship of an activity, event or person, and
- Brand-stretching in products and services (whereby NVP branding is used in relation to unrelated products or services, and vice versa).

60. The powers can make contravening a prohibition or restriction on domestic advertising or promotion an offence and make related provision. In particular, the powers can be used to make exceptions such as for point of sale advertising, which, as mentioned, the Scottish Ministers intend to permit as this offers a legitimate means for smokers to be informed about, and to find out information about NVPs. However, the intention is that this exception would not include displays visible from outside shops that have the same effect as non-point of sale advertising (e.g. posters taking up entire shop windows are little different to billboard advertising).

61. The purpose of the powers in the Bill in respect of published advertising, sponsorship and brand-stretching is to enable regulations to reduce the visibility and attraction of NVPs, to children and young people under 18 and adult non-smokers. This is not about controlling misleading advertisements (i.e. adverts which mislead consumers by misinforming them or

\textsuperscript{43}http://cap.org.uk/News-reports/Media-Centre/2014/~/media/Files/CAP/Consultations/ecig%20consultation/Regulatory%20Statement.ashx
otherwise impair a fair choice to purchase) or comparative advertising (advertising explicitly or by implication which makes reference to a competitor or competing goods or services). The issue is the promotion of NVPs in general. The Bill will make NVPs age-restricted products and it follows that controls are needed to protect how they are advertised and promoted, in particular, to protect children. Similar to the objective of tobacco advertising and display bans, the aim of measures to reduce NVP advertising and promotion is to prevent the take up of these products amongst children and young people under 18 and adult non-smokers. The public health and public interest reasons which underpin this are set out above. The balance to be struck in weighing the health benefits against the health harms of controlling NVPs forms part of a wider tobacco and NVP control strategy across the population, yet recognises that NVPs are distinct products from tobacco products.

62. In relation to the powers in the Bill to prohibit or restrict free distribution, the purpose is slightly different from the powers in respect of published advertising, sponsorship and brand-stretching. It is not so much about reducing visibility and attraction. It is about protecting children and young people under 18 and adult non-smokers from being encouraged to try NVPs for free. Similarly, in so far as NVPs which do not contain nicotine are concerned, and are not in themselves addictive, the power aims to protect children and young people under 18 and adult non-smokers from being encouraged to try them for free and then potentially go on to try products which do contain nicotine or the conventional tobacco products which they mimic. A prohibition or restriction on nominal pricing is desirable to support a prohibition or restriction on free distribution, to ensure it is not easily circumvented by selling at prices reduced so low that it is tantamount to giving NVPs away for free. Free distribution and nominal pricing are promotions which by their nature have the same effect: encouraging people to try NVPs.

63. Young adults are heavily exposed to NVP marketing, particularly through the internet, which is one of the primary channels for their promotion and where it is estimated around half of all NVPs are bought. A survey of 2,000 secondary pupils in Scotland was undertaken in October-December 2014, before and just after the introduction of the new CAP/BCAP code which came into effect on 10 November. The survey asked the pupils several questions about their exposure to the use of and the marketing of NVPs. The results of the survey demonstrated that, in the previous week, pupils had been exposed to NVP adverts in a wide range of cross-border and domestic marketing contexts (radio and TV, in print, outdoor billboards and posters, in retail outlets, on social media, use by celebrities, and events sponsorship).

64. While the industry has a voluntary age of sale restriction in place, and has welcomed the UK Government’s intention to bring in regulation for an age restriction in England, the same consideration of age is not always reflected in the industry’s approach to marketing. Formal analyses of the content of websites, adverts and promotional materials in the UK and the USA have shown that some NVP marketing appears to have been aimed at a younger demographic and that some of it could appeal to adolescents and children. In the UK analysis was undertaken for Cancer Research UK which systematically audited all forms of NVP marketing, and related PR and editorial comments in tobacco industry and the retail press trade. Findings from that

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44 Scottish Government survey data which will be reported on in summer 2015 showed that secondary school pupils were exposed to NVP promotions through a diversity of channels.
45 SG Health Analytical Services Division will publish a summary analysis of the survey results in the summer.
study concluded that: NVPs were being promoted as lifestyle accessories with a possible appeal for young people; some NVP marketing could still suggest or inadvertently promote the act of tobacco smoking or could be mistaken for banned tobacco promotion.47

**Tobacco advertising: lessons and common issues**

65. As noted in paragraph 53, a well-established evidence base underpinned legislation to protect young people and non-smokers from exposure to tobacco advertising. Children and young people are particularly susceptible to marketing as they have fewer life skills and less knowledge to make informed consumer, lifestyle and health choices. While combustible tobacco products and NVPs are clearly distinct products, there are sufficient similarities between their recreational use, the method of use and their addictive potential to justify drawing a comparison between how the two products have been promoted. It seems reasonable to assume that many of the same factors at play in tobacco and its marketing are also at work with NVPs given the many elements they have in common. Such assumptions underpin the extension to nicotine containing e-cigarettes of cross-border tobacco advertising regulations in the TPD. The independent review of standardised packaging evidence by Sir Cyril Chantler48 observed that there is very strong evidence that exposure to tobacco marketing increases the likelihood of children taking up smoking. This is relevant because the use of NVPs can resemble aspects of smoking behaviour and imagery in NVP marketing could lead to confusion with tobacco products and smoking.

66. There is no good reason why NVPs should be marketed to non-smokers or to children and young people but there is also no practical way to ensure that permitted mass advertising only targets adult smokers, so a partial restriction is not an option in that respect. Extending the restrictions which the TPD will introduce to cover domestic advertising in Scotland of all NVPs would be in line with developments in other countries.49 In contrast to the situation with tobacco, where the public health ambition is to eradicate all use, the public health aim for NVPs is not to prevent all use of NVPs for the foreseeable future, but to restrict their use to those who might benefit (i.e. adult smokers). It is not the intention of the Scottish Government’s policy to prevent those who might benefit from having access to factual material or to be made aware of where NVPs are being sold. Point of sale seems, on balance, to be the best channel for the provision of information about NVPs, where the buyer can ask questions and be shown how to

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[47] The study pre-dated the introduction of the CAP/BCAP rules and at the time of writing no independent analyses had yet replicated the CRUK study to assess the impacts the new rules are having on industry practice.


[49] The World Health Organisation undertook a study in 2014 that showed that comprehensive advertising, promotion and sponsorship bans on NVPs were in place in 39 countries (in which 31% of the world’s population live): [http://apps.who.int/ibc/cop6/FCTC_COP6_10-en.pdf?ua=1](http://apps.who.int/ibc/cop6/FCTC_COP6_10-en.pdf?ua=1)
use a device and therefore should be exempt from any outright ban (such an exemption would, however, be for the regulations made under the Bill to set out).

67. A majority of respondents (66% of those who responded to the question) to the consultation on these measures believed that further regulation of the domestic advertising and promotion of NVPs, in addition to the cross-border restrictions to be introduced by the TPD, is required. However, both NVP and tobacco industry respondents were against additional regulation. Respondents were asked whether regulation was needed in relation to specific domestic advertising channels or media. Of the 106 who answered this question, a clear majority thought that all forms of domestic advertising and promotion should be regulated and for each specific form more than 90% of those who responded to the question agreed that it should be regulated, with the exception of point of sale, where 80% were in favour of regulation. The consultation paper asked whether any exemptions should be allowed. One-third of respondents thought there should be no exemptions and the most frequent reason for any exemptions was the need to balance restricting young people’s exposure to the marketing against the potential contribution NVPs could make to harm reduction or as a cessation tool which means that smokers would need to know about the products.

Supporting the age restriction for the purchase of both tobacco and nicotine vapour products

68. Two measures in the Bill apply to both NVPs and tobacco products, and are primarily intended to support the enforcement of the minimum age of 18 for legally buying these products. The World Health Organisation considers tobacco to be one of the biggest public health threats the world has ever faced, killing nearly six million people a year worldwide. Each year in Scotland, tobacco use is associated with over 13,000 deaths (around a quarter of all deaths in Scotland each year) and 56,000 hospital admissions. The annual costs to Scotland’s health service associated with tobacco-related illnesses are estimated to exceed £300m and may be higher than £500m each year. Smoking makes a significant contribution to Scotland’s health inequalities, with smoking prevalence rates at 39% in Scotland’s most deprived areas, compared to 11% in the least deprived areas. Helping people who smoke to stop, and creating an environment that supports non-smokers to choose not to smoke, are therefore clear public health priorities.

69. Scotland is a recognised world-leader in tobacco control. Scotland’s ban on smoking in public places led the way in the UK and is widely regarded as the most significant piece of public health legislation for a generation. The primary aim of the smoking ban was to tackle second-hand smoke and evaluation has shown measurable improvements in health since its introduction in March 2006.

70. The Scottish Government was amongst the first countries in the world to set a timescale for creating a tobacco-free nation. Its latest five-year Tobacco Control Strategy included a

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50 http://www.who.int/mediacentre/factsheets/fs339/en/
commitment to reduce smoking prevalence to less than 5% by 2034. This means that a child born in 2013 would turn 21 in a country largely free of tobacco use. The Strategy sets out a range of measures to drive progress towards achieving this target. This includes a commitment to consider the need for measures to protect public health from any risks posed by new smoking related products and a specific commitment to consider the need for further advice on NVPs.

71. **It is illegal to sell tobacco to a person under the age of 18.** It can be difficult to judge age by appearance. This can potentially result in tobacco products being sold illegally if the retailer has not asked for proof of age. Schemes have been developed, now commonly known as “Challenge 25” or “Think 25”, which prompt retailers to ask customers who appear to be under 25 years of age for proof that they are 18 years or older before making a sale of age restricted product, the best known statutory example being alcohol. These schemes have been welcomed and very widely applied by many retailers as they encourage responsible practice. They also encourage people to carry identification. Acceptable forms of proof of age are listed in the regulations associated with the age of sale restrictions for tobacco and for alcohol.

72. Improved trade practice, including age verification (Challenge 25), and enforcement mechanisms, including test purchasing, have been partly credited with a reduction in sales of alcohol to those under 18 years of age.

73. Enforcement data shows that there are retailers who make illegal sales of tobacco products to persons under 18 despite legislation setting an age restriction being in place since 2007. There is also evidence that NVPs are being sold to persons under 18 despite a voluntary ban by retailers being in place.

74. Currently there is no age restriction on the age of the person selling tobacco or NVPs. Retail staff who are aged under 18 may feel less confident in challenging the age of a customer and refusing to make a sale to a customer on the grounds of age. The customer could be a friend or peer or may appear to be much older than them. This could be exacerbated if the proposals in the Bill are introduced which will require retailers selling to have an age verification policy in place (Challenge 25). Best practice suggests that either under 18s should not make sales of age restricted products at all or that each sale should be supervised by someone over the age of 18: the Tobacco Retailers Alliance advise retailers that “under-18s are supervised, as refusing sales

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59 SSI 2007/431 increased the age restriction from 16 to 18 years old.

to people in the same age range can be extremely difficult and young people are often more easily intimidated."^61.

**Age verification policy for tobacco and nicotine vapour products**

75. SALSUS 2013 found that of 13 year olds who smoked regularly, 15% purchased cigarettes themselves and 31% of 15 year olds who smoked regularly also purchased cigarettes themselves.^62

76. The Alcohol etc. (Scotland) Act 2010 introduced a licensing requirement for all premises selling alcohol to operate an Age Verification Policy, whereby retailers must ask for proof-of-age from any customers they believe to be under 25 (or a higher age which the policy may determine). The policy helps reduce the scope for ambiguity and should prevent illegal sales being made in borderline cases where it is not clear whether or not the customer is over 18. It supports compliance with the prohibition on underage sales.

77. The age verification policy has been welcomed by alcohol retailers as it supports them to ask for identification without confrontation.^63 It also encourages young people to habitually carry identification. Many tobacco retailers (primarily those who also sell alcohol) already implement an age verification policy for sales of tobacco products. *Creating a Tobacco-free Generation* welcomed this approach and encouraged all tobacco retailers to do the same.

78. The Bill will introduce a similar mandatory age verification policy for retailers of NVPs and tobacco products (but excluding premises from which only distance sales are made - e.g. internet sales). However, as these products are not subject to a licensing scheme, this requirement will not operate in the same way as for alcohol. Rather than being a licensing requirement, the Bill will make it an offence for a retailer to not operate an Age Verification Policy. An Age Verification Policy lays down the steps to be taken by a person selling (e.g. to ask for proof-of-age identification) to a customer seeking to purchase NVPs or tobacco where the person selling thinks or suspects that the customer is aged under 25 (or an older age set in the policy). The Scottish Ministers can amend the minimum age of 25 years old by regulations; there are equivalent powers in alcohol licensing legislation. The Scottish Government will consult with key stakeholders in the development of guidance relating to the policy. The guidance will set out what an age verification policy should include. Retailers should have regard to the guidance in operating a policy, which may cover matters such as training, awareness raising and appropriate identification. It is not the intention of this policy to prevent legal sales from taking place (e.g. where the customer is over age 18), rather it is intended to ensure that steps are taken to reduce the likelihood of illegal sales taking place. It is also intended to help encourage employers to give staff proper training and support on age verification.

79. A majority of respondents (75% of those responding to the question) to the consultation who commented on this proposal agreed with the introduction of Challenge 25 for sales of NVPs.


and tobacco. A majority also agreed that penalties should be the same as for selling tobacco or NVPs to someone aged under 18.

Unauthorised sales of tobacco and nicotine vapour products by under-18s

80. It is legal for persons under 18 to sell both tobacco and NVPs, however it may be more difficult for young people to challenge the age of or refuse sales to their peers or customers who are older than them. This would be especially true with the introduction of the age verification policy, which would result in under 18s having to challenge the age of customers who may be significantly older than them. Without the appropriate support and training, young people may be at risk of making illegal sales of these products.

81. If under 18s were prohibited from selling NVPs and tobacco altogether, or were required to have each individual sale authorised in person by someone over the age of 18, there might be a disproportionate effect on some smaller businesses. For example, where a business does not have the staffing capacity to have an over 18 present on site at all times. The Scottish Government does not wish to place undue burden on these retailers or to discourage retailers from employing under 18s.

82. This Bill will prohibit unauthorised sales of tobacco and NVPs by under 18s. This supports compliance with the prohibition on underage sales. It is also intended to protect persons under 18 who make sales and to encourage employers to give them proper supervision, training and support. The “responsible person” commits an offence if the prohibition is breached on their premise. The registered person will be the responsible person; only in cases where a person is unregistered will it be someone else. The registered person can authorise a person under 18 to allow that person to sell tobacco and NVPs without an adult member of staff being present or they can authorise transactions on a case by case basis. This means that sales by the person under 18 are not unauthorised and the registered person does not commit the offence of allowing unauthorised sales.

83. All premises should be registered if they are selling tobacco or NVPs. In cases where a premises is not registered, and a person under 18 is found to be selling tobacco or NVPs unauthorised, the offence is committed by the employer and / or the person who has management and control of the premises (this is in addition to the offence of carrying on a tobacco or NVP business unregistered). Again, this measure brings the sales of tobacco and NVPs further into line with alcohol legislation. The due diligence defence mentioned at paragraph 34 is also made available in respect of this offence by the Bill.

84. Records of authorisations must be kept on the premises to aid enforcement and, if they cannot be produced, they are presumed to not exist. The Scottish Ministers are given a power by the Bill to make regulations setting out the form and content of such authorisations.

85. A large majority of respondents (87% who responded to the question) to the written consultation agreed that people under the age of 18 should be prohibited from selling tobacco and non-medicinal NVPs and refills unless authorised by an adult.
Smoke-free hospital grounds

Background

86. Section 2 of the Smoking, Health and Social Care (Scotland) Act 2005 makes it an offence to smoke in wholly or substantially enclosed public spaces. This had the effect of making it an offence to smoke inside a NHS hospital building but there are currently no legal restrictions on smoking outside on NHS hospital grounds.

87. Creating a Tobacco-free Generation included an action for all NHS Health Boards to implement smoke-free policies across all NHS grounds by April 2015. This built on existing Scottish Government guidance to Health Boards on the development and implementation of smoke-free policies and the creation of health-promoting hospitals. To support Health Boards to take a consistent approach across Scotland and to raise public awareness, NHS Health Scotland developed implementation guidance for Health Boards and launched a national information campaign in March 2015. While early signs suggest this is having a positive impact, there remain concerns about compliance. The Scottish Government does not have comprehensive and reliable empirical data from across Health Boards on how many people smoke on NHS hospital grounds, where people smoke on the grounds, and the levels of second-hand smoke (“SHS”) in and around NHS hospital building entrances and windows.

88. Health Boards have reported difficulties in enforcing the ban as there is no sanction that can be applied if someone refuses to comply with the policy, other than asking the person to leave the grounds. However, this may not be desirable should a person be a patient. It is also difficult to enforce on large hospital grounds where a person could easily re-enter undetected. The Bill introduces a framework for smoke-free areas around NHS hospital buildings.

89. The Scottish Government has considered introducing measures to make it an offence to smoke anywhere within all NHS hospital grounds (with and without exempted zones where smoking would be permissible) but does not believe that this is a proportionate response to the current situation. The Bill will therefore make it an offence for a person to smoke within a designated area outside of buildings on hospital sites. The area will be bounded by a perimeter of a specified distance from hospital buildings (unless a building is exempted) but the perimeter cannot extend beyond the hospital grounds. The detail is to be set out in regulations under powers in the Bill. This approach will effectively extend the indoor smoking ban under the Smoking, Health and Social Care (Scotland) Act 2005 to include an outside area. This is important given the size of some grounds. Setting a perimeter around buildings focusses on the areas where there is the highest level of traffic of people on foot leaving and entering the hospital and where there is a risk of smoke entering hospital buildings as a result of people smoking close to the building, in particular at entrances. It is also easier to enforce a prohibition backed by the criminal law near buildings given that some hospital grounds are vast in size. For areas beyond

64 2005 asp 13. Schedule 1 to the Prohibition of Smoking in Certain Premises (Scotland) Regulations 2006 (SSI 2006/90) includes “Hospitals, hospices, psychiatric hospitals, psychiatric units and health care premises” within the meaning of “no-smoking premises”
65 Section 4 of the 2005 Act defines “no-smoking premises”.
67 http://www.scotland.gov.uk/Publications/2005/12/21153341/33417
68 http://www.smokefreegrounds.org/
the perimeter, Health Boards will continue to operate smoke-free policies, as required by *Creating a Tobacco-free Generation*, in ways which best meet local needs. This is supported by an existing national campaign and investment in cessation support.

90. Fixed penalty notices can be issued to those who smoke within the defined perimeter in the same terms as those already issued under the 2005 Act. The outside smoking ban will likewise be enforced primarily by local authorities. Warning signs will be mandatory at entrances to NHS hospital grounds and hospital buildings. It will be an offence for a person having management and control of a hospital building to fail to put up signs. The Scottish Ministers have powers to specify the form and content of signage. A duty will be placed on the relevant NHS Health Board to display signage at every entrance to NHS hospital grounds. The Bill contains powers to make various exemptions in relation to the outside smoking ban, including exempting certain hospitals (e.g. the state hospital and psychiatric hospitals), exempting certain hospital buildings (e.g. where long term residential care is delivered such as adult hospices) on hospital grounds which are otherwise subject to the outside smoking ban and exempting areas of land from being a part of hospital grounds (e.g. residential areas otherwise associated with the hospital, like staff accommodation) or a part of the no-smoking area (e.g. to prevent the perimeter of a neighbouring building preventing smoking near an exempt building). The Bill also provides powers to include land within hospital grounds (e.g. where it might be unclear if land forms part of hospital grounds and it is desirable to ensure it is included) and to modify signage requirements as a consequence of the inclusion of land and the exemptions. The Bill provides a framework within which regulations can be made setting out the detail.

91. The proposal reflects the NHS’s direct but compassionate message: it appreciates that smoking is a difficult habit to break but advises people to seek support to quit. The policy supports people who visit hospital for smoking cessation treatment, who have given up or who have reduced their smoking, and who might find it difficult to pass through areas close to entrances where people have congregated to smoke. The proposal will help people who have been advised to stop or reduce their smoking for periods of medical treatment. Social acceptability has a strong bearing on health behaviours and evidence shows that quitting is made more difficult if a smoker’s social environment is filled with smokers. It is well established that one of the factors which influence whether a quit attempt will be successful is the extent to which a smoker is exposed to ‘cues’. This has partly motivated policies in Scotland such as the display ban and, although the enclosed public spaces smoking-ban in the 2005 Act was motivated by the desire to cut exposure to SHS, it may also have played an important part in de-normalising smoking. Support for the smoking ban increased significantly between 2006 and 2007 amongst smokers and non-smokers; and there has been a high level of compliance. The ban on smoking in hospital grounds is an important contribution to the progressive de-normalisation of smoking.

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92. Another aim of the proposal is to prevent or reduce public, patients and staff from being exposed to SHS around entrances and near windows and vents through which smoke could drift into hospital buildings. The health harms from SHS are well understood and the World Health Organisation advises that there is no safe level of exposure to the small particles in cigarette smoke.

93. It is difficult to measure SHS out of doors as the chemical markers in the air may come from a range of other sources (for example, vehicle emissions). There is some evidence from studies of outdoor environments (primarily hospitality settings) which shows that it is possible, under certain conditions, to record levels of chemicals or particulates that could be attributable to SHS which approach those which are found in indoor areas where smoking is permitted. Smoke-drift from outside can lead to SHS levels inside building entrances and windows which may be high enough to warrant concern for those exposed to it over a prolonged period (for example, NHS staff working near vents)\(^{72}\). This evidence largely relates to SHS outside entrances to hospitality venues but it does serve as a useful comparator.

94. In Scotland, there is public support for smoke-free hospital grounds. A recent ASH/YouGov survey indicated that 73% of a representative sample (n=1,064) of the Scottish population would be in favour of a complete ban on smoking in hospital grounds.\(^{73}\) The survey asked, “How strongly, if at all, do you agree or disagree with the following statement? Smoking should be banned in hospital grounds.”

<table>
<thead>
<tr>
<th></th>
<th>All Adults</th>
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</tr>
<tr>
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</tr>
<tr>
<td>Agree</td>
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</tr>
<tr>
<td>Strongly disagree</td>
<td>4%</td>
<td>21%</td>
</tr>
<tr>
<td>Don’t know</td>
<td>2%</td>
<td>5%</td>
</tr>
<tr>
<td>Net: Agree</td>
<td>73%</td>
<td>32%</td>
</tr>
<tr>
<td>Net: Disagree</td>
<td>15%</td>
<td>48%</td>
</tr>
</tbody>
</table>

95. Public opinion in Scotland is consistent with that in many other high-income countries with well-developed tobacco control laws, where outdoor smoke-free areas are increasingly being considered and introduced.

96. A majority of respondents to the written consultation (67% of those who responded to the question) were in favour of national legislation including all but one of the 18 Health Boards and health partnerships which responded to a question on this. Respondents had diverse views about where and how such a policy should be enforced. A majority of those who responded to a question on where such a ban should apply thought that it should apply to all NHS grounds (including offices, dentists and GP practices); almost none chose only hospital grounds; and about one tenth chose only within a designated perimeter around NHS buildings. The Scottish


\(^{73}\) YG-Archive-140314-ASH-Scotland
Government believes that legislation on smoking on hospital grounds should be applied and enforced in a consistent and proportionate manner across Scotland. The rules should be as simple and as easy to comply with, and enforce, as possible. The size of NHS hospital grounds varies considerably across Scotland, from small to large and complex hospital sites. Many people who use these facilities as patients will have temporary or permanent impeded mobility due to an illness or disability and it would not be safe for some patients to go far from the hospital building with or without someone accompanying them. The existing policy approach allows NHS Boards to make decisions about how they choose to implement and enforce local smoke-free policies. This includes raising public awareness, providing alternatives to tobacco and asking those who visit NHS sites to respect the policy. People who do not comply, including those with impeded mobility and serious illness, do not face a criminal penalty. In considering the option of legislation, which would introduce criminal penalties issued to those who do not comply, the impact of such action needs to be balanced with the commitment to treat all users of hospitals, particularly those who are most vulnerable, with dignity and respect.

97. The primary aim of these provisions in the Bill is to support the de-normalisation of smoking in NHS hospital grounds in order to help reduce the use of tobacco across the population, in particular to reinforce that the NHS should be seen as an exemplar of health promotion within society and to support people in their efforts to reduce or stop smoking. The secondary aim is to help prevent or reduce exposure to second-hand smoke by people in NHS hospital grounds, at entrances and near windows/vents to buildings. These aims seek to improve and protect public health, and also as a matter of public policy, to ensure the NHS in Scotland is an exemplar in the health field. The need to achieve these aims is not in any doubt. People smoke at entrances and near buildings on hospital grounds. The evidence of harm from smoking behaviour and second-hand smoke is well established and the NHS should clearly be at the forefront of reducing these harms. Yet the provisions strike a balance, by not going as far as allowing a prohibition to apply in a blanket fashion to entire hospital grounds and enabling regulations to make exceptions, which is practical from an enforcement perspective and compassionate.

Consultation

Public written consultation

98. A public consultation paper, *Electronic Cigarettes and Strengthening Tobacco Control in Scotland*, was published on 10th October 2014 and closed for submissions on 2nd January 2015. It contained 49 questions and covered all of the tobacco and NVP policies in the Bill as well as other topics which are not included in the Bill. By the closing date, 172 written responses had been received. These were analysed by an external contractor and a summary report of this analysis was published on the Scottish Government website. There were 78 responses from individual members of the public and 94 responses from organisations. Organisational respondents were assigned to a specific category to allow for respondent group or sectorial analysis.

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75 [http://www.gov.scot/Publications/2015/05/7711](http://www.gov.scot/Publications/2015/05/7711)
This document relates to the Health (Tobacco, Nicotine etc. and Care) (Scotland) Bill (SP Bill 73) as introduced in the Scottish Parliament on 4 June 2015

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<tr>
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</tr>
<tr>
<td>General Retail or Pharmacy</td>
<td>9</td>
</tr>
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<td>Health Body or Partnership</td>
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</tr>
<tr>
<td><strong>TOTAL</strong></td>
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</tr>
</tbody>
</table>

99. There was a mix of 49 closed and open questions. Many respondents did not respond to every question and many provided text which did not refer to a single question but discussed an issue more generally. To assess where the weight of opinion lay, quantitative analysis was undertaken of responses to closed questions and qualitative analysis was undertaken of free text responses to open questions and of additional text.

100. It is important to remember that the respondents to formal consultations are self-selecting and tend to be individuals and organisations with a particular interest or stake in the consultation topic. The results of consultation exercises are not reflective of wider public opinion.

**Youth Commission on Smoking Prevention**

101. The Scottish Government’s Tobacco Control Strategy: *Creating A Tobacco-Free Generation*\(^{76}\) included an action to establish a Youth Commission on Smoking Prevention. The Commission was established by the Scottish Government, its members are young people aged 12-22, from a range of backgrounds. It undertook its own research to provide the Scottish Government and local delivery partners with a series of recommendations and solutions aimed at supporting young people to choose not to use tobacco.

102. The Commission published its final report\(^ {77}\) on 14 October 2014. The report contained a number of recommendations, including:

- implementation of a 50m smoking ban around public places including schools and hospitals,
- a call on the Scottish Government to support the proposed Member’s Bill around a ban on smoking in cars,


an increase in the age limit for those wishing to purchase tobacco products to 21 years old, and
a ban on the sale of all e-cigarettes in shops and retail outlets – the product must be regulated and distributed as a medicinal product only.

Alternative approaches

103. The Business and Regulatory Impact Assessment and the Equality Impact Assessment which will accompany the Bill will outline in further detail the reasoning involved when considering policy options in terms of their likely impacts.

Minimum age for sales of non-medicinal nicotine vapour products

104. The following options to prevent NVPs being sold to under 18s were considered:

- Option 1 – do nothing,
- Option 2 – create an offence for a person under 18 to purchase or attempt to purchase an NVP as well as the offence for a retailer to sell an NVP to an under 18,
- Option 3 – create an offence for a retailer to sell an NVP to an under 18. This is the chosen option.

105. Option 1 would offer no safeguards to prevent young people from accessing NVPs. Although there is a widespread voluntary approach in place across manufacturing and retail elements of the sector, test purchasing exercises and survey data show that under 18s are able to access NVPs despite these voluntary measures. This option was ruled out.

106. Option 2 would support the aim of protecting young people and create greater consistency for retailers by aligning NVPs with other age restricted products, such as tobacco and alcohol, where it is also an offence for a young person to purchase or attempt to purchase these products. However, it would lead to the criminalisation of under-18 year olds who attempt to purchase or purchase a product which appears to be less hazardous than tobacco. For this reason, Option 2 was discounted and Option 3 was chosen.

Proxy purchase of non-medicinal nicotine vapour products

107. The following options were considered to prevent adults buying NVPs on behalf of children:

- Option 1 – do nothing,
- Option 2 – create an offence for an adult to purchase NVPs for a child or young person aged under 18 (this is the chosen option).

108. Option 1 would mean that while young people aged under 18 could not be sold NVPs, adults could purchase and legally supply them to a young person. Adults who have legitimate concerns for a young person who smokes and wish to purchase an NVP for them as a means of harm reduction would be permitted to do so. However, this would not prevent an adult who does
not know the young person or does not have a harm reduction motivation to purchase an NVP for them. Since Option 1 offers no protection for young people, this was discounted and Option 2 was chosen.

109. By creating an offence of purchasing NVPs or related products on behalf of a person under 18, Option 2 sends a clear and consistent message that NVPs are not suitable for young people. It supports the ban on underage sale. Since young people over the age of 12 can be prescribed Nicotine Replacement Therapy, which is available free on prescription, an adult concerned about a young person using tobacco would still be able to seek medical advice on treatment options.

**Ban on sales of nicotine vapour products from vending machines**

110. The options considered were:
- Option 1 – do nothing,
- Option 2 – introduce a ban on the sale of NVPs from vending machines. This is the chosen option.

111. Option 1 would allow NVPs to be purchased from vending machines. This would mean that the age of customers could not be verified at all, or not verified in a way that is necessarily secure nor conducive to general and simple rules capable of being easily applied and enforced, and under 18s could likely access NVPs if they became available on sale from vending machines. Similar to the rationale for banning the sale of tobacco from vending machines, Option 1 was therefore rejected and Option 2 was chosen. Option 2 supports the ban on underage sale and it forms part of a wider NVP control strategy across the population.

**Mandatory registration to retail nicotine vapour products**

112. There is currently no requirement to register as a retailer of NVPs. Three policy options were considered:
- Option 1 - do nothing,
- Option 2 - create an entirely separate register for retailers of NVPs,
- Option 3 - create a combined register of tobacco and NVP retailers, based on the existing Tobacco Retailers Register, where businesses will be required to identify the type of business they are carrying on and whether they are selling tobacco, NVPs or both. It follows that the banning order also applies to both the sale of tobacco and NVPs. This is the chosen option.

113. Option 1 would be the least burdensome option for retailers. However, Trading Standards would have difficulty in enforcing the new statutory measures to regulate NVPs (in this Bill and under the EU TPD) if they were not able to easily identify NVP retailers. This may lead to irresponsible retailers being able to operate unnoticed and illegal sales being made and so Option 1 was rejected.

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78 In the future, the MHRA may also license NVPs which could be prescribed for children as NRT.
114. Option 2 would create a new register of NVP retailers entirely separate from the Scottish Tobacco Retailers Register. This option would recognise the differences between the two product groups. However, it would involve an additional administrative burden for the many retailers who sell both NVPs and tobacco, who would be subject to two separate registration schemes, and there would be a small additional cost to the Scottish Government for the creation of a new register, so this was rejected.

115. The chosen policy, Option 3 would create a combined register of NVP and tobacco retailers by expanding the existing Register. It supports the ban on underage sale. Many businesses which sell NVPs also sell tobacco. They would not need to register anew on a separate NVPs system but would just need to update their entry to reflect that they sell both. It was considered that this option does not wholly address concerns that NVPs could be conflated or confused with tobacco if treated in a single register. However, businesses will identify whether they sell NVPs, tobacco or both. If a person is not responsibly selling one product then they may not be responsibly selling the other, so in that respect, it makes sense for a banning order (if granted by a sheriff) to apply to retailing both tobacco and NVPs rather than just one or the other; this also keeps the legislation on banning orders and the register simpler and easier to work in practice – a single register lends itself to a single banning order. The Scottish Government recognises that tobacco and NVPs are distinct products and are regulating them differently, but believe that Option 3 offers a proportionate and efficient administrative approach.

Domestic advertising and promotion of nicotine vapour products

116. Three options for regulating the domestic advertising and promotion of NVPs were considered:

- Option 1 – do nothing,
- Option 2 – introduce powers capable of banning or restricting on all forms of domestic advertising and promotion of NVPs,
- Option 3 – introduce powers capable of banning or restricting all forms of domestic advertising with exceptions which can be made, for example, for in-store point of sale marketing. This is the chosen option.

117. Option 1 would benefit retailers and manufacturers of NVPs, as they would be able to market their products to attract new customers and expand their businesses. Domestic advertising and promotion would still be subject to the CAP and BCAP codes and the ASA could require the removal of any advertising which breaches these codes. However, the codes are not as robust or as extensive as statutory controls backed by the criminal law; and there could continue to be examples of marketing which might be attractive to under-18s and non-smokers who would be exposed to such marketing before it was retroactively removed by the ASA in the event of a breach. It is also reasonable to expect that, following the implementation of the TPD, there would be an increase in domestic advertising to offset not being able to use cross-border forms. It is for these reasons that Option 1 was rejected.

118. Option 2 would allow for a ban or restriction (without the possibility of exceptions being made) on all forms of domestic advertising and promotion of NVPs. However, such a ban or
restriction would make it difficult for current smokers, who might benefit from substituting tobacco with NVPs, to learn about non-medicinal NVPs and their use. Option 2 was therefore rejected.

119. Option 3 provides for powers which are intended to be used to ban or restrict most forms of advertising and promotion of non-medicinal NVPs, apart from in-store point of sale advertising. This would allow for a channel of information for current smokers to be told about (e.g. when they are asking for NRT or tobacco products) and to find out about NVPs and to make a more informed decision about whether or not to switch to NVPs. This was chosen as a proportionate approach to achieving the aim of limiting NVP marketing to forms that would be almost solely aimed at smokers. However, it is important to note that the Bill establishes the powers and the detail of a ban or restriction, and the exceptions, would be for regulations.

**Age verification policy for tobacco and nicotine vapour product sales (Challenge 25)**

120. The options considered were:
- Option 1 – do nothing,
- Option 2 – require retailers to have in place a “Challenge 25” policy for the sale of tobacco and NVPs. This is the chosen option.

121. Option 1 would mean no additional burdens for retailers and allow retailers who voluntarily implement a Challenge 25 policy to continue doing so. There would be no additional legislative safeguards to prevent sales of these products to young people in borderline cases where it is not clear whether the customer is over 18. It would also mean continued inconsistency between the approaches taken by different retailers. Option 1 would not support or strengthen the age of sale restriction so it was rejected.

122. Option 2 would support the age of sale restriction for tobacco and NVPs purchases, aiding enforcement, empowering retailers to ask for proof of age, sending a clear message to customers that they may need to prove their age, and it would be in line with the law on alcohol.

**Unauthorised sales of tobacco and nicotine vapour products by under 18s**

123. A number of options were considered:
- Option 1 – do nothing,
- Option 2 – require a responsible person to specifically authorise and be present for each sale of tobacco or NVPs by an under 18,
- Option 3 – require a responsible person to authorise an employee under 18 to sell tobacco or NVPs. This is the chosen option.

124. Option 1 would mean that all under 18s continue to be legally allowed to sell tobacco and NVPs and there would be no additional support or safeguards in place for them to challenge their peers or those older than them for identification should the sale of sale restriction and the mandatory age-verification policy be introduced. Since Option 1 does nothing to offer additional protection and support for young people to make legitimate sales, it was discounted.
125. Option 2 would mean that under 18s would be supported in asking for identification when selling NVPs and tobacco as they would have a responsible adult authorise each sale in person. This would decrease the risk of illegal sales being made. This option would mean that under 18s would not be able to make sales while alone or unsupervised on the premises. Businesses which do not have the capacity to have more than one staff member on duty at all times may therefore be less likely to employ an under 18. Small to medium enterprises and family businesses would be especially impacted. For this reason, this Option 2 was rejected.

126. Option 3 takes into account the impacts on these businesses. It means that the responsible person should take responsibility for deciding whether they need to authorise each sale by the under 18 of tobacco or NVPs (Option 2) or provide a young person who has been appropriately trained with general authorisation to make sales when an adult is not present. In this case the employer must make a judgement that the young employee is responsible and skilled enough to comply with the law without an over-18 being present. By having to give prior authorisation, it encourages retailers to support young employees they authorise. Authorisation encourages responsible sales and thereby supports the ban on underage sales.

Smoke-free hospital grounds

127. Three approaches to support smoke-free hospital grounds policies were considered:
   - Option 1 – do nothing,
   - Option 2 – to ban smoking everywhere in the grounds of NHS hospitals with or without the option of making exceptions by regulations,
   - Option 3 – to ban smoking within a designated area around buildings on NHS hospital grounds but allowing exceptions to be made in regulations. This is the chosen option.

128. Option 1 would not introduce measures to strengthen and enhance the smoke-free grounds-wide policies which NHS Health Boards were asked to implement by the Scottish Government by 1 April 2015. This would mean that no action would be taken to mitigate the concerns raised by NHS Chief Executives that there are no statutory requirements to support compliance with their policies. Option 1 was therefore rejected.

129. Option 2 would send a clear and consistent message that NHS Scotland is a health-promoting health service and that smoking on hospital grounds is not socially acceptable. It would help to reduce second-hand smoke exposure. This option would underpin the current smoke-free grounds policy. However, in terms of applying penalties, rather than allowing flexibility for NHS Health Boards to decide on locally appropriate and proportionate action to support compliance, with or without making complicated exceptions for certain areas on the grounds it would disproportionately and indiscriminately impact on addicted smokers who struggle with mobility, such as the elderly, disabled and seriously ill, and who may already feel stigmatised. This is especially the case on large hospital grounds where the exit to grounds could potentially be miles from a hospital building. On large hospital grounds enforcement of the entire site becomes impractical and the issues of second-hand smoke and social acceptance are primarily a concern at the entrances to, and near windows/vents of, buildings. Option 2 was therefore rejected.
This document relates to the Health (Tobacco, Nicotine etc. and Care) (Scotland) Bill (SP Bill 73) as introduced in the Scottish Parliament on 4 June 2015

130. Option 3 was chosen because a smoke-free perimeter around buildings protects in law, the area where there is the highest volume of foot traffic and the greatest risk of exposure to second-hand smoke and smoke-drift into buildings. People tend to smoke near buildings, which means that the visibility of smoking behaviour is most pronounced in these areas; countering this visibility further reduces the social acceptability of smoking. It compliments existing smoke-free policies while taking a balanced, more realistic and more compassionate and safe approach while still supporting the Scottish Government’s ambition for the health service. This option would allow NHS Boards to continue to have the flexibility to make decisions about how they choose to implement and enforce smoke-free policies on their estate beyond the statutory smoke-free area.

EFFECTS ON EQUAL OPPORTUNITIES, HUMAN RIGHTS, ISLAND COMMUNITIES, LOCAL GOVERNMENT, SUSTAINABLE DEVELOPMENT, ETC.

Equal opportunities

131. The Bill’s provisions on NVPs and tobacco products are not discriminatory on the basis of gender, race, disability, sexual orientation, LGBTI status or pregnancy/maternity status. Several of the Bill’s provisions are deliberately and justifiably discriminatory on the basis of age in order to protect the health of young people. The provision for smoking-free perimeter zones around hospital buildings is not directly discriminatory on the basis of age, gender, race, disability, sexual orientation, LGBTI status or pregnancy/maternity status. It may be indirectly discriminatory towards people who have limited mobility because of their age, a disability or pregnancy, but this has been carefully considered in the development of the policy.

Human rights

132. In relation to the provisions on nicotine vapour products, on tobacco, and on smoking in hospital grounds, the Scottish Government has assessed and is satisfied that these provisions in the Bill are compatible with the European Convention on Human Rights. In the assessment of the Scottish Government the rights which could arguably be considered relevant to the Bill are Article 8 (right to respect for private and family life), Article 10 (right to freedom of expression) and Article 1 Protocol 1 (right to peaceful enjoyment of property). Should there be any interference in these rights the Scottish Government has assessed that the provisions in the Bill fall within a state’s margin of appreciation and are justified. As described in this Policy Memorandum, the measures pursue legitimate aims (public health and public interests), they are necessary and they are a proportionate response to that need.

Island communities

133. The provisions of the Bill will apply equally to all communities in Scotland and there are no particular implications for island communities.

Local government

134. The implementation of measures in the Bill will undoubtedly have implications for local government given their lead role in the enforcement and monitoring of tobacco and NVP provisions. COSLA and individual local authorities had the opportunity to contribute to the
formal written consultation and the Scottish Government will continue its on-going engagement with COSLA. The Scottish Government will engage with the new Scottish Local Government Partnership. COSLA have been consulted in the process for developing the Business and Regulatory Impact Assessment which will be finalised and published shortly after the Bill’s introduction.

Sustainable development

135. The Bill will have no impact on sustainable development.

PART 2: DUTY OF CANDOUR

Background

136. The Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry79, chaired by Robert Francis, QC included recommendations in support of an essential aim to ensure openness, transparency and candour throughout the health system about matters of concern. It was recommended that every healthcare organisation and everyone working for them must be honest, open and truthful in all their dealings with patients and the public, and organisational and personal interests must never be allowed to outweigh that duty to be honest, open and truthful. The Inquiry recommended that where death or serious harm has been or may have been caused to a patient by an act or omission of the organisation or its staff, the patient (or any lawfully entitled personal representative or other authorised person) should be informed of the incident, given full disclosure of the surrounding circumstances and be offered an appropriate level of support, whether or not the patient or representative has asked for this information.

137. The Berwick Report80 ‘A Promise to learn – a commitment to act’ emphasised the importance of the requirement that patient or carers affected by serious incidents should be notified and supported. It recommended that where an incident qualifying as a serious incident occurs the patient or carers affected by the incident should be notified and supported. The report cautioned against an automatic ‘duty of candour’ where patients are told about every error or near miss, highlighting that this will lead to defensive documentation and large bureaucratic overhead that distracts from patient care. The importance of providing patients with all the information they ask for was emphasised.

138. The Dalton Williams Review81 clearly outlined the expectations that all those involved in caring roles have a responsibility to be open and honest to those in their care. They noted that the evidence they heard reaffirmed what was already known: that when things do go wrong, patients and their families expect three things: to be told honestly what happened, what can be done to deal with any harm caused, and to know what will be done to prevent a recurrence to someone else. Health and care organisations have a responsibility to ensure that all of these are reliably undertaken.

139. It is internationally recognised that between 10-25% of episodes of healthcare (in general hospital, community hospital and general practice) are associated with an adverse event. However, it has been recognised that as few as 30 per cent of incidents resulting in harm are disclosed to people who have been affected. Denial and dismissal of mistakes often results in distress and people spending several years seeking the truth, accountability and an apology.

140. Adult social care providers already work within a well-developed framework for incident reporting. This involves a range of statutory reporting and practice arrangements that support engagement with an external reporting regime. This has driven a culture of candour in adult social care for some time. Adult social care providers are commonly already candid with people using their services when things go wrong. The less episodic nature of adult social care means that people are supported by social care providers for longer periods of time. The resulting establishment of longer term relationships tends to promote candour in practice, as something that is accepted as the ‘right thing to do’.

141. There are a range of factors that have been consistently shown to facilitate disclosure of harm and some that impede disclosure. Known barriers to disclosure include fear, a culture of secrecy and/or blame, lack of confidence in communication skills, fears that people will be upset and doubt that disclosure is effective in improving culture. Factors that facilitate disclosure are an emphasis on accountability, honesty, restitution, trust and reduced risks of claims. Disclosure is inhibited by professional or institutional repercussions, legal liability, blame, lack of accountability and negative family reactions.

142. Improvements in arrangements to support the disclosure of harm, is a key element supporting a continuously improving culture of safety. There are several healthcare systems and organisations worldwide that have introduced initiatives or arrangements to support open disclosure of harm. For example, The Australian Open Disclosure Framework is a national initiative of the Australian National, state and territory governments, in conjunction with private health services, through the Australian Commission on Safety and Quality in Health Care. It is intended to contribute to improving the safety and quality of health care.

143. Ethically and morally, health and care professionals are already required to tell people about instances of harm. However of the eight UK wide professional regulatory bodies, only the General Medical Council (GMC) and Nursing and Midwifery Council’s (NMC) standards explicitly require their registrants to be candid with people harmed by their practice. The General Pharmaceutical Council has a standard that requires their registrants to respond ‘appropriately’

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when care goes wrong however, it does not specify that this involves being candid with the patient. The Professional Standards Authority has been overseeing the work of the professional regulatory bodies to reflect a common position on candour.

144. The General Medical Council and Nursing and Midwifery Council have recently consulted on a professional duty of candour.\(^{89}\) The new Code issued by the Nursing and Midwifery Council includes new content emphasising the professional duty of candour for nursing and midwifery registrants. Further guidance will be issued by the General Medical Council in summer 2015.

145. NHS Boards are required to implement the requirements outlined in ‘Learning from adverse events through reporting and review: A national framework for NHSScotland’\(^{90}\) \(^{91}\) and also the ‘Can I Help You?’ guidance in respect of feedback, comments, concerns and complaints received \(^{92}\). This includes a requirement to submit Annual Reports on Comments, Concerns, Feedback and Complaints to the Scottish Government and the Scottish Health Council. The Scottish Health Council have published two reports following reviews of NHS Boards Annual Reports.\(^{93}\) \(^{94}\)

146. ‘Learning from Adverse Events, through reporting and review: A National Framework for Scotland’ (the National Framework) a document published by Healthcare Improvement Scotland is intended to provide an overarching approach, developed from best practice to support health and care providers to effectively manage adverse events.

147. The aims of the National Framework are to:

- learn locally and nationally to make service improvements that enhance the safety of our care system for everyone,
- support adverse event management in a timely and effective manner,
- provide a consistent national approach to the identification, reporting and review of adverse events, and allow best practice to be actively promoted across Scotland,
- present an approach that allows reflective review of events which can be adapted to different settings, and
- provide national resources to develop the skills, culture and systems required to effectively learn from adverse events to improve services across Scotland.

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\(^{89}\) Nursing and Midwifery Council and General Medical Council (2014). ‘Openness and honesty when things go wrong: the professional duty of candour. A draft for consultation’
\(^{90}\) http://offlinehbpl.hbpl.co.uk/NewsAttachments/PGH/Openness_and_honesty_draft.pdf
\(^{91}\) http://www.healthcareimprovementscotland.org/his/idoc.ashx?docid=3b248733-5f86-4379-9a28-35beae432004&version=1
\(^{92}\) http://www.healthcareimprovementscotland.org/his/idoc.ashx?docid=3e877507-c77e-4bef-9566-852329abe425&version=1
\(^{93}\) http://www.gov.scot/Publications/2012/03/6414
\(^{94}\) http://www.scottishhealthcouncil.org/publications/research/listening_and_learning.aspx#.VUASwxdFAhs[Link no longer active]
http://www.scottishhealthcouncil.org/publications/research/complaints_and_feedback_report.aspx#.VUAS1BdFAhs
148. The National Framework seeks to ensure that no matter where an adverse event occurs in Scotland:

- the affected person receives the same high quality response,
- any staff involved are treated in a consistent manner,
- the event is reviewed in a similar way, and
- learning is shared and implemented across the organisation and more widely, to improve the quality of services.

149. All care homes, care at home, childminders, daycare of children, adoption and fostering, housing support, secure care, school accommodation, nurse agencies, and offender accommodation are required to notify the Care Inspectorate of the death of a service user and the circumstances of the death under The Regulation of Care (Requirements as to Care Services) (Scotland) Regulations 2002. Additional requirements are placed on providers of care home services to notify the Care Inspectorate of any serious injury of a service user, accident or any allegation of misconduct by the provider or any person who is employed by the care service.

150. For care services registered on or after 1 April 2011, additional notification requirements are in place. These are not specified in legislation but are determined by the Care Inspectorate and include accidents, incidents or injuries to a person using a service. The Care Inspectorate regards accidents requiring notification as unforeseen events resulting in harm or injury to a person using the service which results in a GP visit or a visit or referral to hospital. An incident is defined as a serious, unplanned event that had the potential to cause harm or loss, physical, financial or material. The Care Inspectorate also requires notification of allegations of abuse in relation to a person using a service. These additional notification requirements relate to all services regulated by the Care Inspectorate except childminders.

151. Healthcare Improvement Scotland requires that independent healthcare providers notify them of serious injury or unintended death of a service user as part of their notification requirements.

Policy objectives

152. The overarching purpose of the duty of candour provisions of this Bill are to support the implementation of consistent responses across health and social care providers when there has been an unexpected event or incident that has resulted in death or harm, that is not related to the course of the condition for which the person is receiving care.

153. The Scottish Government believes that openness and transparency in relation to adverse events is increasingly recognised as an important element to establish a culture of continuous improvement in health and social care settings. The inclusion of the duty of candour procedure in this Bill reflects on the Scottish Government’s commitment to putting people at the heart of health and social care services in Scotland, while also recognising and respecting the need of staff to feel supported when contributing to system review and learning.
154. The duty of candour procedure (which will be set out in regulations to be made using powers in the Bill) will emphasise learning, change and improvement - three important elements that will make a significant and positive contribution to quality and safety in health and social care settings.

155. The new duty of candour on organisations will create a legal requirement for health and social care organisations to inform people (or their families/carers acting on their behalf) when they have been harmed (physically or psychologically) as a result of the care or treatment they have received. This will act as a powerful signal that when harm occurs, the focus will be on personal contact with those affected, support and a process of review and action that is informed by learning and improvement. These proposals will have a positive effect on professional practice, patient and service user safety and public confidence. There will be a requirement for organisational emphasis on staff support and training to ensure effective implementation of the organisational duty. Staff must feel they have the necessary skill and confidence if they are to be meaningfully involved in the delivery of duty of candour procedures.

156. The duty of candour reporting requirements will provide a way for organisations to outline the approaches that they adopt in responding to reports of unintended or unexpected events, resulting in harm. Public reporting will help people’s understanding of the health and social care environment and empower them by providing information for those seeking care and treatment. It will also encourage organisations to involve people.

157. The introduction of the statutory duty of candour must not become a ‘box-ticking’ or ‘form-filling’ exercise. The concerns about the introduction of an unnecessary administrative burden will be addressed through clear guidance that supports integration with existing processes for responses to complaints, adverse event and incident reporting – emphasising the requirements for support, training and identification of learning and improvement actions.

158. Actions must be focused on review of systems and processes, delivered within a supportive and learning-focused culture, not one that is focused on individual fear and blame. Guidance based on the work of the National Patient Safety Agency Incident Decision Tree 95 will inform implementation guidance to ensure that all elements of a ‘just culture’ inform organisational decision-making after incidents involving death or harm.

**Alternative approaches**

159. Health and care professionals in Scotland already have a professional duty of candour. There is also guidance across organisations in relation to reporting unexpected events that result in death or harm, and established procedures in support of public protection that includes similar reporting requirements. An alternative approach would therefore be to continue to rely upon professional duties and existing guidance.

160. However, there is currently variation in implementation of existing guidance and it does not consistently include the need for training, support and emphasis on publication of learning.

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Research that has highlighted the multiple organisational factors that influence optimal conditions for disclosure and learning from harm all suggest a need for alternative approaches to improve the current position across health and social care organisations in Scotland.

161. Healthcare Improvement Scotland has visited all Health Boards in Scotland as part of the national programme supporting learning following adverse events. This confirmed that there is variation across the country in respect of the rigour and standard of open disclosure and support for families and staff when harm occurs.

162. The following extracts from the review reports illustrate the variation that currently exists across the NHS in Scotland:

- “The three significant cases showed evidence of a consistent, robust approach to the involvement of patients and families throughout the process”,
- “…there was no consistent approach for involving patients, families and carers in the incident investigation, or a systematic process for documenting these events”,
- “Of the four cases we reviewed, only two documented some level of engagement with the family or relatives”,
- “We were unable to identify from the policy how NHS Board X actually involves patients, families or carers in investigations of adverse events”,
- “However the level of support provided to staff was sometimes variable”,
- “The level of engagement with the patient or family varied across the six cases” “Most policies lacked guidance on how to involve stakeholders and there were significant inconsistencies in practice”. 

163. The observations made by Healthcare Improvement Scotland are consistent with observations from work that has shown that ethical and policy guidance has largely failed on its own to improve rates of disclosure.

164. In relation to health care, the Professional Standards Authority has published a summary of research that outlines that the existence of a professional duty might not always be sufficient to ensure that this is consistently delivered within organisations. Their review of research identified that there are factors that in some circumstances mean that staff might not always feel able to discharge their professional duty of candour – these relate to matters such as to diffusion of responsibility, divided loyalties, profession-specific cultures and concerns about career progression.

165. The Professional Standards Authority document makes a compelling case in support of the need to move beyond the current reliance on standards and guidance. They have outlined the
marked mismatch that has been noted between people’s attitudes and actual behaviours in relation to disclosure of harm and emphasised that disclosure in principle does not regularly translate into action. They outline the impact on health and social care professionals to exposure to stressful situations and heavy workloads, often linked with a requirement to process complicated information and focus on specific goals and targets. This ‘stimulus overload’ is cited as a potential contributor to unreliable implementation of best practice regarding a duty of candour. Normalisation of abnormal events as a way of coping with high risk situations has been noted and, in some circumstances, suboptimal situations become viewed as normal features of care. This can result in passive tolerance that leads to inaction following an unexpected event resulting in harm. Inter-professional tensions may also contribute to different approaches to disclosure of harm and a hierarchical approach to decisions about which profession is obligated to lead on disclosure.

Consultation

166. The Scottish Government consulted on proposals for the introduction of a statutory organisational duty of candour from 14 October 2014 to 15 January 2015. The responses to the consultation have been published on the Scottish Government’s website. The analysis of consultation responses also has been published.

167. Respondents regarded the development of a culture of openness and honesty as key to ensuring safe, high-quality health and social care services in Scotland. It was this openness and honesty which would support organisational learning and service improvement. Some respondents believed that the proposed legislation was helpful in promoting and supporting such a culture, while others saw it as potentially counterproductive. The general consensus amongst those broadly supportive of the introduction of the new duty was that it could not, on its own, be an effective lever for change. Respondents suggested that change would require a clear message from management at all levels that openness and honesty were valued and encouraged.

168. Respondents generally supported the introduction of the new duty – seeing it as complementary to existing arrangements – but were clear about the need for a primary focus on learning and the requirement for alignment of the new procedures wherever possible to support a consistency of approach.

169. Respondents thought the duty and its implementation had to take full account of the entire health and social care landscape, particularly in the light of moves towards service integration. They highlighted the need for the duty to be consistent with existing processes and procedures operating in health and social care services; the primary and secondary care sectors; large and small organisations; and a full range of professions and specialisms.

170. Respondents largely agreed that being candid with patients/service users when something went wrong, should be inherent to a person-centred approach to service provision. It should reflect a positive relationship based on open communication between professionals and service users at all stages of care and treatment (e.g. in explaining care options and treatment risks).

100 http://www.gov.scot/Publications/2015/02/6913/downloads
171. It was stressed that it would be important for the public to be aware of the duty and what it entailed, that the disclosable events should be meaningful to non-professionals, that those harmed were actively involved and supported at all points in the disclosure process, and that public reporting took account of the needs of a wide audience. The duty of candour, thus, had to be developed to meet the needs of patients and services users (and should not result in worrying people unnecessarily about minor incidents.)

172. The importance of taking account of the needs of different equality groups was raised by respondents in relation to a range of questions. The groups referred to most often were children and young people, those with communication difficulties and those who lacked mental capacity. It was argued that written information (e.g. summaries of disclosable events, information on sources of advice and guidance, public reports) should be provided in suitable formats for different groups, and that support should be provided by appropriately trained staff. It was further suggested that the provisions to inform ‘relevant persons’ should allow for carers, parents / guardians or ‘named’ persons to accompany or represent a harmed person. This would ensure that all groups understood and had the opportunity to be fully involved in proceedings.

173. Respondents emphasised the importance of clarification in relation to specific aspects of the proposed new duty, its requirements and its implementation. In particular, respondents called for clarity about the definitions of harm that would be used and of terms such as ‘relevant person’ and ‘reasonable support’.

174. Respondents emphasised the importance of the development of resources to support the implementation of the duty, such as guidance with examples and case studies and the development of national training courses and support materials.

175. Concern was expressed both by those in favour and those opposed to the proposed new duty about possible unintended consequences. These included the impact on professional practice and organisational culture; on compensation claims and litigation; and on public confidence in services. There was concern the new duty might lead to risk-averse decision-making in care and treatment, a tendency to classify events in ways which avoided the need for disclosure and the encouragement of a ‘blame’ culture with attention focused on the individuals involved in disclosable events. There was also concern that the definition of disclosable events might move attention away from the learning opportunities presented by less serious incidents and ‘near misses’.

176. In terms of claims and litigation, there was concern that any increase could impact on resources for services and in turn could impact on professional practice and organisational culture. Those concerned about undermining public confidence highlighted the need for careful handling of the public reporting requirements.

177. Frontline staffing and staff training were seen as the key resource issues, although respondents also highlighted the resource implications of administrative, communication and system support, management input, and the provision of support services. In general, respondents argued that the resource implications would be significant and on-going and could impact disproportionately on smaller organisations. It was also argued by some that a poorly resourced duty would ‘do more harm than good’. There was a general plea that minimising the
burden on organisations should be a key objective in developing the proposed requirements further, for example, by making use of existing procedures and systems for recording events and in setting the frequency of reporting.

178. There were calls for further work with stakeholder groups – particularly in relation to the definitions and supporting guidance for implementation.

EFFECTS ON EQUAL OPPORTUNITIES, HUMAN RIGHTS, ISLAND COMMUNITIES, LOCAL GOVERNMENT, SUSTAINABLE DEVELOPMENT, ETC.

Equal opportunities

179. The Scottish Government has considered potential equalities impacts and does not consider that the Bill’s provisions on duty of candour are discriminatory on the basis of age, gender, race, disability, marital status, religion or sexual orientation. The provisions of the Bill are not intended to eliminate any specific form of discrimination or promote equality of opportunity. A full Equalities Impact Assessment (EQIA) has been undertaken, and the Scottish Government will continue to monitor and examine any potential equalities impacts which emerge as the policy is implemented.

Human rights

180. The Scottish Government has assessed and is satisfied that these provisions are compatible with the European Convention on Human Rights (ECHR). In disclosing information regarding instances of harm, to the individuals concerned and for the purposes of reporting, it is important that the Article 8(1) right to private life for all parties involved is respected. The provisions for the disclosure of personal information ensure Article 8 rights are protected.

Island and rural communities

181. The Scottish Government is satisfied that the Bill has no significant differential impact on island and rural communities. In some instances staff involved in application of the duty of candour procedure may not have access to training in geographical locations, though this will be addressed through the provision of a national training resource and online support materials.

Local government

182. The provisions will have costs implications for local government in respect of: provision of support for people affected by unexpected incidents or events that result in harm; and for training and implementation of the duty. Detailed costs are set out in the accompanying Financial Memorandum.

Sustainable development

183. The Bill will have no impact on sustainable development.
PART 3: ILL-TREATMENT AND WILFUL NEGLECT

Background

184. As part of its response to the Francis Report into the breakdown of care at Mid-
Staffordshire hospitals, the UK Government commissioned Professor Don Berwick to carry out a
review of patient safety in England. One of the recommendations in his report was to create an
offence to place wilful neglect or ill-treatment of all NHS patients on a par with the offence that
currently applies only to mental health patients in England and Wales. An equivalent criminal
offence of wilful neglect or ill-treatment of mental health patients exists in Scotland in section
315 of the Mental Health (Care and Treatment) (Scotland) Act 2003 (“the 2003 Act”).

185. In November 2013, the First Minister announced in Parliament, the Scottish
Government’s intention to examine the best way to legislate for a similar offence in Scotland.

186. Existing legislative and regulatory provisions that may apply in some cases of wilful
neglect or ill-treatment (including the 2003 Act) are not considered sufficient to cover all
situations of neglect or ill-treatment that may arise.

187. The intention of the provisions on wilful neglect/ill-treatment is to ensure that the worst
cases of ill-treatment or deliberate neglect, which may be uncommon, can be dealt with
effectively by the criminal justice system.

188. The provisions on wilful neglect/ill-treatment will establish a new criminal offence which
will apply to individual care workers, managers and supervisors, either employed, or
volunteering on behalf of a voluntary organisation, who provide care or treatment and to
directors or similar officers.

189. The offence will also apply to organisations. The Bill provides courts with additional
penalty options in respect of organisations who are convicted of wilful neglect or ill-treatment.

Policy objectives

General

190. The provisions on wilful neglect/ill-treatment are intended to create an offence which will
allow the courts to deal with instances of ill-treatment or neglect across a range of health and
social care settings. This will improve accountability for care that falls well below the accepted
standard.

191. The Bill creates two separate offences: a care worker offence and a care provider
offence.

Scope of the offences

192. The consultation document described a number of settings where the offences would
apply, and respondents indicated strong support for its application right across health and social
This document relates to the Health (Tobacco, Nicotine etc. and Care) (Scotland) Bill (SP Bill 73) as introduced in the Scottish Parliament on 4 June 2015

care. The range of services to be covered by the Bill is consistent with the views provided in the responses to the consultation.

193. The offences described in the Bill only relate to health or social care provided to adults. The consultation asked for views on applying this offence to social care for children, and did not ask about health care situations. A number of the responses received indicated the need for further discussion about implementation, and how these offences would work alongside other legislation that impacts children and young people. There were further queries about extending it to health care situations for children. Further detailed consultation will take place about extending the provisions to children in both health and social care situations and whether this should be done at Stage 2 in the parliamentary process.

194. In line with proposals set out in the consultation and the responses received, the offence will not apply to unpaid carers but it will apply to volunteers who are volunteering on behalf of a voluntary organisation. In respect of volunteers, voluntary organisations often provide services on a commissioned basis and it is right that such contractual arrangements, and the role that voluntary organisations play in the provision of health and social care services, should be recognised by these provisions.

195. The existing offences of wilful neglect/ill-treatment of mental health patients and adults with incapacity do not require any set level of harm. The new offence is consistent in this way and will not specify a required level of harm in order to trigger the offence. The consultation responses strongly supported this and the Scottish Government feels that this is the right approach given that there may be some situations where a person could perpetrate neglect or ill-treatment but is discovered before any actual physical or psychological harm occurred.

196. The organisational offence will apply to care providers (which can be self-employed individuals who have others working for them, partnerships, companies, or unincorporated associations) who provide or arrange for the provision of adult health or social care. Neglect or ill-treatment in some circumstances may be symptomatic of failings within the wider organisation and some organisational policies and practices may contribute to a culture of poor care. Therefore it is important that these issues, where identified, can be addressed by the justice system.

197. Recognising the challenges associated with establishing an offence that will be effective for organisations, the offence is described with regard to the way that an organisation’s activities are managed or organised. Several replies to the consultation referenced the Corporate Manslaughter and Corporate Homicide Act 2007 as a possible model for determining an organisation’s culpability and this has been drawn on in developing the policy in this area.

Penalties

198. For the care worker offence, the Bill sets out a penalty of five years maximum imprisonment on indictment (as well as, or instead of, a fine). A number of responses to the consultation called for tougher penalties for those convicted of wilful neglect or ill-treatment, therefore the maximum penalty on indictment is now five years imprisonment as opposed to the two year maximum set out in the consultation document. For consistency, the Bill will also amend the penalty for the offence of wilful neglect/ill-treatment in section 315 the Mental Health
(Care and Treatment) (Scotland) Act 2003 to a maximum of five years imprisonment on indictment.

199. A majority of those responding to the consultation agreed that the courts should have additional penalty options in respect of organisations. While the imposition of a fine will often be appropriate, it may not always be a means of bringing about a positive change in organisational policies, standards, or culture. In the consultation responses, reference was made to publicity orders and remedial orders. Provision for publicity orders can be found in the Regulatory Reform (Scotland) Act 2014 and both publicity and remedial orders in the Corporate Manslaughter and Corporate Homicide Act 2007. The Bill gives the courts the power to make a publicity order, or a remedial order (or both) in respect of organisations convicted of wilful neglect or ill-treatment.

200. A remedial order is an order which will require the convicted organisation to take particular steps to remedy the breach of the duty of care owed to the person neglected or ill-treated. The order can also require the organisation to take any other steps to address other issues or deficiencies in the organisation’s policies or practices which are relevant to the breach.

201. A publicity order is an order which will require the organisation to publicise details of its conviction and any penalties imposed (including the terms of any remedial order).

**Alternative approaches**

202. There is no alternative approach to primary legislation that would achieve the Bill’s policy objectives of creating a new offence of wilful neglect or ill-treatment.

203. It would be possible to take no action but this would leave the situation whereby people in similar care settings could be wilfully neglected or ill-treated in the same way but charges could only be brought in respect of those neglected or ill-treated falling within the provisions of the 2003 Act.

**Consultation**

204. The consultation paper *Proposals for an Offence of Wilful Neglect or Ill-treatment in Health and Social Care Settings* launched on 10 October 2014 for a period of 12 weeks. The consultation responses were analysed by an external contractor and a summary report of this analysis was published on the Scottish Government website [www.gov.scot/Publications/2015/05/9655](http://www.gov.scot/Publications/2015/05/9655).

205. The consultation received 103 responses in total: 95 from organisations and 8 from individuals. Organisational respondents included: NHS organisations; local authorities; third sector organisations; professional bodies and trade unions; scrutiny and regulatory agencies; adult/child protection bodies; and partnership bodies.

206. Although the consultation did not specifically ask whether the proposed offence should be created, respondents nevertheless offered views on this issue. In general, respondents were supportive of the introduction of the offence and saw the legislation as helpful in offering a
consistent level of protection to all individuals receiving health and social care, and in holding to account those who have intentionally harmed or neglected these individuals. There were also high levels of agreement with the specific proposals set out in the consultation document, although respondents often also expressed a range of caveats or concerns.

207. Nearly one-fifth of all organisational respondents questioned the need for, or expressed serious reservations about, the creation of a new offence, arguing that existing legislation and professional regulation already provided adequate protection; that the intended beneficiaries did not require special protection; that the creation of a new offence was a disproportionate response to a relatively small number of recent incidents; and that there was no evidence that a criminal sanction would act as a deterrent.

208. These respondents were also concerned about unintended consequences relating to costs, the potential for undermining existing regulatory frameworks, and the possible negative impacts on organisational culture and quality of care. These comments were also frequently reflected in the caveats and concerns expressed by other respondents.

EFFECTS ON EQUAL OPPORTUNITIES, HUMAN RIGHTS, ISLAND COMMUNITIES, LOCAL GOVERNMENT, SUSTAINABLE DEVELOPMENT, ETC.

Equal opportunities

209. The Scottish Government has considered potential equalities impacts and does not consider that the Bill’s provisions on ill-treatment and wilful neglect are discriminatory on the basis of age, gender, race, disability, marital status, religion or sexual orientation. The provisions of the Bill are not intended to eliminate any specific form of discrimination or promote equality of opportunity. A full Equalities Impact Assessment (EQIA) has been undertaken, and the Scottish Government will continue to monitor and examine any potential equalities impacts which emerge as the policy is implemented.

210. Consultation respondents were largely positive about the equality implications of the proposed new offence. Older people and disabled people were seen as particularly likely to benefit from the legislation; it was also suggested that those from minority ethnic groups may be less likely to benefit from the protection offered as they were more likely to be cared for by family at home. Responses highlighted the need to facilitate access to justice for vulnerable groups.

Human rights

211. The Scottish Government has assessed and is satisfied that these provisions are compatible with the European Convention on Human Rights (ECHR). The Scottish Government has assessed that each offence is set out with enough clarity and certainty so as to allow a person to regulate their behaviour and to allow the authorities to effectively inform a person suspected of committing one of these offences of the reasons for their arrest, detention, and any subsequent charge in relation to that offence. Those prosecuted in Scotland are guaranteed to receive a fair trial. These provisions are proportionate to the aims described in the Policy Memorandum and are in the public interest.
Island communities

212. The Scottish Government is satisfied that the provisions have no significant differential impact on island and rural communities.

Local government

213. The provisions will have an impact on Local Government insofar as the offences will cover care or treatment provided by a local authority or its employees.

Sustainable development

214. The Bill will have no impact on sustainable development.
INTRODUCTION

1. This memorandum has been prepared by the Scottish Government in accordance with Rule 9.4A of the Parliament’s Standing Orders, in relation to the Inquiries into Fatal Accidents and Sudden Deaths etc. (Scotland) Bill. It describes the purpose of each of the subordinate legislation provisions in the Bill and outlines the reasons for seeking the proposed powers. This memorandum should be read in conjunction with the Explanatory Notes and Policy Memorandum for the Bill.

2. The contents of the Memorandum are entirely the responsibility of the Scottish Government and have not been endorsed by Parliament.

OUTLINE OF BILL PROVISIONS

3. The policy objective of the Bill is to reform and modernise the law governing the holding of fatal accident inquiries (FAIs) in Scotland. It largely implements the recommendations made in the 2009 Review of the Fatal Accident Inquiry Legislation led by the Rt Hon the Lord Cullen of Whitekirk KT, the former Lord President of the Court of Session, insofar as these have not already been implemented.

4. The Review made 36 recommendations for change. The Scottish Government published a response to the Review in March 2011 and has accepted the majority of these recommendations, but has diverged in a small number of areas which are explained in this Policy Memorandum. Many of the recommendations of the Review will be implemented by rules to be made under a power given in the Bill as they concern matters which either do not require primary legislation or are more appropriate for setting out in rules as they concern the routine organisation of FAIs.

RATIONALE FOR SUBORDINATE LEGISLATION

5. The Bill contains a number of delegated powers provisions. In deciding whether provisions should be specified on the face of the Bill or left to subordinate legislation, the Scottish Government has considered the importance of each matter against:

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1 http://www.scotland.gov.uk/Publications/2009/11/02113726/0
2 http://www.scotland.gov.uk/Publications/2011/03/18150120/1
• the need to ensure sufficient flexibility in the future to respond to changing circumstances and to make changes quickly without the need for primary legislation;

• the principle that FAI Rules should be drafted under judicial supervision (subject to the transitional arrangements described below);

• the need to allow detailed administrative arrangements to be kept up to date within the basic structures and principles set out in the primary legislation;

• the need to ensure proper use of parliamentary time;

• the possible frequency of amendment; and

• the need to anticipate the unexpected, which might otherwise impact on the purpose of the legislation.

6. The relevant provisions are described in detail below. For each provision, this memorandum sets out:

• the person upon whom the power to make subordinate legislation is conferred and the form in which the power is to be exercised;

• why it is considered appropriate to delegate the power to subordinate legislation and the purpose of each such provision; and

• the parliamentary procedure to which the exercise of the power to make subordinate legislation is to be subject, if any.

7. Subordinate legislation is required to implement the Scottish Government’s policy and some form of parliamentary procedure is appropriate. For the decision on negative or affirmative procedure, the Scottish Government has considered carefully the degree of Parliamentary scrutiny that is thought to be required for the instrument, balancing the need for the appropriate level of scrutiny with the need to avoid using up Parliamentary time unnecessarily. The balance reflects the views of the Government on the importance of the matters being delegated by the Parliament.
DELEGATED POWERS

Section 11(1) – Places at which inquiries may be held

Power conferred on: The Scottish Ministers
Power exercisable by: Regulations made by Scottish statutory instrument
Parliamentary procedure: Affirmative

Provision

8. This provision permits the Scottish Ministers to make regulations to designate places at which a sheriff court may be held for the purposes of holding an FAI. Subsection (1) makes it clear that these places will be additional to the places already designated for the holding of sheriff courts under the Courts Reform (Scotland) Act 2014. “Places” in this sense means the towns and cities where sheriff courts are held – it does not mean specific buildings. It therefore follows that a sheriff court may be held in a building within a sheriff court district which is not normally used for court purposes and this existing law has already permitted FAIs to be held in ad hoc locations such as the Council Chamber in, for example, Aberdeen City Chambers and the Maryhill Community Centre in Glasgow. Subsection (1) will permit places to be designated for the holding of FAIs where there is no sheriff court.

9. Since the Scottish Courts and Tribunals Service (SCTS) has the statutory responsibility of providing property for the Scottish courts under section 61(1) of the Judiciary and Courts (Scotland) Act 2008, the Scottish Ministers will only make regulations under subsection (1) following the submission of a proposal by SCTS – with the agreement of the Lord President – for the designation of a place for the holding of FAIs under subsection (3), but this procedure will be subject to consultation with appropriate persons under subsection (4).

10. Given the statutory responsibility which the Lord President has for the efficient disposal of business in Scotland’s courts under section 2(2) of the 2008 Act, and the equivalent responsibility of SCTS set out above, the Scottish Ministers must obtain the consent of both the Lord President and SCTS under subsection (7) before making regulations to designate places for the holding FAIs under the Bill.

11. By virtue of subsection (8) regulations may include certain ancillary provision which may be required.

Reason for taking power

12. At present, under section 1(1) of the Fatal Accidents and Sudden Deaths Inquiry (Scotland) Act 1976 (“the 1976 Act”), an FAI is required to be held in the sheriff court in the district with which the Procurator Fiscal decides the death appears to be most closely connected, which restricts the options of places for the hearing to be held. The removal of this restriction is proposed, so that an FAI may be held in the most appropriate accommodation in any sheriffdom. Under section 12(2) of the Bill the Lord Advocate may choose the sheriffdom in which the proceedings are to be held, after consulting SCTS.
13. Lord Cullen recommended that FAIs should be taken out of court buildings into other accommodation more suitable for such proceedings. He suggested that an FAI should, where possible, not be held in a sheriff courtroom, but in other appropriate premises; and, where it was unavoidable that the FAI should be held in a courtroom, care should be taken to select one with the least connection with criminal proceedings.

14. SCTS have previously held larger, long running FAIs outwith court buildings, such as that into the 2009 Super Puma crash which was held in the Council Chamber of Aberdeen City Chambers. Currently non-court premises are only used to accommodate longer and more high-profile FAIs. The use of such ad hoc accommodation could, however, be extended for use in greater numbers of FAIs ensuring that more FAIs could be taken out of court rooms as recommended by Lord Cullen.

15. This power is required to permit the Scottish Ministers to designate places for the holding of FAIs outwith existing sheriff courts and sheriff court districts in order to build in more flexibility into the system and to possibly permit FAIs to be held more quickly than might be the case if the inquiry had to wait until capacity can be found in a local sheriff court.

Choice of procedure

16. As this power relates to the choice of accommodation for FAIs which is additional to, and separate from, locations where there is already a sheriff court, and because it may oblige bereaved families and witnesses to travel further than might otherwise be the case (though in some circumstances such persons could benefit from reduced travel distances), the Scottish Government believes that it is appropriate that this power is subject to affirmative procedure.

17. The broadly comparable power in section 2 of the Courts Reform (Scotland) Act 2014 (Power to alter sheriffdoms, sheriff court districts and sheriff courts) is also subject to affirmative procedure.

Section 34(1) – Power to regulate procedure etc.

Power conferred on: The Court of Session
Power exercisable by: Act of sederunt
Parliamentary procedure: Laid-only

Provision

18. Section 34(1) provides powers for the Court of Session to make rules by act of sederunt to regulate practice and procedure to be followed at FAIs in the sheriff court. This section replaces section 7 of the 1976 Act, widening the powers available to the court with the aim of enabling it to make the kind of comprehensive and self-contained powers envisaged by Lord Cullen. The provisions set out a wide enabling power in subsection (1). Subsection (2) puts beyond doubt what the power in subsection (1) includes, but expressly provides that subsection (1) is not limited by the specific examples of the power in subsection (2). The powers set out in section 34 are similar to those set out in sections 103 and 104 of the Courts Reform (Scotland) Act 2014. Sections 15(4) and 17(1) provide for matters which must be contained within FAI
Rules. Further, sections 14(1)(c), 15(1), 16(2)(b), 19(4), 26(4) and (5) and 30(1)(d) describe matters which may be contained within FAI Rules.

19. By virtue of subsection (3) acts of sederunt may include ancillary provision as may be required.

**Reason for taking power**

20. The rules of practice and procedure relating to FAIs in the sheriff court relate to the management of such inquiries before the court and rules under which those inquiries must be conducted. They very often deal with administrative matters. As rules of procedure they may require regular amendment to deal with new eventualities or to adapt to changing circumstances. It is therefore considered appropriate that they be set out in secondary legislation, as at present. This is of course the position for the rules of courts and tribunals.

**Choice of procedure**

21. This is the main power the Court of Session will use to regulate the practice and procedure to be followed at FAIs across Scotland. To preserve the courts from political interference, in accordance with the principle of the separation of powers, acts of sederunt are not usually subject to Parliamentary scrutiny.

**Section 39 – Ancillary provision**

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**Provision**

22. Section 39(1) provides that the Scottish Ministers may by regulations make freestanding ancillary provision, namely incidental, supplementary, consequential, transitional, transitory or savings provisions which they consider appropriate for the purposes of, or in connection with, or for the purposes of giving full effect to, any provision of the enacted Bill. Subsection (2) provides that such an order may modify any enactment, instrument or document (including the Bill).

**Reason for taking power**

23. The Bill largely replaces the existing legislation underpinning the existing system for FAIs in Scotland. It is therefore necessary to effect the smooth transition from the 1976 Act legislative regime to the new regime set out in the Bill. The Scottish Government considers it appropriate to take power to deal with anything that might be missed, for example interactions with secondary legislation or older statutes or rules of law. Without the power proposed it would be necessary to return to the Parliament, through subsequent primary legislation, to deal with a matter that is clearly within the scope and policy intentions of the original Bill and this would not be an effective use of Parliamentary or Government resource. This power is broader than the commencement power in section 40. It is possible that the need for transitional and savings
provisions may be identified after the commencement of particular sections and associated with exercise of other ancillary powers when the power in section 40 will no longer be available.

24. It is envisaged that the Bill will be commenced in April 2016.

25. Other such points of fine tuning consistent with the general policy of the Bill, where provision would be outside the Parliament’s competence, will be dealt with in the section 104 order referred to in the Policy Memorandum.

Choice of procedure

26. Regulations under this section are subject to the negative procedure except where they add to, replace or omit any part of the text of an Act, in which case they are subject to the affirmative procedure. These procedures provide the necessary safeguards with regard to the type of legislation which can be made. It is common for ancillary powers of this nature to be subject to the proposed levels of scrutiny.

Section 40 – Commencement

Power conferred on: The Scottish Ministers
Power exercisable by: Regulations made by Scottish statutory instrument
Parliamentary procedure: Laid-only

Provision

27. Section 40(2) enables the Scottish Ministers to commence the Bill by conferring a power on Ministers, by regulations, to bring the provisions of the Bill into force on such day as the Scottish Ministers appoint. Section 40(3) provides that such regulations may include transitional, transitory or saving provision.

Reason for taking power

28. It is standard for Ministers to have powers over the commencement of Bills. It is considered appropriate for the substantive provisions of the Bill to be commenced at such a time as the Scottish Ministers consider to be suitable. Transitional arrangements may be required specifically for the commencement arrangements which might be different or discrete from other transitional provision. It is common for there to be both standalone transitional powers and transitional powers forming part of the commencement powers.

Choice of procedure

29. As is now usual for commencement regulations, the default laying requirement applies (as provided for by section 30 of the Interpretation and Legislative Reform (Scotland) Act 2010).
Schedule 1, paragraph 2 – Transitional arrangements

Power conferred on: The Scottish Ministers
Power exercisable by: Regulations made by Scottish statutory instrument
Parliamentary procedure: Negative

Provision

30. The power to regulate procedure in section 34(1) described in paragraphs 16 to 19 is subject to the following transitional arrangements. Paragraph 2 of schedule 1 confers a power on the Scottish Ministers, until such time as the Scottish Civil Justice Council is involved in the making of FAI Rules, to make such rules in regulations.

Reason for taking power

31. The Bill requires the Court of Session to consult with the Scottish Civil Justice Council when making acts of sederunt which were not prepared in draft by the Council. For the next few years, however, the Scottish Civil Justice Council will be concentrating on reforms under the Courts Reform (Scotland) Act 2014 and the Tribunals (Scotland) Act 2014.

32. Until such time as the Scottish Civil Justice Council is in a position operationally to assume its role in the formulation of FAI Rules, it is considered appropriate to confer a power on the Scottish Ministers to make those rules in regulations. Broadly similar transitional provisions appear in schedule 9 to the Tribunals (Scotland) Act 2014.

33. Before making any such regulations, the Scottish Ministers are required to consult the Lord President of the Court of Session and such other persons as they consider appropriate.

Choice of procedure

34. It is considered that the negative procedure gives the appropriate level of scrutiny to the exercise of this regulation-making power. This is the procedure applicable in the provisions of the Tribunals (Scotland) Act 2014 referred to. Ultimately, inquiry rules made via acts of sederunt will not be made subject to substantive Parliamentary procedure so the Scottish Government is proposing additional opportunity for scrutiny during the transitional period.
Justice Committee

Stage 1 Report on the Inquiries into Fatal Accidents and Sudden Deaths etc. (Scotland) Bill
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Justice Committee

To consider and report on a) the administration of criminal and civil justice, community safety and other matters falling within the responsibility of the Cabinet Secretary for Justice and b) the functions of the Lord Advocate other than as head of the systems of criminal prosecution and investigation of deaths in Scotland.
Committee Membership

Convener
Christine Grahame
Scottish National Party

Deputy Convener
Elaine Murray
Scottish Labour

Christian Allard
Scottish National Party

Jayne Baxter
Scottish Labour

Roderick Campbell
Scottish National Party

John Finnie
Independent

Alison McInnes
Scottish Liberal Democrats

Margaret Mitchell
Scottish Conservative and Unionist Party

Gil Paterson
Scottish National Party
Introduction

1. The Scottish Government introduced the Inquiries into Fatal Accidents and Sudden Deaths etc. (Scotland) Bill on 19 March 2015 with the aim of reforming and modernising the law in Scotland in relation to fatal accident inquiries (FAIs)\(^1\). The Parliamentary Bureau designated the Justice Committee as lead committee in consideration of the Bill on 31 March 2015.

2. On 24 March, the Committee issued a call for views on the provisions contained in the Bill, which closed on 28 April. Forty responses were received and an additional two submissions from the Crown Office and Procurator Fiscal Service and the Scottish Government.

3. The Committee held four public meetings in May 2015 to hear evidence on the Bill, beginning with evidence from Lord Cullen to set the scene and explain his views on those areas where the Scottish Government decided not to take forward his recommendations. Details of all of those who gave evidence and the videos of those meetings can be viewed on the Parliament’s website\(^2\).

4. The Committee would like to thank all those who contributed to this Stage 1 scrutiny of the Bill without whom, the Bill would not have had such rigorous scrutiny. We look forward to receiving the Scottish Government’s response to our recommendations and, should the Bill pass at Stage 1, to discussing amendments to the Bill at Stage 2 in the autumn.

Petitions

5. The Committee has a number of petitions\(^3\) on issues related to fatal accidents and sudden death referred to it and considered PE1280, PE1501 PE1567 as part of its overall Stage 1 scrutiny of the Bill.

Report

6. This report will outline some areas where the Committee believes the Bill could be improved and strengthened particularly in relation to—

- the scope of mandatory FAIs
- deaths abroad
- delays
- the role of the family
- sheriffs’ recommendations
Alongside its scrutiny of this Bill, the Committee took evidence on the Inquiries into Deaths (Scotland) Bill, Patricia Ferguson’s Members’ Bill, and heard from Ms Ferguson on her Bill at its meeting on 9 June 2015. In advance of that session, the Scottish Government wrote to the Committee on 4 June, setting out its views on the Bill, and highlighting where her proposals deviated from the provisions in the Scottish Government’s Bill.

The comments from the Scottish Government and of other witnesses on Ms Ferguson’s Bill are discussed in the key themes section of this report. However, the Committee does not comment or make any recommendations on her Bill in this report. Instead, the Committee will publish a separate Stage 1 report containing recommendations on the detail of her Bill in September 2015.

General principles of the Bill

7. Generally speaking, the Committee shares the view of all those who gave evidence that this Bill is a much needed and welcome piece of legislation. An update to the law relating to FAIs, building on the valuable work done by Lord Cullen, is essential given that the existing provisions were enacted almost 30 years ago.

8. The Committee supports the general principles of this Bill.

Background and policy objectives of the Bill

9. An FAI is an inquiry into the circumstances of death in order to determine the time, place and cause of death. Such inquiries are undertaken in the public interest and are not intended to establish any guilt in a criminal sense. The role of an FAI as set out in the Fatal Accidents and Sudden Deaths Inquiry (Scotland) Act 1976 is to establish, as far as possible—

- where and when the death, and any accident resulting in the death, took place
- the cause(s) of death and any accident resulting in the death
- whether there were reasonable precautions which could have been taken to avoid the death
• whether there were any defects in working practices which contributed to the death

• any other facts which are relevant to the circumstances of death.

Current legislative framework for Fatal Accident Inquiries in Scotland

10. The 1976 Act sets out the current legislative framework for FAIs. The procedure for dealing with these inquiries is set out in the Fatal Accidents and Sudden Deaths Inquiry Procedure (Scotland) Rules 1977, which were made under the 1976 Act.

11. An FAI must be held when a death occurs in Scotland as a result of a work-related accident or when the deceased was in legal custody at the time of their death.

12. The Lord Advocate is the ministerial head of the Crown Office and Procurator Fiscal Service (COPFS) and is responsible for the prosecution of crime and the investigation of deaths in Scotland.

13. Procurators fiscal investigate all sudden deaths where the circumstances surrounding the death appear suspicious, accidental or unexplained. At present in Scotland, only the procurator fiscal can apply for a fatal accident inquiry, which is a public examination of the circumstances of death.

14. In such cases where an FAI would be mandatory, it is open to the Lord Advocate to decide not to hold an FAI if he believes the circumstances of the death have been established sufficiently during criminal proceedings.

15. In addition, an FAI may be held at the discretion of the Lord Advocate if it is in the public interest to hold an inquiry where the deaths were sudden, suspicious or unexplained. The aim being to establish the time, place and cause of death and whether any lessons can be learned to prevent similar deaths occurring.

16. The procurator fiscal is responsible for carrying out an investigation and for presenting evidence about the accident. A sheriff presides over the FAI and makes a determination covering the facts surrounding the death. Determinations which are of public interest are published on the Scottish Courts and Tribunals Service’s (SCTS’s) website. FAIs are not usually held until after any related criminal proceedings have been concluded.

17. It is generally considered that an FAI is an inquisitorial process where the sheriff’s role is to establish the facts rather than to apportion blame or to find fault. The inquisitorial nature of an FAI differentiates it from criminal proceedings, where the object is to establish whether the accused is guilty of a crime.

18. It is not possible to appeal a decision made in relation to an FAI, such as the sheriff’s findings or the Lord Advocate’s decision not to hold an FAI, however,
such decisions can be subject to a judicial review. Sheriffs’ FAI determinations are not admissible in evidence in any other court proceedings however the evidence led at an FAI is in the public domain and can be used in other court proceedings.

Other death investigations

19. Death investigations are carried out by the COPFS in roughly half of the deaths reported to the procurator fiscal which, on average is roughly 11,000 deaths a year. Of those death investigations, 50-60 FAIs carried out in Scotland each year.

20. The Scottish Parliament Information Centre briefing\textsuperscript{6} outlined the range of organisations who have a role in investigating deaths in Scotland—

- **Crown Office and Procurator Fiscal Service**

21. Investigations are carried out by a specialist unit within COPFS known as the Scottish Fatalities Investigation Unit. This unit was established as a result of recommendations made in Lord Cullen’s Review of Fatal Accident Inquiry legislation, which is covered in more detail later in this report.

22. In carrying out its investigations, COPFS will usually review evidence, such as post-mortem and other medical reports. Statements may also be taken from witnesses. Once the evidence has been collected, COPFS will make decisions about how to proceed, such as whether criminal charges should be pursued or whether an FAI should be held.

23. Family members are given a point of contact in the procurator fiscal’s office so that they can raise any issues or concerns directly. COPFS indicated that family members have access to the key evidence and input into the decision about whether to hold an FAI. The decision about whether or not to hold an FAI will be explained to the family. In addition, families have access to victim information and advice officers employed by COPFS, who can provide information about the FAI process.

- **Health and Safety Executive**

24. The Health and Safety Executive (HSE) has a policy of investigating all fatal work-related accidents unless there are specific reasons for not doing so (HSE 2009). However, the HSE will not always be the appropriate agency to carry this out. In particular, local authorities have responsibility for enforcing health and safety obligations in relation to some premises, including offices, shops, hotels and food outlets.

25. HSE Investigations are carried out to decide: what caused the accident; whether action should be taken to prevent a recurrence or to ensure compliance with the law; whether existing law or guidance could be improved; and what response is appropriate to deal with any breach of the law.
26. Prosecutions in Scotland (unlike in England) can only be carried out by the procurator fiscal in the public interest. It will therefore be up to the procurator fiscal, rather than the HSE, whether criminal charges are actually brought. Evidence collected by the HSE – and any conclusions drawn from it by investigators – may also be presented to an FAI.

27. The HSE may, separately, hold an inquiry into particular incidents or matters of health and safety. Where such an inquiry has been held in relation to a work-related death in Scotland, the Lord Advocate can decide not to also hold an FAI.

- Healthcare bodies: NHS boards; local authorities; the Care Inspectorate; Mental Welfare Commission for Scotland

28. NHS boards carry out “adverse event reviews” where there are concerns about the circumstances of a death. Their purpose is to discover if any lessons for future practice can be learned. In many cases, the facts of the death will also be reported to the procurator fiscal, who may carry out a separate investigation. NHS boards set their own policies in relation to adverse event reviews so practice varies from area to area. Healthcare Improvement Scotland has an active role in reviewing deaths from suicide and promoting any lessons learned across the NHS.

29. Local authorities have systems in place to review some deaths, through a critical incident review or multi-agency review type process. However, the approach is also not standardised across local authorities.

30. 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. In many cases, the death will also be reported to the procurator fiscal, who may carry out a separate investigation.

31. The Mental Welfare Commission for Scotland is an independent organisation which works to support the rights of people with mental illness, learning disability and related conditions. It 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 condition. Such investigations can be carried out during the lifetime of the person concerned as well as after a death.

- Deaths of children

32. Depending on where a child died, there may be a review by a healthcare or social care body, but again these procedures are not standardised. The Care Inspectorate has a legal duty to review deaths of children who are “looked after” by their local authority. This covers children who are being cared for by foster parents, kinship carers, prospective adopters or in residential accommodation provided by the local authority.

33. Where the death of a child results from abuse, the local authority will carry out a “significant case review”. There are systems in place to disseminate lessons
learned from such reviews more widely. NHS boards organise reviews into cot deaths, and Healthcare Improvement Scotland co-ordinates all findings from the reviews.

### Lord Cullen’s Review of Fatal Accident Inquiries legislation

34. The Bill seeks to reform and modernise the law governing the holding of fatal accident inquiries (FAIs) in Scotland and largely implements the recommendations made in the 2009 Review of Fatal Accident Inquiry Legislation\(^7\) led by Lord Cullen of Whitekirk KT, former Lord President of the Court of Session.

35. The Bill repeals the 1976 Act and enacts new provisions to govern the system of FAIs in Scotland. The Scottish Government has confirmed\(^8\) that recommendations from Lord Cullen addressed to COPFS have all been taken forward by the establishment of the Scottish Fatalities Investigation Unit. The Bill therefore, largely implements a number of recommendations set out by Lord Cullen in his review\(^9\) which require primary legislation. There are some notable exceptions, where the Scottish Government has chosen not to take forward his recommendations on—

- extending mandatory FAIs to cover children who die while in residential care\(^10\) (other than those who die while in secure accommodation\(^11\)) as well as those who die while subject to compulsory detention by a public authority
- holding an initial early court hearing soon after a death is reported to COPFS
- enabling relatives who are represented at an FAI to receive legal aid without having to demonstrate that it is reasonable in the circumstances; and
- giving the Scottish Government responsibility for publishing responses to Sheriffs’ recommendations.

### Bill overview

#### Consultation on the Bill

36. In 2011, the Scottish Government published its response to Lord Cullen’s Review and issued a consultation on its proposals in July 2014. Fifty seven responses were received and an independent analysis of responses to the consultation was published in November 2014.\(^12\)
37. The Scottish Government also held a number of meetings with key stakeholders throughout the consultation process.

Policy objectives and provisions

38. This policy objectives of the Bill as outlined in the Policy Memorandum are to—

- build on the recommendations implemented by the COPFS,
- extend the categories of death in which it is mandatory to hold a fatal accident inquiry,
- place a requirement on those to whom sheriffs direct recommendations at the conclusion of the inquiry to respond,
- permit discretionary FAIs into deaths of Scots abroad where the body is repatriated to Scotland
- permit FAIs to be re-opened if new evidence arises or, if the evidence is so substantial, to permit a completely new inquiry to be held; and
- provide flexibility for the locations and accommodation for FAIs.

39. The Bill is in 41 sections and has 2 schedules, summarised as follows—

- **Inquiries into deaths occurring in Scotland**: Sections 1-5 sets out whether an FAI may or must be held into the death of someone in Scotland.
- **Inquiries into deaths occurring abroad**: Sections 6 and 7 make provision for inquiries into deaths occurring abroad in both general terms and for service personnel and stipulate that, for an FAI to be undertaken, the body must be repatriated.
- **Reasons where an inquiry is not held**: Section 8 requires that, if requested, the Lord Advocate must give reasons (in writing) as to why an inquiry into a person’s death is not being held.
- **Procurator fiscal’s investigation – witnesses**: Section 9 allows the procurator fiscal to cite a person to attend for precognition as part of a death investigation.
- **FAI – participants and location**: Section 10 provides details of who may participate in an FAI inquiry. The location of the inquiry and under which sheriff’s jurisdiction it lies is set out in sections 11 and 12. Section 13 makes provision for inquiries into multiple deaths.
- **Pre-inquiry procedure**: Sections 14 to 17 set out the procedure for the pre-inquiry process including initiating the inquiry (section 14), preliminary hearings (section 15), notice of the inquiry (section 16) and agreement of the facts before an inquiry (section 17).
• **The FAI – Sheriff powers, evidence and witnesses and publishing restrictions:** Sections 18 to 24 set out the provisions for the inquiry outlining the powers of the sheriff (section 18), evidence and witnesses (section 20) and that the inquiry is to be conducted in public (section 20). Section 21 provides publishing restrictions in relation to children and offences by bodies corporate is covered under section 22. Sections 23 and 24 deal with assessors and expenses respectively.

• **Sheriff’s findings and recommendations:** Sections 25 and 26 provide for the Sheriff’s determination and the dissemination of the determination as soon as possible after the conclusion of evidence and submissions in an inquiry. The Bill requires that the Scottish Courts and Tribunals Service (SCTS) must publish the determination and give a copy to all relevant people including the Lord Advocate, all those who participated in the inquiry and each person to whom any recommendations are directed to. Section 27 details compliance with the sheriff’s determination which makes the person to whom the recommendation applies required to respond in writing and make the response available in the public domain. The response must set out what the person has done or proposes to do in relation to the recommendation.

• **Further inquiry proceedings:** Sections 28 to 33 detail the provisions relating to any further inquiry which is to be held. The Bill sets out the circumstances in which a further inquiry may be held (section 28) and the initiation of a further inquiry (section 30) and section 29 provides for the precognition of witnesses. Re-opened inquiries are dealt with under section 31 and section 32 applies to fresh inquiries. The difference between fresh evidence and new evidence is that fresh evidence was in existence at the time of the original inquiry but, for whatever reason, was not considered whereas new evidence is evidence which has become available since the original inquiry and did not exist at the time of the original inquiry.

• **Inquiry procedure rules** Section 34 gives the Court of Session the power to regulate procedure in relation to inquiry practice and procedure.

• **Specialist sheriffs and summary sheriffs** Sections 35 and 36 allow the sheriff principal to designate one or more sheriff or summary sheriff as a specialist on the inquiry and give that sheriff the powers to conduct an inquiry.

• **General, interpretation, schedules, ancillary provision, commencement and short title.** Section 37 repeals the Fatal Accidents and Sudden Deaths Inquiry (Scotland) Act 1976 and sub-section 2 provides that Schedule 2 modifies other enactments. Section 38 outlines various definitions in the Bill and section 39 gives Scottish Ministers the power to make regulations in respect of giving full effect to any provisions of the Bill. Schedule 1 on procedural rules sets out the role of the Scottish Civil Justice Council and provides for transitional arrangements and Schedule 2 modifies other enactments, as referred to in section 37.
40. Patricia Ferguson MSP introduced the Inquiries into Deaths (Scotland) Bill on 1 June 2015 and the Parliamentary Bureau designated the Justice Committee as lead committee in consideration of that Bill at Stage 1 on 2 June 2015.

41. The Bill, like the Scottish Government’s proposals, replaces the Fatal Accidents and Sudden Deaths Inquiry (Scotland) Act 1976 and gives effect to many recommendations of Lord Cullen’s review of FAIs report\(^4\). In addition, it seeks to address concerns raised by trade unions and campaigners such as Families Against Corporate Killers and Scottish Hazards.

42. The Policy Memorandum\(^5\) outlines the main provisions in this Bill which go beyond the Cullen recommendations and which are different from the Government’s FAI Bill. These recommendations are designed to achieve three overarching policy objectives—

- extending the scope of mandatory FAIs
- placing families of the deceased at the heart of the inquiry process and giving them their proper place in relation to the investigation of the death of their loved one, and
- ensuring that lessons are learned from the death and enforced for the purpose of ensuring the future safety of Scottish citizens.

43. The Government made comments on the broad policy elements of the Bill namely—

- Mandatory FAIs (industrial diseases; deaths of mental health patients; notification of relevant persons,
- Application to hold an inquiry,
- Time limits,
- Specialist sheriff courts,
- Holding of an inquiry, and
- Enforcement of sheriffs’ recommendations and appeals
Clarity around the purpose of FAIs and investigations into deaths

44. Throughout its scrutiny of the Scottish Government’s Bill, the Committee was struck by the lack of clarity surrounding the purpose of a fatal accident inquiry and a lack of understanding as to what is meant by inquiries which are held in the public interest.

Public interest

45. Tom Marshall from the Society of Solicitor Advocates highlighted the fact that inquiries in the public interest can vary —

There is almost a conflict of interest for the procurator fiscal, because the public interest in having a prosecution is not the same as the public interest in having an inquiry that is there so that lessons can be learned for the future. Those two things are entirely distinct, and therefore, if the Crown is to remain in charge of both aspects, separating the responsibilities within the Crown Office and Procurator Fiscal Service would be a good thing.

46. He elaborated further on the different aspects of public interest in the enforcement of the criminal law by prosecution and the public interest in lessons learned for the future by the holding of an FAI. His view was that the Lord Advocate presently has the responsibility for both of these issues and the tendency increasingly is to pursue the prosecution avenue at the expense of an inquiry.

47. The Solicitor General for Scotland, Lesley Thomson, did not agree that these differing aspects of what was in the public interest caused a tension —

The public interest encompasses all those things at different times. Ensuring that someone who has been involved in criminality is brought to court is the public interest that takes precedence at that stage. That is why, if there are criminal proceedings, there is not always an immediate decision on whether there should be a further inquiry, because an inquiry relates to different aspects... At the start, it may be thought that a matter will have to be inquired into in public by a fatal accident inquiry. By the time that all the investigations, reviews and remedial actions have been taken, there may be nothing left that requires to go into the public domain for further public scrutiny.

48. The Solicitor General also confirmed that no decision is made on whether there will be an inquiry without the views of the family having been taken on board and that there are occasions when FAIs can take place where the family does not want one.
Investigatory work

49. Alistair McNab, representing HSE, explained some of the processes involved in their investigatory work and suggested that improvements could be made.

We have to control expectations, because we cannot say at an early stage whether or not there may be proceedings, which is not our decision. There could be improvement to that phase... There is no doubt that there could be improvements in the liaison with the families and in explaining how the process works... Our main aim in life is to prevent incidents from happening again by enforcing things by enforcement notice, if necessary, and by issuing safety alerts where that can be done. Safety alerts can be issued in agreement with the Procurator Fiscal Service so as to avoid prejudice.

50. The work done to advise the general public on safety issues while the inquiry is ongoing was described by Stephen McGowan COPFS—

During investigations, the HSE accident investigation branches and bodies of that nature regularly put out material on public safety in order that any public safety aspects can be taken into account quickly. We also have an arrangement with Healthcare Improvement Scotland so that similar things can be done in the medical sphere. Although a criminal inquiry may be ongoing, steps can be taken immediately if a particular issue of public safety needs to be addressed. That is fairly routine and happens regularly…”

51. The Committee considers that, in the interests of those who have lost a loved one in often tragic circumstances and who must navigate the system, it is imperative that there be greater clarity and understanding around FAIs, their purpose and how they relate to other death investigations and civil or criminal proceedings.

52. The Committee therefore recommends that the Scottish Government should work closely with the Crown Office and Procurator Fiscal Service to promote a better understanding across Scotland of the purpose of an FAI, how it fits together with other death investigations, and the role of the family in the process.

Key themes

Mandatory Fatal Accident Inquiries

53. The remainder of this report will outline the key themes emerging from the evidence heard by the Committee on the specific provisions contained in the Bill and where the Bill could be strengthened.
54. Under the Bill’s proposals, FAIs remain mandatory where someone dies in an accident relating to their work or in legal custody, however the definitions will be updated. It will extend situations in which it will be mandatory to hold an FAI to include children kept in secure accommodation and will extend discretionary FAIs for deaths abroad.

55. The Scottish Government does not agree that an FAI should be mandatory if the death of a child occurs whilst they are resident at other residential child care settings, an issue that respondents to the consultation on the Bill were divided on.

Children in secure accommodation

56. The Financial Memorandum estimates that extending the definition to include children in secure accommodation would result in no more than one or two extra FAIs every few years.

57. The Committee heard there was confusion as to the definition of secure accommodation. The Scottish Government confirmed its intention was that such children would be covered even if the death occurred while the child had absented themselves from the accommodation. Stephen McGowan of COPFS told the Committee that it would be helpful to have in the Bill clarity about the legislative intent with regard to the situation where the child may be out for the day, whether at school or elsewhere.

58. The Scottish Government therefore agreed to reflect on the drafting of this provision saying “the intention in all those cases, including for secure accommodation, is that the provision does not only apply literally within the building. However, if it is felt that there is a lack of clarity we will certainly take that away and reflect on it.”

Looked-after children

59. Lord Cullen recommended that mandatory FAIs should also be triggered where a child living in a “residential establishment, or someone subject to compulsory detention by a public authority, died.

60. He explained why he felt mandatory FAIs should be undertaken when a child dies while in residential care saying —

> When a child is put into the care of others, away from the family, a responsibility of care and protection is owed to that child. I felt that it would be appropriate for such a situation to be considered by a fatal accident inquiry...the idea is simply that those children are in the protection of others and that, if something happens while they are being protected, it is right and proper that there should be an FAI.

61. Some witnesses also believed that FAIs should be extended to include deaths of children in residential care. James Wolffe told the Committee—
We have expressed the view that the scope of the mandatory inquiry requirement should be expanded to cover the category of children who are not in secure accommodation but who are in residential establishments listed in the Children (Scotland) Act 1995 and the Social Work (Scotland) Act 1968... it strikes me that the issue is one that the Government should think about again.

62. Glasgow City Council\(^{30}\) (GCC) argued that there were already sufficient statutory protections in place to ensure the deaths of children looked after by their local authority are thoroughly investigated. It stated that most deaths in residential establishments are as a result of life-limiting health conditions.

63. The Scottish Government highlighted that the law already provides for the investigation of deaths of looked-after children through the reporting requirements of the Looked After Children (Scotland) Regulations 2009. The Minister stated\(^{31}\) —

"Deaths of children in residential establishments are investigated and reviewed by the Care Inspectorate and many (half) are as a result of health issues. It is difficult to see how the public interest would be served by having a FAI for every such case."

"I would suggest that a mandatory FAI into the death of a child in wider circumstances than those specified in the Bill may cause the bereaved family unnecessary distress. As with mental health-related deaths I invite the relevant stakeholders to reflect on whether they might produce flow diagrams or other materials to make clearer the proper working practices in this field and more clearly demonstrate circumstances and decision making process as to when an FAI might be considered."

Compulsory detention by a public authority

64. The Mental Welfare Commission for Scotland\(^{32}\) (MWCS) and the Royal College of Psychiatrists in Scotland\(^{33}\) believed that an FAI in every death where the individual was detained by a public authority was not necessary or welcome. MWCS referred to its research\(^{34}\) in this area, which concluded that—

"patients subject to detention were no more likely to die than other people being treated for mental illness, learning disability or related conditions, and that it was important to maintain a policy focus on the much wider issue of the huge inequality of life expectancy between the general population and people with mental health problems."

65. Dr Morrison, MWCS, explained further the difficulties associated with extending the mandatory FAI categories to include all those subject to a compulsory detention or by a public authority. He referred to those on community based treatment orders saying\(^{35}\) —

"It would be very hard to say that their liberty is being restricted or that they are being deprived of their liberty by the state. However, there will be other people
Justice Committee
Stage 1 Report on Inquiries into Fatal Accidents and Sudden Deaths etc. (Scotland) Bill, 13th Report, 2015 (Session 4)

on community orders who have to stay in a certain place—possibly supported accommodation—and who cannot go out freely without staff with them. … There are close to 10,000 people under welfare guardianships in Scotland at the moment. About 40 per cent of them are older people with dementia. Their liberty is being restricted—most of them are in care homes where they cannot freely go out. Because of their age and their frailty, they are highly likely to die over any given period.”

66. Lord Gill warned against imposing unnecessary rigidity in the system by extending mandatory FAIs to all who are in the care of the state and said he believed the Crown currently exercises its prerogative responsibly.

67. The Scottish Government argued that it was not appropriate to extend mandatory FAIs to include all those who die while subject to compulsory detention—

The Scottish Government accepts the principle of an independent investigation for all deaths where a person has been detained by a public authority. However, we have concluded that there should continue to be some discretion to determine whether an FAI is appropriate in a particular case. The crucial distinction is between an independent investigation and a fully led hearing in the form of an FAI.”

Detention under mental health legislation

68. As outlined in the Policy Memorandum, where there is a death of a person detained under mental health legislation, there is a graduated scale of investigations—

- adverse incidents (internal review)
- critical incident reviews (involving a consultant from another Health Board area)
- significant adverse incident reviews (involving another Health Board)
- independent investigations by the Mental Welfare Commission for Scotland (MWCS)
- independent investigation by the procurator fiscal and possibly a discretionary FAI.

69. The current system was described by confusing and as having gaps. The Mental Welfare Commission for Scotland suggested that there was a need for a streamlined approach to investigating deaths of those held under mental health legislation.

70. The Scottish Government acknowledged that there may be a case for these investigations to be rationalised and formalised but did not believe that this Bill was the vehicle for this.
71. Article 2 of the European Convention of Human Rights creates a right to life. The courts have interpreted this to include a duty on governments to investigate loss of life in certain circumstances. The courts have developed the law to require certain procedural standards to apply to investigations. Investigations must: be independent; be effective; be reasonably prompt; allow for sufficient public scrutiny; and involve the next of kin.

72. Dr Morrison stated that critical incident reviews and adverse incident reviews where no-one out with the local services is involved could cause a potential breach of the requirement for independence under article 2. He suggested the MWCS oversee these reviews to ensure that they are taken seriously and the conclusions are robust. 39

73. Cathy Assante, representing Scottish Human Rights Commission (SHRC), supported this view regarding the lack of independence of the graduated scale of investigations 40 —

More needs to be added into the system to ensure that all the article 2 requirements are met. Whether that happens under the bill or under mental health legislation is not something we have a specific view on.

74. The Scottish Human Rights Commission 41 suggested that one way of meeting the legal requirements would be to require a mandatory FAI for deaths in mental health detention. The Lord Advocate could then have discretion (similar to that provided in relation to criminal proceedings) not to hold an FAI where a MWCS investigation had sufficiently established the circumstances of death.

75. Louise Taggart, representing Families Against Corporate Killers (FACK) agreed with SHRC’s position 42 —

FAIs should be mandatory in cases involving people with mental health issues, particularly in cases of suicide… Those people are some of the most vulnerable people in our society and are under the hospital’s care”.

76. However, the Royal College of Psychiatrists in Scotland were pleased that the Bill does not include extending the categories of those who should be subject to a mandatory FAI to all those detained under mental health legislation. 43 Lord Gill was also not convinced that there was a need for an FAI in suicide cases as often the circumstances related to the cause of death are conclusive. He told the Committee “it would be very difficult to legislate in such a way as to make FAIs mandatory only for those particular deaths. To be honest, I cannot see the justification for that.” 44

77. Dr Gary Morrison representing MWCS also did not support holding mandatory FAIs in all such cases and suggested that there should be changes to the current system to introduce more independent oversight. 45 He questioned whether it was proportionate, effective or reasonable to carry out an FAI in every case and used statistics to make his point 46 —
In one year, there were 78 deaths. We have reviewed the case notes of 73 of those. Of those 73 people, 39 died of expected natural causes, a further 14 deaths were unexpected but natural. We argue that having a mandatory fatal accident inquiry for 53 deaths out of 73 would not be an efficient use of resources. Importantly, it would be distressing for the families of people who died of natural causes while detained.

78. A proposal for a two-tier system was mooted by MWCS whereby an initial investigation is carried out to rule out deaths from natural causes or cases where there is no cause for concern, and that all other deaths of those detained under mental health legislation should be included within the mandatory FAI category.

79. The Minister for Community Safety and Legal Affairs said that he recognised these concerns but still did not believe that FAIs should be mandatory in every case—

80. He emphasised the need for a flexible and adaptable system. However he acknowledged that there was a lack of clarity about how the current system of investigations works in practice and gave a commitment to look at the current guidance and address any gaps which may raise human rights issues.

81. In supplementary evidence, the Minister confirmed his belief that the Bill was human rights compliant—

82. In response to the criticism that there were gaps in the system of investigating the deaths of those detained under mental health legislation, the Minister stated—
I repeat my call for the relevant authorities to collaborate to produce any flow diagrams, protocols or Charters that might set out the optimal working practices in this field and secure greater confidence that everything is in order."

Industrial diseases and work-related exposure

83. Patricia Ferguson’s proposed Members’ Bill would require mandatory FAIs to be held for deaths due to industrial diseases or work-related exposure to hazardous substances. Her proposals would also require mandatory FAIs to be held in other circumstances and allow the Lord Advocate to opt out of holding an FAI if it is not in the public interest to do so.

84. The Scottish Government believes that Patricia Ferguson’s proposals would significantly increase the number of FAIs being held when nothing new may be learned about the circumstances of the death. In addition, it argues that there may also be difficulties investigating matters which may have occurred decades ago.  

85. The RMT argued that extending mandatory FAIs to industrial disease cases would encourage employers to keep employers’ liability insurance records. Ian Tasker representing the STUC argued that the extensions would allow risks to health to be identified at the earliest possible opportunity and emphasised the importance that mandatory FAIs for industrial diseases should not cover old ground and throughout—

The STUC’s view is quite clear that it would be impractical to have fatal accident inquiries into every death caused by an industrial disease….Our intention in seeking mandatory inquiries in relation to industrial disease is to future proof against new technologies—such as fracking, and nano-technology and the materials that are used in that process—and the ways in which they may cause problems for individuals. Our intention is not to place a burden on the fatal accident inquiry process by covering old ground; it is to investigate new ground.

86. James Wolffe QC and Tom Marshall both believed that FAIs relating to industrial diseases should be undertaken in certain circumstances in order to promote good working practices. James Wolffe was content with the Bill as drafted saying—

I would be concerned about putting all deaths through industrial disease into the mandatory inquiry category, partly because of the potential for a death to take place long after exposure to a substance and also because, if one is dealing with a case in which there are multiple exposures, and consequences, a series of deaths may effectively raise the same issue. That may be a good reason for having a discretionary inquiry in those circumstances, but to have to have a mandatory inquiry in each case might be thought not to be necessary.

87. When asked about extending mandatory FAIs to cover industrial diseases, Lord Gill said he was not in favour, believing that it is the Crown’s prerogative to decide when and where an FAI should be applied for. He said—
In many cases the holding of an FAI is completely unnecessary because the facts are staring us in the face and there is simply no need for it. That is where the Crown exercises judgment... the proposal could be hugely costly to the public. I am not at all convinced that there would be any cost benefit to it.

Where new industrial processes or diseases are identified, the Solicitor General explained that this would be exactly the situation where there should be discretion as to whether to hold an FAI depending on levels of public concern and the need to air these concerns. She said “I do not feel that it would be necessary to have such cases in the mandatory category because there are all sorts of difficulties around definition, but those are exactly the types of situation that would lead to discretionary FAIs.”

The Minister questioned whether it was in the public interest to extend the mandatory FAI category to include industrial diseases when the exposure causing the fatality may have been decades ago, at a work place that no longer exists, and where in any event the risks and dangers of that exposure are now fully known and understood. He also highlighted the Lord Advocate’s discretion to hold an FAI saying “when there is public interest in a death as a result of industrial disease or exposure to hazardous substance...The Scottish Government, and 83% of respondents to the Government’s consultation, believe that the current provisions for work-related deaths are sufficient”.

Finally, the Minister also advised that in circumstances where deaths arise in any new industry which raise issues of public concern but do not currently fall within the types of death which require a mandatory FAI that these could and would be addressed by the holding of a discretionary FAI.

Patricia Ferguson was asked if she was reassured by the evidence heard that there would be a discretionary FAI where new industrial disease deaths were uncovered to which she replied —

The practical difference is that there will be a presumption that there will be an FAI until it is decided that there will not be... We are saying that it should be the other way round—they should have to exercise their discretion not to do so and explain why they came to that conclusion.

Police custody

The Scottish Government’s Bill will update the definition of legal custody to ensure that any death while someone is detained by the police – in any location – is covered.

Witnesses, including the Equality and Human Rights Commission (EHRC), welcomed this provision.

Hamish Goodall, the Bill Team Leader, outlined the policy intention behind this provision —
The amendment was made to the legislation in line with Lord Cullen’s recommendation and at the request of the former Association of Chief Police Officers in Scotland. The association pointed out that there was a slight discrepancy in the law. The existing legislation applied only to police cells and police stations. The bill widens the definition to police custody outwith police stations.

95. The Committee notes the range of witnesses’ views on whether it should be mandatory to hold an FAI following the death of a person detained under mental health legislation or a child who is looked after.

96. The Committee asks the Scottish Government to further consider whether the Bill should be extended to include mandatory FAIs for both these categories of death, with the Lord Advocate having discretion not to hold an FAI in certain circumstances. The Committee also considers that it would be helpful if the Scottish Government could provide further information on the proposal to rationalise and formalise the current investigatory processes.

Service personnel

97. Flt Lft James Jones urged that an FAI should be mandatory in the event of the death of service personnel while on duty in Scotland. He highlighted concerns regarding the legal definition of those who die while acting in the course of ‘employment or occupation’ and why service personnel who die in Scotland are not covered.

98. Speaking to the Committee, Flt Lft Jones said—

As far as the Crown Office is concerned, the 1976 act talks about employees and employers and, for some reason, because service people do not have an
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official signed contract—they are Crown appointees—they are not considered to be employed. That came as a big surprise to me and to a lot of my colleagues, who must obviously have been unemployed for many years. The Crown Office’s interpretation is that service people are not employees.

99. In advance of giving evidence, COPFS wrote to the Committee to explain Crown Counsel’s view of the law as it currently stands as to whether an FAI is mandatory in the event of the death of service personnel whilst on duty—

Historically, a member of the Armed Forces is not an employee of the Crown. Members of the Armed Forces are appointed by the Crown under the Royal Prerogative, and hold an appointment at the Crown’s pleasure. It is therefore a matter of law that deaths of Service Personnel in the course of their duties are not mandatory Fatal Accident Inquiries. There is no employer/employee relationship between the parties.

100. The Scottish Government confirmed that this was not an issue which was raised during Lord Cullen’s review or as part of its consultation on the draft Bill. The Minister said “I must confess that I, too, was surprised to learn that service personnel are not considered to be employees, but I appreciate that that represents long-standing legislative practice.”

Section 104 Order

101. The Bill, as introduced, relates to the devolved matter of FAIs in Scotland. The Coroners and Justice Act 2009 contains arrangements for FAIs to be held into deaths of Scottish military service personnel which occur abroad and the Bill re-enacts these provision without any amendment.

102. It would appear that the Bill as it stands, is worded widely enough to encompass service personnel and therefore address concerns in this area. However, it is not clear whether the issue of the deaths of service personnel in Scotland while on duty may raise issues around reserved competency for the Scottish Government. The Minister confirmed that there may be legislative competence issues around the proposals—

Given the defence reservation, any change to the law would have to be achieved by means of a section 104 order, which is already being contemplated for the bill, and agreed by the UK Government. We have had some initial informal discussion with the Ministry of Defence on the matter, and we believe that there might be room for further discussion in an effort to bring deaths of service personnel in Scotland within the scope of the bill.”

103. The Minister provided further evidence which stated—

Having reflected on the evidence at Stage 1, the Government believes that it is inconsistent to have discretionary FAIs into military deaths abroad (but only if the death is notified to the Lord Advocate) and coroners’ inquests into such
deaths in England and Wales, but not when the death occurs in Scotland. Crown Office have confirmed to the Committee that they would not have difficulty with a change to the law which would permit FAIs to be held into deaths of military personnel in Scotland...The latest position is that the Scottish Government is seeking the view of the Ministry of Defence on having mandatory FAIs into service employment deaths in Scotland.

104. He committed to update the Committee on the response from the UK Government.

105. The Committee welcomes the commitment from the Scottish Government to look at amending the Bill to allow the deaths of service personnel in Scotland to fall within its scope and to update the Committee on its discussions with the UK Government.

Deaths abroad

Overview

106. The Bill would enable a discretionary FAI to be held when someone who lives in Scotland dies abroad and their body is repatriated. It sets out the factors the Lord Advocate would consider when deciding whether it would be in the public interest to do so. The Financial Memorandum estimates that creating a power to hold FAIs into deaths abroad would result in no more than one extra FAI per year. COPFS is likely to carry out more death investigations too, at a total cost of approximately £157,350.

107. Almost all witnesses welcomed this new power and Julie Love, representing Deaths Abroad – You’re Not Alone (DAYNA) summed up the general feeling “that the provision, section 6, will definitely make a difference.”

108. However, witnesses highlighted the potential difficulties in obtaining evidence from abroad as there are no formal arrangements for requiring evidence to be provided and, in addition, there are no mechanisms to enable any sheriff’s recommendations to be taken forward. COPFS would therefore be reliant on the goodwill of the country concerned.

109. Police Scotland highlighted the issue of limited resources and the impact of introducing FAIs for those who die abroad and the body is repatriated. Detective Chief Superintendent Robbie Allan was asked if he had concerns regarding resources available to investigate deaths abroad and responded—
We wrestled with what the exercise in relation to deaths abroad would look like, as it would apply to the COPFS and Police Scotland. Would it be very much a paper exercise in which we would take information from abroad and review it, or would we need to be more proactive? What level of intrusion would be required? That is not something that we do at the moment, so additional resources would obviously be required to undertake that role, and it would depend on what level of scrutiny was to be applied.

Witnesses felt sections 6 and 7 lacked detail in relation to engagement with other jurisdictions and what the role of Scottish organisations, such as Police Scotland in international death inquiries would be. DSC Allan said — That needs to be made clear—it was certainly not clear from my initial reading of the bill. Indeed, my first question was whether the bill would require us to deploy Police Scotland officers in foreign countries.

However, it was not envisaged that police forces would be deployed abroad according to the Solicitor General — We do not have power to send investigators abroad in relation to such matters, and the bill does not give us that power. We would do that as a result of co-operation with other countries through the Foreign and Commonwealth Office.

More generally, Julie Love highlighted the lack of support currently available to families of those who die abroad — When a death occurs abroad, the difficulty is that legal aid is not available, because the case is in another country. Most families I know of have definitely not had legal aid or aid for travelling outwith the country to attend court or whatever. They have had no assistance whatsoever.”

Repatriation

A number of witnesses expressed concern regarding the requirement that the body must be repatriated and suggested that the Bill should be amended to allow the Lord Advocate discretion, where appropriate, to hold an FAI without the body being repatriated.

For example, Jake Molloy of RMT told the Committee that he believed cases where the body could not be repatriated should be included in the Bill and explained the potential benefits, not only to the families of the deceased — If a fatal accident inquiry were to be held and the recommendations shared, that could have the impetus to improve health and safety understandings and operations. Sharing such learning could prevent recurrence globally.
115. The Solicitor General highlighted that while repatriation of the body is very important to the Crown as it is valuable evidence, she agreed that there should be some flexibility—

"I would have no difficulty with there being exceptional circumstances when a body has not been repatriated, although such circumstances would require to be justified to allow the Lord Advocate to go down that route."\(^78\)

116. The Scottish Government explained the reasons behind the repatriation requirement in the Bill but conceded that this may not always be possible. The Minister said\(^79\)—

"We are flexible about the bill and will look at what we can do. We want to be realistic with the committee and not raise expectations that an inquiry would automatically lead to an explanation for the death; it will be more difficult without the body, unfortunately."

117. The Committee welcomes the provision in the Bill to allow FAIs to be undertaken when a death has occurred abroad.

118. The Committee understands why the Scottish Government chose to replicate existing legislation and stipulate that, in order for an FAI to be undertaken into a death abroad, the body must be repatriated. However, we consider that there could be exceptional circumstances where it may be appropriate to hold an FAI when it has not been possible to bring the body back to Scotland.

119. The Committee therefore recommends that the Scottish Government considers bringing forward an amendment at Stage 2, to allow for some discretion to hold an FAI where repatriation has not been possible.

### Delays

120. A major criticism of the current regime is long delays between the date of death and the start of an FAI, a point acknowledged by the Scottish Government. The Policy Memorandum explains the reasons for these delays as being—

- the need to wait for the outcome of other investigations by bodies like the Health and Safety Executive or the Air Accident Investigation Branch;
- the possible need to obtain expert advice;
- the need to consider whether criminal proceedings are appropriate; and
- the overriding necessity of conducting death investigations thoroughly – this factor is of particular relevance in relation to the complexity of some investigations, especially those involving medical cases and of course helicopter crashes\(^80\).
121. The Cullen Review contained several recommendations designed to address delays. These included better organisation of COPFS and the introduction of early\textsuperscript{81} and preliminary hearings.

122. Eric McQueen, Chief Executive of the SCTS, highlighted that delays in process were not related to the point at which the court is informed that an FAI is proceeding until the time that the hearing takes place\textsuperscript{82}—

- About 45 per cent are one-day hearings, and they are largely held within three to four months of the fatal accident inquiry application coming forward. A further 45 per cent are hearings that last between two and 10 days. Most of those take place within three to four months, with some possibly taking place within seven months if they are particularly long or if more evidence is required. Only 10 per cent of cases are of long duration—of about 11 days or more—and most of those will be held within a four to five-month period, with some of the longer ones possibly taking place within nine to 10 months. We are certainly not aware of there being a problem for the parties involved in FAIs or of the issue being raised in the evidence sessions.

123. The Bill would introduce preliminary hearings with the aim of speeding up the FAI process. It is anticipated that the parties would provide information about witnesses, evidence and any areas of agreement at a preliminary hearing, allowing better judicial management of the FAI process.

124. The preliminary hearings would establish the facts and Lord Gill suggested that good case management by the sheriff was the key to conducting the inquiry efficiently and effectively\textsuperscript{83}—

- I strongly favour the idea that, in an inquiry procedure, as much of the evidence as possible should be presented in written form. That eliminates unproductive use of time in the inquiry...In practice, we find that a great deal of the evidence—probably two thirds or more of it—is completely uncontroversial and is taken as read.

**Early hearings**

125. Lord Cullen recommended that an early hearing be held in relation to mandatory FAIs and suggested this could be done within three months of a death being reported. The purpose of this hearing would be for COPFS to provide an update on the progress of investigations. Lord Cullen thought it would act as a “spur” to reduce delays. He took care to differentiate between an early hearing and a preliminary hearing as outlined in Section 15 of the Bill, which is concerned with the practicalities of an FAI once it has been agreed that one will take place—

- That is something quite new and the idea is to let relatives and interested parties know what is going on. I thought that it would be useful to have an independent person in the position of a sheriff who was able to say, “Can you give me an explanation of what is going on here?”
I proposed such a procedure simply to let the families and other persons who are directly involved know what is going on so that they can be satisfied that all proper steps are being taken to progress matters.  

126. Campaigners were broadly in favour of an early hearing. Julie Love said this would be beneficial for families as well, because they could express their thoughts at this stage.  

127. Jake Molloy representing RMT agreed with the principle of an early hearing to deal with the facts and to “dispel perceptions, fears and concerns, address the family’s issues and share as early as possible the specific facts of the accident to prevent recurrence.”  

128. Tom Marshall from the Society of Solicitor Advocates also said he was sympathetic to the idea of an early hearing—  

It seems to me that having an early hearing does not leave the matter entirely within the hands of the Crown Office and Procurator Fiscal Service. It brings the court into play at an early stage and, therefore, it gives the court an element of control of the pace at which matters happen in future. That must be important.  

129. Lord Gill was less enthusiastic about holding early hearings and the Crown having a supervisory role over the Crown’s decision-making process. He suggested improved protocols would work better—  

It is not that I am not conscious of the need for expeditious conduct of the process, but I am just not sure that that would be the best way to go about it… …The real answer would be for the Crown to establish good protocols of conduct whereby the relatives would be kept in touch and would know what was going on. We could achieve the same thing without the need for meetings.  

130. Patricia Ferguson stated that until the Lord Advocate has decided there will be an FAI, sheriffs would have no jurisdiction and therefore the proposal seems slightly out of sequence, although she said she had a lot of sympathy with the idea and aim of having an early inquiry.  

Criminal proceedings  

131. The Policy Memorandum highlights the fact that FAIs are not usually held until a decision has been taken on whether any criminal proceedings will take place into the death. Following any criminal or civil proceedings, under current legislation, the Lord Advocate may decide that there is no need for an FAI as the circumstances of death have been established in criminal proceedings and it is not in the public interest to undertake another inquiry where the same evidence will be heard.  

132. The Committee heard from campaigners about the impact of such matters. The result being that there is no public discussion of the evidence or any opportunity
for the families to play an active part in the process. In addition, there is no opportunity to consider what lessons might be learned, a point made by the RMT and the Fire Brigades Union.\textsuperscript{91}

133. The STUC, when asked if holding an FAI before criminal proceedings are concluded is not in the public interest as it could prejudice those proceedings replied\textsuperscript{92}—

That is very much the case, but more could be done...It is clear that the public interest has to come first, but more could be done to publish reports on fatal accidents at work—we are talking mainly about such accidents—that would help us to improve safety standards at an earlier stage than we do now.

134. However, this was a view not shared by Lord Cullen—

The general answer to that is that it would not be wise for a fatal accident inquiry to start before the conclusion of criminal proceedings.. My problem with that idea concerns how much could usefully be achieved during that initial phase, because even an explanation of how the deceased came to die might be relevant to the criminal prosecution. There is always a danger that whatever is said could create a problem for an on-going criminal prosecution, so it is better to have the criminal proceedings finished.

135. The Solicitor General acknowledged the need to keep families informed of progress throughout what can be a lengthy death investigation and told of plans to produce a milestone charter\textsuperscript{93}—

I have asked the Crown Office team in the Scottish fatalities investigation unit to produce a charter that would be in the public domain and would indicate the various milestones. In relation to early hearings, the equivalent at the investigative stage would be a hearing or a meeting—whatever you want to call it—set by the fiscal at a certain time. What I have in mind at the moment is three months from the date that the death was reported. At that point, the fiscal would be required to provide to the family specific information on the stage at which the investigation is and the timescale for it...We are working on that—we will consult on that milestone charter with the various victims groups and a number of the groups that have given evidence, and we will publish the results of that consultation.

136. The Minister welcomed the plan to introduce a charter\textsuperscript{94}—

I think that that is a constructive suggestion, and I understand that she is going to come back to the committee on it. In a sense, it would mean that, in the three-month interval that the Solicitor General referred to, the Crown Office would review where it was at with an inquiry and what needed to be done to ensure that it happened and that any delays were kept to a minimum. As I have said,
that is a very constructive suggestion that will, I hope, largely deal with the intent behind Lord Cullen’s recommendation.

137. Patricia Ferguson expressed an interest in the charter but said—

"Why wait for a new idea of a charter just to avoid something being laid down in law? That seems to be counterproductive."

138. It is expected that the Committee will receive a draft version of the milestone charter in advance of any Stage 2 consideration.

Statutory timescales

139. Patricia Ferguson’s Bill would create specific time limits in which an FAI has to be held. In situations where there is no intention to bring criminal proceedings, the Bill proposes that an FAI should take place within a year. The Lord Advocate would have six months from the death to notify the relatives as to whether he intended to hold an FAI.

140. The STUC supported the idea of mandatory timescales saying “we believe that the timescales proposed by Patricia Ferguson MSP in her Inquiries into Deaths (Scotland) Bill are necessary in order to address one of the most significant failures in the current system.”

141. Ian Tasker also expressed his disappointment that the Scottish Government’s Bill did not contain mandatory timescales. However, James Wolfe representing the Faculty of Advocates, said he was not in favour of statutory timescales—

"There is such a range and diversity of circumstances and such complexity in the subject matter and nature of an inquiry that it is very difficult to be prescriptive about timescales for starting an inquiry…I suggest that being overly prescriptive is not necessary or helpful."

142. Patricia Ferguson, when giving evidence on how statutory timescales proposed in her Bill would address delays in the FAI process, stated—

"Our view is that we need to specify a time when the Lord Advocate will formally communicate to families and those with an interest the decision that he has made or the likelihood of his decision. We are suggesting six months for that, where there have not been criminal proceedings, and three months where there have been criminal proceedings. We are not being completely rigid about that; rather, we are saying that the Lord Advocate can give an explanation as to why that is not possible."

Resources

143. Alistair McNab from HSE, told the Committee that delays can be caused by the complex nature of some death investigations and police resource available. He said—
We were working with the police and the Procurator Fiscal Service well before the COPFS health and safety division was set up, but since that came into being, we have all made a concerted effort to try to speed up the investigation process… after five years of tripartite working involving the police, the HSE and the COPFS, we are looking at what we have learned in that time and how we can improve the speed of investigations.”

144. The Committee notes the concerns of witnesses regarding delays in holding FAIs, but understands the need for criminal proceedings to be concluded before an FAI can begin. The Committee notes the argument for early hearings, as proposed by Lord Cullen. However, given the commitment by the Solicitor General to produce a milestone charter outlining what families can expect from COPFS in terms of the timings of investigations and decision-making, it is not convinced this is now necessary. The Committee believes that this step will bridge the gap between the Bill as drafted and those who called for an early hearing.

145. The Committee asks the Solicitor General to make available a draft copy of the milestone charter in advance of Stage 2 consideration of the Bill, should it progress past Stage 1.

146. The Committee welcomes the provisions in the Bill requiring preliminary hearings to be held and agrees with witnesses that this should allow better judicial management of the FAI process.

The role of the family

147. The Bill would require the Lord Advocate to give written reasons (on request) for a decision not to hold an FAI. Patricia Ferguson’s Bill would require written reasons to be provided in a range of circumstances.

148. COPFS stated that families have access to key evidence as well as input into the decision about whether to hold an FAI. Families also have access to information about the FAI process through COPFS’s victim information and advice officers.

149. Currently, the family can challenge a decision not to hold an FAI by means of judicial review. However, a judicial review is expensive as it is heard in the Court of Session. The process can only look at the administrative aspects of a decision, rather than its wider merits. Witnesses questioned how effective the existing arrangements were and disputed the fact that they had access to all the relevant information.

Family participation and access to information

150. Witnesses, including the STUC, called for the Bill to give the family a specific right to make representations in relation to the scope of the inquiry. It was also
suggested that family members beyond a spouse/partner or nearest relative should have a right to participate in the process. This, they felt, would better reflect the fact that different family members may have different attitudes to the situation.

151. James Wolfe also mooted that families should be given the opportunity to participate, he said—

I notice, for example, that, under section 12, where the sheriff makes an order transferring the proceedings to a sheriff of another sheriffdom, he has to give “participants in the inquiry an opportunity to make representations”. The family will not always be participants in the inquiry, and one could add in a requirement that the family be given the opportunity to make representations.

152. In order to conduct the FAI efficiently, Lord Gill said that sheriffs must have the discretion to decide who can participate in the inquiry, thus making the most productive use of time. He concluded that—

The sheriff must make a judgment on that based on the circumstances of the case and the representations that are made to him by those who claim to have an interest. That is a perfectly normal facet of effective case management.

153. Stephen McGowan was asked if there was any mechanism for families to challenge the conclusion as to whether a death was self-inflicted or accidental, to which he replied—

We come to certain conclusions but we do not make any determination as to whether a death is self-inflicted. An investigation might reach that point, we might have a discussion with the families about it and a certain statistical return might be put in, but we do not make a formal finding.

Written reasons from the Lord Advocate

154. The Bill would require the Lord Advocate to give written reasons (on request) for a decision not to hold an FAI. It was suggested that this information should be provided to families whether or not it was requested.

155. However, the Solicitor General told the Committee that this happens automatically at the moment and she would not have a problem if the Bill were amended to remove the requirement that this information is requested—

In practice, we currently provide the reasons. We have been considering other ways in which we could ensure that families are continually kept advised of progress.

156. The Law Society of Scotland proposed that families should have a right to request an FAI where the Lord Advocate refuses one. A sheriff would consider at a hearing whether such a request was in the public interest.
157. Scotland’s Campaign against Irresponsible Drivers (SCDI) stressed that families need to understand how the death occurred and that lessons have been learned.\footnote{107} families need to understand what happened to their loved one, why it happened and, most important of all, to know that lessons have been learned from their loss to ensure that no other family will suffer as they have.

158. DCS Allan acknowledged that improvements could be made in keeping families informed of ongoing police investigations—

\begin{itemize}
  \item The police will deploy to every death, and in cases involving unexplained or suspicious deaths, we also deploy family liaison officers. That initial engagement with the family happens, and we keep them updated during the initial stage of the police inquiry. They will know what we are doing, particularly with regard to how we are managing the initial investigative strategy, the scene and so on. I think that where we need to tighten things up a fair bit is what happens when we complete the initial investigation and report the circumstances to the COPFS.
\end{itemize}

Legal aid

159. Parties to an FAI can claim legal aid to cover the costs of representation. However, they must demonstrate that it is “reasonable” for them to have separate representation.

160. Whether families of lost loved ones should qualify for legal aid when making representations during an FAI was discussed by the Committee. Lord Cullen said he believed that the reasonableness test should be removed, a point echoed by STUC in their written submission.\footnote{108}

161. The financial burden placed on families was highlighted by Louise Taggart from Families Against Corporate Killers who said “in a work-related death, it is often the main breadwinner who has been killed, so there are significant financial issues for the families who are left behind. If legal aid were to be more readily available, that would certainly be a positive move”.\footnote{109}

162. Ian Tasker, STUC, said that individuals should have access to legal aid if they want to be represented at a fatal accident inquiry.\footnote{110} He went on to highlight the need for families to be supported through the process\footnote{111}—
Lawyers advise families in fatal accident inquiries at present; families need that support because they have not been part of a legal process before. We have trade unions that support members at fatal accident inquiries.”

163. Tom Marshall, when asked if the reasonableness test for legal aid should be removed, replied—

“In my opinion, it is important that families are represented. In some workplace accident cases, there may be support from a trade union, but in other circumstances financial backing may not be available. My own experience of last year’s Super Puma helicopter inquiry was that the families wanted to bring forward a number of different issues that did not seem to be on the procurator fiscal’s agenda. Without the support of the trade union movement, those issues might not have been aired at all—that is an important point.”

164. Scotland’s Campaign Against Irresponsible Drivers (SCID) supports Lord Cullen’s recommendation that relatives of the deceased should not have to justify reasonableness of the granting of legal aid and also that the limit should be increased for legal aid for FAIs.

165. The Scottish Legal Aid Board welcomed the provisions in relation to mandatory inquiries stating that extending the scope of mandatory inquiries to cover death beyond those occurring in the course of a person’s employment could put additional pressure on legal aid expenditure.

166. Following the evidence session with the Minister on 26 May, the Committee requested further information from the Scottish Government in relation to legal aid costs associated with FAIs over the last 3 years. In response, the Minister stated—

“The Committee has suggested that the Scottish Government was not implementing Lord Cullen’s recommendations regarding legal aid on cost grounds. That is not the only reason why the Scottish Government is not proposing that Lord Cullen’s recommendations should be implemented, though it is a significant one.”

167. The Minister provided costs to the legal aid fund of supporting families at FAIs in the past three years, which totalled £2,472,600 between 2011 and 2014. He confirmed that the figures provided in the Financial Memorandum were constructed differently in that lifetime costs of cases were calculated based on the year the FAI case started.

168. The Minister highlighted the Scottish Government’s response to Lord Cullen’s review which said that it did not agree with this recommendation. While it regards it important that relatives should be able to participate appropriately in FAIs, it did not accept that this requires automatic legal representation in every case.
Since it is for the procurator fiscal to investigate the circumstances of a sudden death, there must be a clear basis for a relative of the deceased requiring their own publicly funded legal representation. The basis of this approach is rooted in the function of the inquiry itself, namely that it is a fact finding exercise, and not one which seeks to apportion blame or fault. Notwithstanding, the reasonableness test is likely to be met if a relative can demonstrate that they have a discernible interest that is unlikely to be subject to investigation by the procurator fiscal, necessitating that they have their own legal representation."

Trade union participation

169. Patricia Ferguson’s Bill does not specifically mention trade unions. However, it does contain proposals to allow the participation in FAIs of anyone who has notified the Lord Advocate and appears to him to have an interest in lessons learned from the death. Patricia Ferguson stated that one of the key purposes of her proposed Member’s Bill is to put the families of victims at the heart of the FAI process.

170. Both the RMT and the STUC called for trade unions to have a formal role in FAIs. Currently the spouse or nearest relative and, for work-related deaths an employer are entitled to participate. The Bill will allow a health and safety inspector to participate and the sheriff may allow anyone else with an interest in the inquiry to participate.

171. Tom Marshall highlighted that in some workplace accidents families are supported by a trade union representative who can bring forward issues which are not on the procurator fiscal’s agenda. He said—

Without the support of the trade union movement those issues might not have been aired at all.

172. We believe it is imperative that families, trade unions and staff associations are able to participate in a meaningful way in an FAI and that families are represented appropriately and are kept informed throughout the process.

173. The Committee welcomes the requirement that the Lord Advocate provides written reasons for a decision not to hold an FAI but does not believe that this information should only be provided to families on request.

174. The Committee recommends that the Scottish Government brings forward an amendment to remove the requirement that this information must be requested.
Sheriffs’ recommendations

175. Currently under the 1976 Act, at the end of an FAI the sheriff is required to set out the place, time and cause of death [and any accident resulting in the death]. The Sheriff can also set out any precautions whereby the death may have been avoided and any defects in the ways of working which contributed to the death.

176. The Bill would require sheriffs’ determinations to be published and that anyone who was a party to the inquiry and to whom a recommendation is addressed would have to respond. If a recommendation were made to a party that did not participate in the inquiry, then there would be no need for that party to respond.

177. There would be no legal sanctions attached to these requirements. Parties would also be free to respond explaining why they will not be implementing recommendations.

178. Patricia Ferguson’s Bill differs significantly from the Scottish Government’s Bill in relation to Sheriffs’ recommendations and their enforcement.

179. Her Bill would make it a legal requirement to comply with a sheriff’s recommendation after the matter has been investigated further by the sheriff. The Lord Advocate would be responsible for monitoring compliance. Where a party had not complied with the recommendation, the sheriff would have the power to hold a hearing to discover why. It would be an offence not to comply with any order issued by the sheriff after the hearing.

Legally binding sheriff’s recommendations

180. Concern was expressed that the recommendations made by sheriffs to prevent future incidents are not always implemented and lessons are not being learned from these accidents. Indeed, in some cases the party may not be aware that a recommendation has been made.

181. The Scottish Government suggested\textsuperscript{116} that there are practical problems to making sheriffs’ recommendations legally enforceable. These include: that the recommendation may not, in fact, be practicable or affordable; that FAIs may become more adversarial as a result; and that sheriffs would become involved in ongoing enforcement.

182. The HSE was not in favour of making sheriffs’ recommendations legally binding\textsuperscript{117}—

\begin{quote}
We would not support mandatory directions because in our experience, important as they are, inquiries do not always cover all the issues, nor do they always call the right witnesses. The sheriff could be left in a position where they are putting mandatory decisions on regulators, such as the HSE, when there may be more risks that have not emerged or been debated at the FAI.
\end{quote}
183. James Wolffe pointed out that often sheriffs’ recommendations are directed at groups of people who were not represented at the FAI and how their views were represented prior to recommendations being made, hence the danger of making recommendations legally binding. He explained—

Sheriffs may well frame their recommendation in such a way deliberately, recognising that it may be for a trade body to issue guidance to its members or for the Government to take forward in certain ways and that it would be wrong for the sheriff to be unduly prescriptive about the outcome of that because there are other parties whose interests need to be taken into account.

184. He stated clearly that the Faculty of Advocates did not believe that sheriffs’ recommendations should be legally binding and explained the reasons were twofold: one of principle and the other being a risk that such a change would make FAIs more adversarial.

185. Lord Gill was not in favour of making sheriffs’ recommendations legally binding, neither was the Solicitor General. Lord Gill stated—

No. I do not think that that is a good idea at all. The sheriff makes a recommendation within the context of an FAI, which, as I have tried to emphasise, has a very tightly constrained remit. There may well be other evidence that is not before the inquiry, which might emerge later or might simply be of only indirect relevance to the purpose in section 1(3), and the sheriff’s recommendation might well require to be reconsidered in the light of that other evidence. To make a recommendation mandatory introduces a completely unnecessary degree of rigidity and could lead to completely unhelpful recommendations having to be acted upon. I do not think that that is in the public interest at all.

186. Lesley Thomson echoed this view—

Legally binding recommendations would widen the scope of an FAI; they might end up being unenforceable, given that the sheriff would have been looking at the particular circumstances of the death, or deaths, before him; and there is the danger that the inquiry would turn into an adversarial process.

187. The Scottish Government commented on the inappropriateness of making sheriffs’ recommendations legally binding.—

The flexibility currently offered by the present system is seen as an advantage, given that the recommendations from a particular inquiry may have wider implications which need to be considered in a broader context.

If recommendations were to become legally binding, the Faculty of Advocates have suggested [in their response to the consultation on the Inquiries into Deaths (Scotland) Bill promoted by Patricia Ferguson MSP] that FAIs would become longer, more expensive and more adversarial, as parties will want to be
represented and will fight harder to ensure that they are not unnecessarily burdened with legally binding recommendations. Furthermore, if sheriffs were aware that any recommendation they make will become legally binding, the Scottish Government is concerned that sheriffs would be disinclined to make recommendations since FAIs as judicial inquiries are not the forum to impose rights or burdens on parties”

188. The Minister added —

"I understand that Patricia Ferguson has proposed a continuing involvement in the enforcement of recommendations by the sheriff. Presumably a sheriff would be required to call a party back to court if another party complained that the recommendation had not been implemented. This causes us significant concern, in that this would have major implications for sherrieval and court resources if such a proposal were to be adopted, since FAI proceedings would effectively continue, possibly indefinitely, while interested parties complained to the sheriff – with justification or not – that recommendations had not been implemented. "

189. Ian Tasker acknowledged the difficulties associated with sheriffs' recommendations involving devolved and reserved areas —

"..road traffic regulations are reserved, but we think that a sheriff should be able to make legally binding recommendations on matters relating to the Scottish Parliament's devolved powers. "

190. Patrick McGuire, representing Thompson’s solicitors in support of Patricia Ferguson, acknowledged the difficulties associated with making sheriffs’ recommendations legally binding where they related to reserved issues and explained —

"..we have reflected that—as we have had to do—in section 25(5), where we recognise that the sheriff’s recommendations as they relate to reserved matters, including health and safety regulations, cannot be enforceable. However, many other recommendations will be enforceable, and they could make a difference
Publication of recommendations

191. There was general agreement that sheriffs’ recommendations should be published alongside the responses from those to whom they are directed, for example Jake Molloy, RMT, said this: “would lead to a lot of emphasis being put on those companies responding positively. It would act as a great deterrent to bad practice and would promote good practice, as long as the process was open and transparent.”

192. However, several respondents argued that SCTS may not be the most appropriate body to co-ordinate responses. Lord Cullen’s original proposal envisaged the Scottish Government taking a more active role in overseeing the implementation of responses. James Wolfe said—

“I expect that, if someone decides not to implement a recommendation, they will wish to explain why, and the requirement in and of itself to consider a response ought to have an impact on those to whom recommendations are directed. There is perhaps a question whether the procedure for publication through the Scottish Courts and Tribunals Service is exactly the right way to go about that, but the broad thrust of the policy in the bill seems to strike the right balance.”

193. Tom Marshall indicated that the SCTS website would be appropriate place for the publication of responses—

“It does have the advantage that those who are looking for information about fatal accident inquiries will probably go first to the Scottish Courts and Tribunals Service website. If they have to go somewhere else to find out information about recommendations that have been made and responses that have been given, the prospect is that they are not going to find it—or, at least, the Scottish Courts and Tribunals Service website is going to have to include a link, which means that it is going to have to do some work somewhere.”

194. Mr McQueen agreed that SCTS should take on the role of publishing sheriffs’ recommendations and responses, subject to adequate resourcing—

“As the Lord President suggests, we are being pragmatic rather than being particularly happy about the situation. Nevertheless, we see a logical link; the SCTS website would include the determinations, recommendations and responses to them. For openness and transparency the information would all be there for everyone to see. We do not have a particular skill in assessing responses, so we would need to put in place a function to deal with that aspect.”

195. He told the Committee that to take on this function would cost in the region of £60,000 per year.

196. The Minister emphasised the Scottish Government’s position regarding SCTS’ role—
I firmly believe that it would be advantageous for the SCTS to publish the response to the sheriff’s recommendations. I do not want to overstate the point but it would probably give more credibility to the process if the sheriff gives recommendations and response is made to the sheriff about whether those recommendations will be taken forward and if not, why not. That would help the process.”

Monitoring of the implementation of sheriffs’ recommendations

197. On the issue of monitoring whether a sheriff’s recommendation has been acted upon, James Wolffe noted\textsuperscript{132}—

“\begin{quote}
The problem would then be who would do that in the Scottish Courts and Tribunals Service. Is it envisaged that it would go back before a sheriff who would have some monitoring role over the way in which a recommendation is implemented or not implemented? If it is to be a sheriff who has that role, what sanction is to be applied other than the sanction of public opinion or the pressure that comes from being forced at least to confront the recommendation and make a response to it?... At the end of the day, however, it has to be for the body concerned to consider the issue at large and to decide for itself what its responsibilities are."
\end{quote}

198. Sheriff Liddle explained that it would be very difficult for a sheriff to maintain control over any determinations they make and manage the case on an ongoing basis but he pointed out that the expectation was that their recommendations would be implemented\textsuperscript{133}—

“\begin{quote}
I fully accept that if I make a recommendation, I want and expect it to be implemented. There is such a wide variety of recommendations that could come out of an inquiry that it is difficult to be prescriptive."
\end{quote}

199. The Minister was not clear on whose role it was to monitor compliance with sheriffs’ recommendations\textsuperscript{134}—

“\begin{quote}
..that would probably be a resource issue that the SCTS would face. So, in some way, shape or form, a relevant organisation or body would monitor progress. As a whole, on the issue that you might be getting at as to whether the SCTS should monitor overall performance and how many recommendations are followed through, I do not think it would be realistic for us to expect the SCTS to do that within its resource.”
\end{quote}

200. The Minister added\textsuperscript{135}—

“\begin{quote}
It would be inappropriate for the Scottish Government, SCTS or the Lord Advocate to actively monitor compliance because this would place them in a quasi-judicial role. “
\end{quote}
201. Patricia Ferguson explained her position in relation to sheriffs’ recommendations and their enforcement saying—

Under natural justice and the ECHR, if we say that a sheriff’s findings are enforceable, we have to offer a right of appeal to those against whom a finding might be made, and we do that in the bill. Similarly, it is only right that the sheriff can set a timeframe against which the recommendation must be implemented and can call back the person or organisation to whom the recommendation was made and find out what action has been taken to implement it. At that point, the person or organisation might say that it has not been possible to implement the recommendation in that timeframe but that they can do it in another six months or a year and that, in the meantime, they can give details of the progress that has been made. It is only right for the sheriff to be able to review that, listen to what has been said and take whatever action he or she thinks appropriate at that point. Those two sides of the exercise need to be in place.”

202. The Committee welcomes the proposals in the Bill to require sheriffs’ determinations to be published and to require parties involved in the inquiry to which a recommendation is addressed to respond to the recommendations. The Committee considers that the proposals strike the correct balance between improving compliance with the recommendations. The Committee, on balance, considers that the Scottish Courts and Tribunals Service is the most appropriate body to do this.

203. The Committee notes the view of witnesses that there could be difficulties in placing a duty on a particular body to monitor the implementation of sheriffs’ recommendations and considers the requirement in the Bill that recommendations are published and responded to by those involved to be sufficient. The Committee asks the Scottish Government to look at ways of ensuring that sheriffs’ recommendations are respected.

Other issues

Location of an FAI

204. Proposals in the Bill would break the current link between the location of the accident and the sheriffdom in which an FAI is held. The Scottish Government argued that this would increase flexibility, and thus assist with delays and better meet the needs of families. However, it has traditionally been considered important that FAIs were held as close as possible to the location of the accident. This was thought to preserve local knowledge. It is also likely to be the most convenient location for witnesses.

205. James Wolffe agreed that the provision in the Bill provided flexibility but warned of the potential negative impacts for the families—
We recognise that it is a good thing to put flexibility into the system to allow inquiries to be held at the appropriate place, which may not always be the local sheriffdom. Our particular concern is that the decision-making process should take into account the interests and views of the family in particular. It may be that that could be built in by way of an amendment.

206. Sheriff Gordon Liddle said that the Bill should contain a presumption that the FAI will be held locally particularly to enable families to attend—

It can be difficult for families to travel long distances...Another equally important aspect is that often cases that lead to an inquiry have a local flavour—the people in the local community are interested in what happens and what the outcome will be. Those people would be excluded from a public inquiry if it were to be held elsewhere.”

207. However, Lord Gill disagreed that there should be a presumption for an FAI to be held locally—

I think that in most cases it will be pretty obvious that the inquiry should take place in the jurisdiction in which the accident happened, but there will be cases in which it is more appropriate that inquiries take place where the families are. That gives us the necessary degree of flexibility. I am all in favour of that.”

208. The Committee welcomes the proposals in the Bill to allow flexibility to determine the sheriffdom in which an FAI can be held and considers this to be a practical step in addressing some of the delays in the system. However, we urge the Lord Advocate, when choosing the sheriffdom, to put families’ interests at the heart of his decision as well as the practicalities.

Summary and specialist sheriffs

209. Concerns were expressed regarding the power given to the Lord Advocate to appoint summary sheriffs to an FAI. Some witnesses were not enthusiastic regarding the appointment of specialist sheriffs, which could lead to specialist centres. Sheriff Liddle described these as undesirable. Sheriff Stewart explained the Sheriffs’ Association’s position—

We have reservations, in that it may create the feeling in the public mind that there are important and less-important fatal accident inquiries, that the decision is made when the Lord Advocate assigns a fatal accident inquiry to a particular sheriffdom, and that if a part-time summary sheriff takes up an FAI it may not get the attention that it would get if a more experienced sheriff got it.

210. This was not the view of Lord Gill who put it simply when he said “a summary sheriff will be perfectly capable of conducting a straightforward fatal accident inquiry. If the inquiry is more complex, a sheriff should do it.”
211. The Committee notes the concerns of sheriffs regarding the appointment of summary sheriffs to FAIs but also notes the view of Lord Gill that a summary sheriff will be able to conduct straightforward FAIs while sheriffs would deal with more complex cases.

Financial implications

212. The Financial Memorandum provides an overview of the financial impact of the Bill on the Scottish Government, COPFS and SCTS and states that the existing cost of an FAI will not change as a result of this Bill. From the FM, the current costs to COPFS and SCTS in preparing and conducting a lengthy FAI is £94,701 and £90,000 respectively. The Finance Committee issued a call for evidence on the Financial Memorandum which closed on 24 April 2015 and received seven responses but agreed not to undertake any further work or to report on the FM.

213. Additional costs incurred as a result of investigating deaths abroad is estimated at £157,350 each year.

214. The Financial Memorandum for Patricia Ferguson’s Bill estimates that there would be an additional one or two FAIs every five years as a result of her proposals to extend the work related deaths category to include deaths from industrial diseases or from workplace exposure to hazardous substances.

215. The Committee believes that, should the scope of mandatory FAIs be extended to include deaths of those detained under mental health legislation, then the financial impact could be significant.

216. The Committee has made comments in relation to legal aid earlier in this report. The Scottish Legal Aid Board (SLAB) concurred with the view that it was difficult to predict the increased cost of legal aid as it is difficult to predict whether the Bill will result in an increase in the number of FAIs. It did however, point out that any additional costs to the Legal Aid Fund would be met by the Scottish Government under the terms of the Legal Aid (Scotland) Act 1986.

Delegated powers

217. The Bill contains a number of delegated powers provisions, the main one being in relation to places at which inquiries may be held. The Scottish Government stated that this provision [section 11(1)], which will allow Scottish Ministers to make regulations to designate places at which a sheriff court may be held to hold an FAI would be subject to the affirmative procedure.

218. The Delegated Powers and Law Reform Committee considered the delegated powers within the Bill and reported to the Committee on 27 May 2015.
DPLRC agreed to raise questions on the powers in section 34(1) (power to regulate procedure etc.) and made the following recommendations—

- that the power in section 34(1)(b) is narrowed so as to limit the ancillary power to matters ancillary to inquiry proceedings in line with the policy intention explained in the Scottish Government’s response and (b) draws the lead committee’s attention to the general breadth and scope of section 34(1) of the Bill.

- The justification given for the width of the power is the need for maximum flexibility to implement the recommendations arising from Lord Cullen’s review. A further justification is that the 2014 Act confers powers in the same terms on the Court of Session to make rules about proceedings in that court and in the sheriff court. However in the Committee’s view the Scottish Government has not explained why the 2014 Act powers constitute a relevant precedent. Those powers were conferred in the context of giving the Court of Session far-reaching powers to reform its own procedures and practice as part of a radical overhaul and modernisation of the civil court system.

219. The Committee endorses the recommendations of the Delegated Powers and Law Reform Committee in relation to the delegated powers in the Bill and asks the Scottish Government to respond to the concerns raised.
Children may be living in a residential establishment (which can be provided by a local authority or a third party) because no one can care for them at home or because they have complex disabilities.

The Fatal Accidents and Sudden Deaths Inquiry (Scotland) Act 1976

As defined from regulations made under the Public Services Reform (Scotland) Act 2010.

As defined in the Children (Scotland) Act 1995.

Inquiries into Fatal Accidents and Sudden Deaths etc. (Scotland) Bill. Explanatory Notes, page 3
Bremner, A. 2015. Inquiries into Fatal Accidents and Sudden Deaths etc (Scotland) Bill SB 15/23
Available at http://www.scottish.parliament.uk/ResearchBriefingsAndFactsheets/S4/SB_15-23_Inquiries_into_Fatal_Accidents_and_Sudden_Deaths_etc_Scotland_Bill.pdf [Accessed June 2015]

Inquiries into Fatal Accidents and Sudden Deaths etc. (Scotland) Bill. Policy Memorandum. page 2
Bremner, A. 2015. Inquiries into Fatal Accidents and Sudden Deaths etc (Scotland) Bill SB 15/23

The Review report can be viewed on the Scottish Government’s website

More information on these petitions can be found on the Committee’s website
http://www.scottish.parliament.uk/parliamentarybusiness/CurrentCommittees/88085.aspx

Inquiries into Fatal Accidents and Sudden Deaths etc. (Scotland) Bill. Policy Memorandum, page 2
Inquiries into Fatal Accidents and Sudden Deaths etc (Scotland) Bill

The HSE investigates between 25 and 35 work-related deaths and give evidence in approximately 10 to 15 FAIs each year.

Society of Solicitor Advocates - written submission FA40
The HSE investigates between 25 and 35 work-related deaths and give evidence in approximately 10
Inquiries into Fatal Accidents and Sudden Deaths etc. (Scotland) Bill. Financial Memorandum, page 28
Children may be living in a residential establishment (which can be provided by a local authority or a
Scottish Parliament Justice Committee Official Report. 5 May 2015, Col 2
Glasgow City Council FA13 – written submission
Letter from the Minister to the Convener – 4 June 2015
Mental Welfare Commission for Scotland – written submission FA17
Royal College of Psychiatrists in Scotland FA1
Scottish Government Response to the recommendations from the Review of Fatal Accident Inquiry

Inquiries into Fatal Accidents and Sudden Deaths etc. (Scotland) Bill. Policy Memorandum, page 22

http://www.scottish.parliament.uk/S4_Bills/Inquiries_into_Deaths_Scotland_Bill/b71s4-introd-pm.pdf [Accessed March 2015]
http://www.scottish.parliament.uk/parliamentarybusiness/CurrentCommittees/88085.aspx
The 1976 Act states that a mandatory FAI must be undertaken when a death has resulted from an accident occurring in Scotland while the person who has died, being an employee, was in the course of his employment or, being an employer or self-employed person, was engaged in his occupation as such.

Section 2(3)(b)
Figures supplied to the Scottish Government estimate that 59% of cases which would otherwise result in a mandatory FAI do not proceed because of this reason. Inquiries Into Fatal Accidents and Sudden Deaths etc (Scotland) Bill SP Bill 63-PM page 7

Written submission - Fire Brigades Union FA10

Scottish Parliament Justice Committee Official Report. 9 June2015, Col 44
Written submission – STUC FA37

Scottish Parliament Justice Committee Official Report. 9 June2015, Col 42


STUC – written submission FA37

Written submission – Scotland’s Campaign against Irresponsible Drivers FA4

[http://www.scottish.parliament.uk/S4_JusticeCommittee/Inquiries/FA4_.SCID.pdf] [Accessed May 2014]

STUC – written submission FA37


Scottish Parliament Justice Committee Official Report. 5 May 2015, Col 15
Written evidence – SCID FA4

Policy Memorandum, paragraphs 37 to 41 and 95


Inquiries Into Fatal Accidents and Sudden Deaths etc (Scotland) Bill SP Bill 63-PM page 11

Letter from the Minister to the Convener – 4 June 2015

Scottish Parliament Justice Committee Official Report. 9 June2015, Col 52
Letter from the Minister to the Convener – 4 June 2015

Scottish Parliament Justice Committee Official Report. 9 June2015, Col 53
144 Written submission – Scottish Legal Aid Board FA32
145 Inquiries into Fatal Accidents and Sudden Deaths etc. (Scotland) Bill. Delegated Powers Memorandum, page 3
[Accessed June 2015]
Annexe A

Extracts from the minutes of the Justice Committee and associated written evidence

10th Meeting, 2015 (Session 4) Tuesday 24 March 2015

Inquiries into Fatal Accidents and Sudden Deaths etc. (Scotland) Bill (in private): The Committee considered its approach to the scrutiny of the Bill at Stage 1 and (a) agreed the timetable for the scrutiny of the Bill; (b) agreed to issue a call for written evidence; and (c) considered a list of suggested witnesses.

11th Meeting, 2015 (Session 4) Tuesday 31 March 2015

Inquiries into Fatal Accidents and Sudden Deaths etc. (Scotland) Bill (in private): The Committee further considered its approach to the scrutiny of the Bill at Stage 1 and agreed panels of witnesses for its forthcoming evidence sessions.

14th Meeting, 2015 (Session 4) Tuesday 5 May 2015

Inquiries into Fatal Accidents and Sudden Deaths etc. (Scotland) Bill: The Committee took evidence on the Bill at Stage 1 from—

- Lord Cullen of Whitekirk
- Julie Love, Chairperson, Death Abroad - You’re Not Alone
- Louise Taggart, Founder Member, Families Against Corporate Killers
- Flt Lt James Jones RAF (Rtd), Campaigner

Written Evidence

- Death Abroad - You’re Not Alone
- Families Against Corporate Killers
- Flt Lt James Jones RAF (Rtd)

Supplementary Written Evidence

- Flt Lt James Jones RAF (Rtd)
- Flt Lt James Jones RAF (Rtd)
15th Meeting, 2015 (Session 4) Tuesday 12 May 2015

Inquiries into Fatal Accidents and Sudden Deaths etc. (Scotland) Bill: The Committee took evidence on the Bill at Stage 1 from—
Jake Molloy, Regional Organiser, National Union of Rail, Maritime and Transport Workers
Ian Tasker, Assistant Secretary, Scottish Trades Union Congress
Alistair McNab, Head of Operations in Scotland, Health and Safety Executive
Dr Gary Morrison, Executive Director (Medical), Mental Welfare Commission for Scotland
Cathy Asante, Legal Officer - Human Rights Based Approach, Scottish Human Rights Commission
Iain Miller, Executive Legal Manager, Glasgow City Council
Detective Chief Superintendent Robbie Allan, Police Scotland

Written Evidence
National Union of Rail, Maritime and Transport Workers
Scottish Trades Union Congress
Health and Safety Executive
Mental Welfare Commission for Scotland
Scottish Human Rights Commission
Glasgow City Council
Police Scotland

16th Meeting, 2015 (Session 4) Tuesday 19 May 2015

Inquiries into Fatal Accidents and Sudden Deaths etc. (Scotland) Bill: The Committee took evidence on the Bill at Stage 1 from—
James Wolfe QC, Dean, Faculty of Advocates
Tom Marshall, President, Society of Solicitor Advocates
Sheriff Gordon Liddle, Vice-President, and Sheriff Nicola Stewart, Sheriffs’ Association
The Rt Hon Lord Gill, Lord President and Lord Justice General
Eric McQueen, Chief Executive, Scottish Courts and Tribunals Service

Roderick Campbell declared an interest as a member of the Faculty of Advocates.

Written Evidence
Faculty of Advocates
Sheriffs’ Association
Lord President of the Court of Session

Supplementary Written Evidence
Society of Solicitor Advocates
17th Meeting, 2015 (Session 4) Tuesday 26 May 2015

Inquiries into Fatal Accidents and Sudden Deaths etc. (Scotland) Bill: The Committee took evidence on the Bill at Stage 1 from—
Lesley Thomson, Solicitor General for Scotland
Paul Wheelhouse, Minister for Community Safety and Legal Affairs,
Hamish Goodall, Policy Officer, Civil Law and Legal System Division, and
Greig Walker, Solicitor, Directorate for Legal Services, Scottish Government.

Inquiries into Fatal Accidents and Sudden Deaths etc. (Scotland) Bill (in private): The Committee considered the evidence received and agreed to further consider the evidence received at a future meeting in order to inform the drafting of its Stage 1 report.

Written Evidence
Crown Office and Procurator Fiscal Service

Supplementary written evidence
Crown Office and Procurator Fiscal Service
Scottish Government

20th Meeting, 2015 (Session 4) Tuesday 9 June 2015

Inquiries into Deaths (Scotland) Bill: The Committee took evidence on the Bill at Stage 1 from—
Patricia Ferguson MSP;
Patrick McGuire, Thompson’s Solicitors.

22nd Meeting, 2015 (Session 4) Tuesday 23 June 2015

Inquiries into Fatal Accidents and Sudden Deaths etc. (Scotland) Bill (in private): The Committee considered a draft Stage 1 report. Various changes were agreed to and the Committee agreed its report to the Parliament.
Annexe B

List of other written evidence

- Association of Personal Injury Lawyers
- Autism Rights
- Centre for Excellence for Look After Children in Scotland
- Commander Toby Everitt Royal Navy (Rtd)
- Digby Brown LLP
- Equality and Human Rights Commission
- Fire Brigades Union
- Forum of Scottish Claims Managers
- Healthcare Improvement Scotland
- Institution of Occupational Safety and Health
- Law Society of Scotland
- Pinsent Masons LLP
- Royal College of Nursing Scotland
- Royal College of Psychiatrists in Scotland
- Royal Society for the Prevention of Accidents
- Scotland’s Campaign against Irresponsible Drivers
- Scottish Civil Justice Council
- Scottish Legal Action Group
- Scottish Legal Aid Board
- Scottish Police Federation
- Sheriff Principal L Murray WS
- Stuart Graham
- Together (Scottish Alliance for Children’s Rights)
- Victim Support Scotland
- Zurich Insurance plc (UK Branch)
Inquiries into Fatal Accidents and Sudden Deaths etc. (Scotland) Bill (in private): The Committee considered its approach to the scrutiny of the Bill at Stage 1 and (a) agreed the timetable for the scrutiny of the Bill; (b) agreed to issue a call for written evidence; and (c) considered a list of suggested witnesses.
Present:

Christian Allard          Jayne Baxter
Roderick Campbell        John Finnie
Christine Grahame (Convener)  Margaret Mitchell
Elaine Murray (Deputy Convener)  Gil Paterson

Apologies were received from Alison McInnes.

Inquiries into Fatal Accidents and Sudden Deaths etc. (Scotland) Bill (in private): The Committee further considered its approach to the scrutiny of the Bill at Stage 1 and agreed panels of witnesses for its forthcoming evidence sessions.
Present:

Christian Allard  
Roderick Campbell  
Christine Grahame (Convener)  
Elaine Murray (Deputy Convener)  
Jayne Baxter  
John Finnie  
Margaret Mitchell  
Gil Paterson

Apologies were received from Alison McInnes

Inquiries into Fatal Accidents and Sudden Deaths etc. (Scotland) Bill: The Committee took evidence on the Bill at Stage 1 from—

Lord Cullen of Whitekirk;

Julie Love, Chairperson, Death Abroad - You’re Not Alone;

Louise Taggart, Founder Member, Families Against Corporate Killers;

Flt Lt James Jones RAF (Rtd), Campaigner.
Present:
Christian Allard  Jayne Baxter  
Roderick Campbell  John Finnie  
Christine Grahame (Convener)  Alison McInnes  
Margaret Mitchell  Elaine Murray (Deputy Convener)  
Gil Paterson  

Also present: Patricia Ferguson.

**Inquiries into Fatal Accidents and Sudden Deaths etc. (Scotland) Bill**:

The Committee took evidence on the Bill at Stage 1 from—

Jake Molloy, Regional Organiser, National Union of Rail, Maritime and Transport Workers;

Ian Tasker, Assistant Secretary, Scottish Trades Union Congress;

Alistair McNab, Head of Operations in Scotland, Health and Safety Executive;

Dr Gary Morrison, Executive Director (Medical), Mental Welfare Commission for Scotland;

Cathy Asante, Legal Officer - Human Rights Based Approach, Scottish Human Rights Commission;

Iain Miller, Executive Legal Manager, Glasgow City Council;

Detective Chief Superintendent Robbie Allan, Police Scotland.

Roderick Campbell declared an interest as a member of the Faculty of Advocates.

**Inquiries into Fatal Accidents and Sudden Deaths etc. (Scotland) Bill – witness expenses**: The Committee agreed to delegate to the Convener responsibility for arranging for the SPCB to pay, under Rule 12.4.3, any expenses of witnesses on the Bill.
Present:

Christian Allard  Jayne Baxter
Roderick Campbell  John Finnie
Christine Grahame (Convener)  John Lamont (Committee Substitute)
Alison McInnes  Margaret Mitchell
Elaine Murray (Deputy Convener)  Gil Paterson

Also present: Patricia Ferguson (items 2 and 3).

Inquiries into Fatal Accidents and Sudden Deaths etc. (Scotland) Bill: The Committee took evidence on the Bill at Stage 1 from—

James Wolfe QC, Dean, Faculty of Advocates;
Tom Marshall, President, Society of Solicitor Advocates;
Sheriff Gordon Liddle, Vice-President, and Sheriff Nikola Stewart, Sheriffs’ Association;
The Rt Hon Lord Gill, Lord President and Lord Justice General;
Eric McQueen, Chief Executive, Scottish Courts and Tribunals Service.

Roderick Campbell declared an interest as a member of the Faculty of Advocates.
Present:

Christian Allard
Roderick Campbell
Christine Grahame (Convener)
Elaine Murray (Deputy Convener)
Jayne Baxter
John Finnie
Alison McInnes
Gil Paterson

Apologies were received from Margaret Mitchell.

Inquiries into Fatal Accidents and Sudden Deaths etc. (Scotland) Bill: The Committee took evidence on the Bill at Stage 1 from—

Lesley Thomson, Solicitor General for Scotland;


Paul Wheelhouse, Minister for Community Safety and Legal Affairs, Hamish Goodall, Policy Officer, Civil Law and Legal System Division, and Greig Walker, Solicitor, Directorate for Legal Services, Scottish Government.

Inquiries into Fatal Accidents and Sudden Deaths etc. (Scotland) Bill (in private): The Committee considered the evidence received and agreed to further consider the evidence received at a future meeting in order to inform the drafting of its Stage 1 report.
Present:

Christian Allard  
Roderick Campbell  
Christine Grahame (Convener)  
Margaret Mitchell  
Gil Paterson

Jayne Baxter  
John Finnie  
Alison McInnes  
Elaine Murray (Deputy Convener)

Inquiries into Fatal Accidents and Sudden Deaths etc. (Scotland) Bill (in private): The Committee further considered the evidence received in order to inform the drafting of its Stage 1 report.
Present:

Christian Allard  Jayne Baxter
Roderick Campbell  John Finnie
Christine Grahame (Convener)  John Lamont (Committee Substitute) (item 2)
Alison McInnes  Margaret Mitchell (except item 2)
Elaine Murray (Deputy Convener)  Gil Paterson

Also present: Margaret Mitchell (member in charge of the Apologies (Scotland) Bill) (item 2).

Apologies (Scotland) Bill: The Committee took evidence, in round-table format, on the Bill at Stage 1 from—

Ronnie Conway, Co-ordinator in Scotland, Association of Personal Injury Lawyers;

David Stephenson QC, Faculty of Advocates;

Graeme Watson, Scottish representative, Clinical Negligence Sector Focus Team, Forum of Insurance Lawyers;

Laura Ceresa, Solicitor and member of the Society Health and Medical Law Committee, Law Society of Scotland;

Paul McFadden, Head of Complaints Standards, Scottish Public Services Ombudsman;

Charlie Irvine, Senior Teaching Fellow, University of Strathclyde;

Dr Sally Winning, Deputy Chair, British Medical Association Scotland;

Dr Anthea Martin, Joint Head of Medical Division, Medical and Dental Defence Union of Scotland;

Dr Gordon McDavid, Medicolegal Adviser, Medical Protection Society;

Bruce Adamson, Legal Officer, Scottish Human Rights Commission;

Geraldine McCann, Head of Administration and Legal Services, South Lanarkshire Council.
Roderick Campbell declared an interest as a member of the Faculty of Advocates.
Present:

Christian Allard  
Roderick Campbell  
Alison McInnes  
Elaine Murray (Deputy Convener)

Jayne Baxter  
John Finnie  
Margaret Mitchell  
Gil Paterson

Apologies were received from Christine Grahame (Convener)

Inquiries into Fatal Accidents and Sudden Deaths etc. (Scotland) Bill (in private): The Committee considered a draft Stage 1 report. Various changes were agreed to and the Committee agreed its report to the Parliament.
Inquiries into Fatal Accidents and Sudden Death etc (Scotland) Bill

Written submission from Death Abroad - You’re Not Alone

Background

After the sudden death of my son Colin Love in January 2009, I found there were no support mechanisms in place to assist me and my family at such a traumatic time. My son had died thousands of miles away in another country and there was no assistance whatsoever from any governing body in the UK. Appalled at this and the total lack of respect towards my deceased son I vowed to ensure no other family were treated like ours. Whilst I believe my son’s death was a tragic accident I was appalled to learn that enquiries were held for English citizens who died abroad and repatriated to the UK yet there was no legal equivalent in Scotland.

I first raised my concerns with my elected representatives for Glasgow City Council and went on to raise them with both my MP and MSP. I also put in writing to the Crown Office and the Scottish Youth Parliament.

Prior to my son’s death I discovered that on 7 March 2008, the Scottish Government had commissioned an independent review into the legislation which governed the operation of fatal accident inquiries (FAIs) in Scotland for more than 30 years. The Review, led by the Rt Hon Lord Cullen of Whitekirk KT, examined the operation of judicial inquiries into sudden, suspicious or unexplained deaths. The consultation paper was launched on 20th November 2008, when Lord Cullen invited responses by 20th February, 2009. With the help of my elected MSP I was able to make a late submission as the report was finally published in November 2009.

Researching this further and with the help of my son’s friend Kenny, we submitted a petition in September 2009 calling for the Scottish Parliament to urge the Scottish Government to give the same level of protection to the families of people from Scotland who die abroad as is currently in place for people from England by amending the Fatal Accidents and Sudden Deaths Inquiry (Scotland) Act 1976 to require the holding of a fatal accident inquiry when a person from Scotland dies abroad. This petition (PE1280 http://www.scottish.parliament.uk/Petitions_Archive/PE1280.pdf) is currently being considered by the Justice Committee and members recently indicated agreement for the petition to remain open during Stage 1 scrutiny of the Bill.

Many Scottish celebrities signed the petition and this prompted media attention and some families contacted me regarding issues surrounding the death of their loved one in another country, I quickly realised that additional support was required when a Scot died abroad no matter what the circumstances.

After meeting with many families I held a meeting at the Scottish parliament in January 2012, inviting affected families and their elected MSP’s. The decision was
taken by a group of families to apply for charitable status which was subsequently pursued and granted in September 2012 and DAYNA was formed.

**Introduction of FAIs for Scots deaths abroad**

I speak for many bereaved Scots families who feel that they have not had a voice in the current Scottish legal system, they welcome this major change to Scots law and the impact this will have for future families who find themselves in such a traumatic situation. In the past they have been powerless to pursue an inquiry when their loved ones death was suspicious or they feel wasn't investigated properly. Of course we cannot insist on other countries carrying out an investigation to the same high standard as Police Scotland but we can now set up a process to allow a FAI when and if appropriate.

The statistics regarding Scots deaths abroad are scarce and whilst an average of 300 per year has been estimated, going by recent referrals to DAYNA we believe there would be no more than 3 required in a 12 month period. Logistically we don’t believe that this would involve a substantial change and that systems could be developed seamlessly. An analogy would be if a foreign tourist were to die in Scotland in suspicious circumstances. (ie. recently Karen Buckley).

We have supported many Scottish families over the years but also families from all regions of the UK and are conscious that many areas need change and not only that of FAI’s for Scots deaths abroad and we seek as part of this process a body is set up to encompass relevant organisations / interested parties to submit their proposals. I believe this is currently being reviewed by the Scottish Office.

Communication with families is important and they should be fully informed and have realistic expectations of what results will come from the inquiry process.

Bob Doris MSP submitted evidence and refers to when bodies repatriated to England and Wales undergo a post mortem, like Bob, I believe it is imperative that this practice is constituted in Scots Law and should also apply in cases where the Lord Advocate does not deem a FAI to be necessary. Where a FAI is not deemed necessary by the Lord Advocate there is still a lot of room for improvement in the support offered to families.

I also question that the sole responsibility lies with the highest office in the land, The Lord Advocate. Surely a Procurator Fiscal could have the legal authority to allow for an FAI to be held in their jurisdiction.

DAYNA has many examples of failings in the investigatory process of families whose loved ones have died abroad.

**Julie Love**  
**Chairperson**  
**Death Abroad - You're Not Alone**  
**30 April 2015**
1. Families Against Corporate Killers (FACK) is an ever-growing group of families, united by the bond of having lost loved ones in work-related incidents. These families have formed a national campaigning network which aims to stop workers and others being killed in preventable incidents and which will direct bereaved families to sources of legal help and emotional support, as well as advocacy and support through investigation and prosecution processes.

2. Families bereaved as a result of unsafe and unhealthy workplaces are angry and frustrated. They feel they have been robbed twice: once of their loved ones in incidents that should have been prevented if employers had simply obeyed the law on workplace health and safety; and secondly of their right to justice.

3. In respect of fatal accident inquiries, there are a number of current failures in the processes which we would like to see remedied, because families who have lost loved ones in work-related incidents want to know as quickly as possibly the how and why of their loved one’s death, and they want to know that lessons are going to be learned to stop others losing their lives or their loved ones in incidents that could and should be prevented.

4. Not all of the families referred to in this evidence have made contact with FACK, but we understand and share their frustrations and concerns and therefore use them for illustrative purposes.

Time limits and timing of FAIs

5. Time limits within which an FAI should be convened must be introduced in order to put an end to the years families are currently having to endure waiting for answers. We also believe the practice of holding off on having an FAI until after the criminal proceedings have been concluded needs to be reviewed. Inquests most commonly take place in England and Wales before the criminal proceedings. We would rather an FAI was commenced within months of a death and adjourned to allow the criminal proceedings to take place should that be deemed necessary, than for an FAI to either not take place, or to take place many years after the death. Fourteen-year-old army cadet Kaylee McIntosh died in a drowning incident on 3 August 2007. Within around 6 months of her death, the Marine Accident Investigation Branch had issued an interim report. Such reports state at their outset: “This report is not written with litigation in mind and, pursuant to Regulation 13(9) of the Merchant Shipping (Accident Reporting and Investigation) Regulations 2005, shall be inadmissible in any judicial proceedings whose purpose, or one of whose purposes is to attribute or apportion liability or blame.”

1 https://assets.digital.cabinet-office.gov.uk/media/547c701eed915d4c1000006f/RigidRaiderReport.pdf
Were such reports to be issued by the HSE, these could be considered alongside witness testimony at an FAI convened in early course.

6. The death of firefighter Ewan Williamson has been a focus for the media in recent months following the guilty plea by the Fire Service. This comes nearly 6 years after Ewan’s death. The press release issued by COPFS\(^2\) after the conclusion of the criminal proceedings stated “Crown Counsel will consider whether or not it is in the public interest to hold a Fatal Accident Inquiry” into his death.

7. So, families are being asked for their views after the conclusion of criminal proceedings which, as Ewan’s case illustrates, can be very many years on from the death. It is not difficult to understand why their views may be rather different after such a length of time, than they would have been just months after the death. A family will very often end up exhausted by the process. Because all too often families are left to engage in a battle with the justice system, a system which should be there to serve them. And just when they are getting to the end of the criminal processes, energies drained, they are being asked to put themselves through more pain to get answers they should have had years ago, and to what end, because any recommendations that could be made are not enforceable, not meaningful. So, little wonder many decide it is not for them.

8. It is the rule, not the exception, for families to have to wait lengthy periods for answers. We would therefore take issue with the assertion in the policy memorandum accompanying the Bill that Lord Cullen’s recommendation in this regard - that FAI’s should be held as promptly as possible after the death - has been implemented. The widows of the three men who died on the Flying Phantom had to wait nearly 7 years for the conclusion of criminal proceedings and for the decision to be taken not to proceed with an FAI\(^3\). The families of those the 16 men who lost their lives in the Super Puma helicopter had to wait nearly 5 years before an FAI was held into their deaths\(^4\).

9. It is utterly unacceptable that families are having to wait so long for answers as to why their loved ones died. The stress of getting through each day without a husband, son, parent, sibling etc by your side is hard enough. Doing that while not knowing how or why they died makes it all the more unbearable.

10. That is not to say that some healing does not take place during the wait for answers. It can. But then any wounds which have begun to heal are ripped open again by finding out new information so long after the event. So, for example, an FAI was held into the death of Dr Graham Meldrum at Allied Bakeries on 12 July 2005\(^5\), a death caused by his head being impaled on the faulty tail-lift of a truck. His partner, friends and family, more than 3 years after his death, had to listen as lawyers argued about which way the blood had been running down his head. They also found out that at least 4 reports had been made in the course of 2 years leading


\(^5\) [https://www.scotcourts.gov.uk/opinions/meldrum.html](https://www.scotcourts.gov.uk/opinions/meldrum.html) [Link no longer active]
up to Graham’s death about faulty tail lifts on the company’s lorries. Opportunities to perhaps have prevented Graham’s death, being disclosed 3 and a half years after his death, and acting like body blows.

**Witness testimony**

11. There is also a very real issue with the quality of witness testimony so long after the event. The families of the 9 people who died in the ICL Stockline explosion – which occurred on 11 May 2004 - waited more than 4 years for a public inquiry into their loved ones’ deaths to begin, and a further year for the final inquiry report to be published. In the lead up to the inquiry, some expressed the opinion that one key problem they could foresee was the fact that survivors didn’t want to be involved. Many were back at work and didn’t want to talk.

12. In other circumstances families have spoken of witnesses saying one thing in the immediate aftermath of the incident which led to the death, then, years on during FAI, inquest or court proceedings, their recollection has either changed, or is so hazy as to be worth very little. This might be because they truly don’t remember because of the passage of time. It may also be because they have been promoted within the same company and don’t want to be seen rocking the boat. Or it may be that they were dismissed after the incident in question and having subsequently found it difficult to find work, they don’t want to be seen raising their head above the parapet again.

13. Often, where a “mandatory” FAI does not take place, it is because it is said that the full facts and circumstances have been explored in criminal proceedings. Yet, in those criminal proceedings, there has often been no trial as the employer has pled guilty. We therefore question how the full facts and circumstances can have been explored when witnesses have not been heard from.

**Learning lessons and making enforceable recommendations**

14. The policy memorandum issued alongside the Bill states that “of the 50-60 inquiries held every year, very few ever come to the attention of the Government, Parliament of the media.” This in itself is surely indicative of the fact that lessons are not being learned from the current system.

15. Expediency is again an issue in ensuring lessons are learned. Brian French, a father of five, and Colin Ferguson were killed when their Land Rover was crushed by a 100 tonne truck at Pennyvenie opencast mine on 26 February 2007. Other than a standard letter received a month later, Brian and Colin’s families received no information from the procurator fiscal until more than 15 months after the deaths of their loved ones. This came only after they wrote to the then Lord Advocate to tell her they had been very patient, and they thought some might say too patient because in the months they waited for news about a prosecution, Jim Griffin (a father of three) was crushed between 2 dumper trucks at Pennyenie. The FAI into the deaths of Brian and Colin didn’t take place until more than 4 years after their deaths.

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7 [https://www.scotcourts.gov.uk/opinions/2011FAI32.html](https://www.scotcourts.gov.uk/opinions/2011FAI32.html) [Link no longer active]
It is painful to suggest, but perhaps if it had been held sooner, Jim’s death could have been avoided.

16. Two years after the death of Michael Adamson in an electrical incident, his sister read about Barry Martin, electrocuted at work in 2003. Barry’s employer had failed to ensure power switches were safely isolated to prevent their inadvertent reconnection. The judge described the 4 years it took to get that case to court as a “matter of regret”. Michael’s sister puts it more strongly than that, because her brother died because of that exact same failure, as did 6 other electricians between 2004 and 2006. Barry Martin's death did not take place in Scotland. But if it had, and if an FAI had taken place swiftly, with binding recommendations made to electrical contractors, Michael's death (and others) may very well have been avoided. The public interest would therefore be served by ensuring binding recommendations can be made (preferably by specialist sheriffs).

Fatal incident inquiries

17. Far too often a work-related death is described as an “accident waiting to happen”. We dispute whether an accident waiting to happen can truly be described as an accident. We would therefore advocate a change of focus away from “accident” to “incident”.

Conclusion

18. A family who loses a loved one in a work-related incident needs to know that the death has not been for nothing. There is a fundamental need to know that some good is going to come from the death. We would urge you to put that at the heart of your deliberations on the Bill.

Families Against Corporate Killers
30 April 2015

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8 http://news.bbc.co.uk/1/hi/england/essex/6647121.stm
Justice Committee

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

Written submission from Flt Lt James Jones, RAF (Rtd)

Preamble

1. On 3rd July 2012 two Tornado GR4 aircraft collided over the Moray Firth, killing three crew members. The aircraft were operating in what is known as class G airspace (uncontrolled, “see and avoid”) and in poor weather conditions (fog/mist). Following the accident a Service Inquiry (once know as a Board of Inquiry) was carried out by the Military Aviation Authority (MAA), which is part of the Ministry of Defence (MoD). The inquiry was governed by strict terms of reference set out by the MAA.

2. Since the completion of the Service Inquiry (SI) in November 2013, and the report’s release to the general public in June 2014, the President of the Inquiry Panel has made it known through a series of emails that (a) he felt bound by the terms of reference, (b) that he was prevented from pursuing certain issues for fear of drawing the Duty Holder (a senior RAF officer into court, and (c) that he did not feel that the Panel had the expertise to explore all aspects of the accident.

3. The President is of the belief that his report should not prejudice an Fatal Accident Inquiry, as this would be the only forum were the accident could be examined by more qualified people (as per his recommendation) and the legal aspect of the Duty Holder’s safety statement could be examined. All of the above facts have been made known to the Crown Office.

Call for a Fatal Accident Inquiry

Aim of a Fatal Accident Inquiry

4. According to recent statements from the Crown Office the purpose of a FAI is simply to establish the cause of death and any lessons which are to be learned are learned for the future. For me this is where the Crown Office’s case not to hold an FAI falls down, as they are only prepared to consider issues brought out by the Service Inquiry. The President of the SI Panel has made it clear that he was prevented from exploring other areas, and that his Panel did not have the necessary expertise to analyse the issue fully.

5. From the Determination set out by Sheriff Principal Derek Pyle in the Super Puma case, he sees one of the main purposes of an FAI as being “an opportunity for the whole circumstances of an accident to be aired in public. [Where] witnesses are examined and cross-examined under oath and documents are considered and scrutinised” The Tornado investigation falls well short of that, and in doing so fails to learn lessons for the future.
6. The Fatal Accidents and Sudden Deaths Inquiry (Scotland) Act 1976 makes provision for what can be regarded as the mandated route, and the discretionary route.

**Mandated route**

7. Since the release of the Service Inquiry report into the public domain there have been numerous calls for a Fatal Accident Inquiry, from the families, the media, and local politicians. To this end the Crown Office’s attention was drawn to the fact that the 1976 FAI Act mandates a FAI for an employee who dies whilst engaged in the course of his/her employment. The reply from the Crown Office was a little surprising;

The current legal position in Scotland is described in The Stair Memorial Encyclopaedia on Armed Forces Chapter 6 which notes “the terms of engagement of members of the Armed Forces are not contractual. All such members are appointed by the Crown under the Royal Prerogative and hold their appointments whatever their rank at the Crown’s pleasure. They may be dismissed at any time without notice and without any cause being assigned.” Consequently members of the armed forces on duty are not considered to be within the course of "employment" and therefore not within the scope of s. 1(1) (a) (i) of the 1976 Act. N.B. See email attachment.

8. This interpretation of the employment status for members of the Armed Service seems to be at variance with that presented by Lord Neuberger in the Smith v MoD (Snatch Land Rover) case. At the 2012 appeal regarding loss of life due to inadequate equipment Lord Neuberger said: "The duty of care owed by the Ministry of Defence, as employer, to the members of the armed forces, as employees, does exist and has been recognised, without demur, by the courts. It includes a duty to provide safe systems of work and safe equipment.” In the case of the Tornado accident MoD (the employer) failed to provide a safe system of risk assessment and safe equipment for the three crew members (employees) who lost their lives.

9. Whilst the Smith v MoD case focussed on “duty of care”, Lord Neuberger clearly identifies members of the Armed Forces as “employees” and the MoD as their “employer”.

**Discretionary route**

10. The basis of the discretionary route rest on public interest, however this has been rejected by the Crown Office on the grounds that the Service Inquiry was very detailed, considered all relevant factors relating to the accident, and any FAI would simply duplicate the months of though work undertaken by the MAA. Clearly, the post inquiry statements made by the President have been ignored.

11. In rejecting this route the Crown Office seems to overlook an important aim of an FAI/Inquest, namely providing public reassurance. There has been no independence (MoD is allowed to judge their own case), so almost by definition there can be no public reassurance. One has tried to demonstrate to the Crown Office in Scotland that public reassurance has NOT been provided because MoD omitted key
facts from the SI report - e.g. the ejection seat safety case, CWS history, validity of risk assessment Tornado Airworthiness Review Team Report etc.

12. Furthermore, it should be borne in mind that "public reassurance" and "airworthiness" are inextricably linked, something the Crown Office may not appreciate. That is because airworthiness is defined as "the ability of an aircraft or other airborne equipment or system to operate without significant hazard to aircrew, ground crew, passengers (where relevant) or to the general public over which such airborne systems are flown". It follows that, by MoD’s own definition, the airworthiness of military aircraft is in the "public interest". The MoD regard the risk of collision as a “Societal Risk”.

13. Returning to the Super Puma case Sheriff Principal Pyle makes it clear that the detailed investigation by the AAIB took 30 months, twice as long as the Tornado SI, and whilst no party questioned the technical data an FAI was established in the public interest. This alone should set a precedent for the Tornado case.

Preventing re-occurrence

14. An important goal of any FAI/inquest is preventing reoccurrence. Whilst most of the discussions to date have focussed on the lack of a Collision Warning System in Tornado aircraft, the accident could have been prevented if the risk of collision had been correctly identified, assessed and managed. As things stood at the time of the Moray Firth collision the safety standard (Tolerable and ALARP) set by the MAA was so subjective that Duty Holders choose to state whether it is or is not safe depending on how they feel the risk is mitigated. (SI Presidents opinion, but not reflected in report). In 2012 the Duty Holder signed off to say that the risk was Tolerable and ALARP, and three people lost their lives. THAT SAFETY STANDARD IS STILL IN PLACE TODAY.

15. In accordance with MAA regulations, set up post Haddon-Cave, MAA RA 1210 makes it clear that Duty Holders are legally accountable for safe operation of systems in their area of responsibility and for ensuring that Risk to Life are at least Tolerable and ALARP. The same regulation goes on to say "the ODH [Operational Duty Holder] is required to make an argument that the risk is ALARP ...................The validity of this argument can only be decided definitively by the courts, if an accident occurs." As things stand at the moment, the Duty Holder’s safety statement will never be tested in a court, and if flawed will remain in effect.

16. It is worth noting that the previous DG MAA, in a letter to the 2nd PUS dated 8th Feb 2011, stated that the ALARP argument was flawed. Both he and the President of the SI Panel do not believe that the risk was/is Tolerable and ALARP (Safe).

Common application of law

17. In September 2012 a change in English and Welsh law meant that investigations into the death of Scottish service people killed abroad (away from home) could take place in Scotland in the form of a Fatal Accident Inquiry, rather than at an inquest in England. The first Chief Coroner of England and Wales was
granted the power to recommend to the Lord Advocate, Scotland's top law officer, that an investigation be transferred to Scotland. It came after changes were made to the Coroners and Justice Act 2009 and it is hoped the new provisions will reduce the ordeal families who have lost a loved one face.

18. In addition, on 20th March 2015, just one week after the Crown Office decided not to hold an FAI into the Tornado collision, a bill was presented in the Scottish Parliament with the aims to enact new provisions to modernise the system of FAIs in Scotland, to extend the categories of death in which it is mandatory to hold an FAI, and permit discretionary FAIs into deaths of Scots abroad where the body is repatriated to Scotland. Minister for Community Safety Paul Wheelhouse stated:

"Fatal Accident Inquiry legislation needs to be brought into the 21st century and this Bill will undoubtedly improve the FAI process in this country. In particular, the introduction of the possibility of a Fatal Accident Inquiry for deaths abroad is a hugely important step in providing answers for families".

19. In view of all the changes to the laws affecting Scottish personnel, it only seems fitting that the families of English personnel, killed outside England, should have the right to seek a public inquiry in the form of an Inquest in England rather than an FAI in Scotland.

20. Furthermore, it also makes sense that there is commonality in the way that air accidents are dealt with in England, Wales and Scotland. It seems totally unacceptable that had the accident occurred over the Lake District, for example, there would have been a Service Inquiry followed by a Coroner’s Inquest. However, because it happened over Scottish territorial waters an FAI is denied because the Tornado crews were not employees, and the Crown Office does not consider the event to be in the public interest.

21. It is ironic to think that had the crew of Nimrod XV230 been repatriated to Scotland for an FAI, rather than an inquest, then applying the same logic as that applied to the Tornado case, no further examination of the facts would have taken place. No Coroner’s Inquest and no Haddon-Cave.

The way forward

22. The interpretation of the current Act, by the Crown Office, discriminates against members of the Armed Forces in that (a) They are not regarded as “employees” (b) Written evidence from MoD in the form of Service Inquiries reports is regarded as being sufficient to satisfy the requirements of a Fatal Accident Inquiry, (c) Public interest is not given the same importance as in civil accidents, and (d) Fails to consider the wider implications of accidents in Scotland, which have safety implication throughout the United Kingdom

23. It is therefore recommended that the new bill should;

- Make it clear that members of the Armed Forces are “employees” when carrying out their duties.
• Ensure that written evidence from MoD should be seen as just one source and "an opportunity for the whole circumstances of an accident to be aired in public. [Where] witnesses are examined and cross-examined under oath and documents are considered and scrutinised"
• Ensure that the criteria for public interest should be common to both civil and military accidents.
• Provide non-Scottish families, whose deceased were killed in Scotland, an opportunity to select a coroner's inquest.
• Ensure that when a military accident occurs, as a result of factors that affect the whole fleet, the most stringent inquiry route is adopted (FAI or Inquest)
• In the event of fresh evidence coming to light, subsequent to an FAI being rejected, the need for an FAI should be reviewed.

James Jones
10 April 2015

Emails regarding employment status of armed services personnel

Dear Mr Jones,
The current legal position in Scotland is described in The Stair Memorial Encyclopaedia on Armed Forces Chapter 6 which notes "the terms of engagement of members of the Armed Forces are not contractual. All such members are appointed by the Crown under the Royal Prerogative and hold their appointments whatever their rank at the Crown's pleasure. They may be dismissed at any time without notice and without any cause being assigned."

Consequently members of the armed forces on duty are not considered to be within the course of "employment" and therefore not within the scope of s. 1(1) (a) (i) of the 1976 Act.

I hope this explanation is helpful.

A MacDonald
SFIU North Principal Investigator

Dear Mr MacDonald,
Please can you advise me on a matter relating to FAIs? I read on the COPS website that:
"Fatal Accident Inquiries in Scotland are held in terms of the Fatal Accident and Sudden Deaths Inquiry (Scotland) Act 1976. There are two classes of inquiry in terms of the Act, mandatory inquiries in terms of Section 1 (1) (a) of the Act which apply to deaths which have either resulted from an accident occurring while the person was in the course of his or her employment or where a person was at the time of their death in legal custody."

In view of the fact that the three Tornado crew members died in an accident whilst employed by the MOD place the event in the mandatory category?

James Jones
Justice Committee

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

Supplementary written submission from Flt Lt James Jones, RAF (Rtd)

Appendix 1 - notes for witnesses on service inquiry procedures and giving evidence

1. Service inquiries are held under the authority of the Armed Forces Act 2006 and the Armed Forces (Service Inquiries) Regulations 2008.

2. The function of a service inquiry is to discover, in accordance with its Terms of Reference, the facts of a matter and any circumstances leading to it, with a view to determining why the incident occurred and what should be done in future to prevent a recurrence. Such an inquiry does not seek to attribute blame or legal liability. It works from Terms of Reference set by the convening authority who is a senior officer with responsibility for the area or establishment where the matter under investigation occurred.

3. The inquiry is undertaken by a panel consisting of a president and 2 or more other members, generally servicemen; but civil servants (or foreign servicemen) are sometimes included. The panel is formed to investigate a specific matter. It carries out its investigation by taking evidence from people involved in or connected with the incident, and technical experts. To reach its findings it may need to review procedures and policies. Once the panel has gathered all the evidence it is required to produce a report in which it may express its findings (based on the evidence) about the matter investigated, and it may make recommendations, or express opinions in accordance with its Terms of Reference in respect of preventing recurrences.

4. The panel will assemble in a suitable place, normally an office, conference room, or classroom on a Service unit/ship/establishment, over a number of days or weeks to carry out its work. The place where the panel sits will depend on the incident being investigated. The panel is not confined to one place and may need to travel between two or more locations to complete its tasks.

5. A service inquiry is not a court; it is not open to the public; it is not adversarial; and it does not make legal rulings. It is important to draw a distinction between the work of a service inquiry and proceedings before a civil court, a Coroner's Inquest or a Fatal Accident Inquiry in Scotland. In a case involving a death, the service inquiry report will, however, be made available to the Coroner or Procurator Fiscal to assist him with his proceedings, if the inquest/inquiry into a death has not already been concluded.

Giving evidence

6. Usually witnesses will travel to the place where the service inquiry is sitting in order to give evidence, which the president may require to be given on oath or solemn affirmation. You may be recalled as required. It may be possible
for the panel to travel to you or for you to give evidence by video teleconferencing or by other means, if the president of the service inquiry considers this appropriate or necessary.

7. When you are called to attend the inquiry the following procedure should be adopted:

October 2008 Version 1.0

Letter from the Ministry of Defence to James Jones

Dear Mr Jones

Thank you for your email of 30 September 13 requesting the following information:

"In July 2012 two Tornado aircraft from RAF Lossiemouth collided over the Moray Firth. The MoD announce that a Board of Inquiry would be set up in order to investigate the cause of the accident. Please can I have a copy of the BO/ report?"

I am treating your correspondence as a request for information under the Freedom of Information Act 2000 (FOIA).

A search for the information has now been completed within the Ministry of Defence, and I can confirm that some information in scope of your request is held.

The Service Inquiry (SI) is being conducted internally and is expected to complete by the end of October 2013. It is possible that this accident may lead to a Scottish Fatal Accident Inquiry, to place this information into the public domain ahead of the Inquiry would risk prejudicing its proceedings and could potentially affect its outcome. The final report will be published on the MOD Publication Scheme once agreed with the Procurator Fiscal. As such, this comes under Section 22 of the FOIA, which exempts from disclosure information intended for future publication.

If you are not satisfied with this response or you wish to complain about any aspect of the handling of your request, then you should contact me in the first instance. If informal resolution is not possible and you are still dissatisfied then you may apply for an independent internal review by contacting the Deputy Chief Information Officer, 2nd Floor, MOD Main Building, Whitehall, SW1A 2HB (e-mail CIO-FOI-IR@mod.uk). Please note that any request for an internal review must be made within 40 working days of the date on which the attempt to reach informal resolution has come to an end.

If you remain dissatisfied following an internal review, you may take your complaint to the Information Commissioner under the provisions of Section 50 of the Freedom of Information Act. Please note that the Information Commissioner will not investigate your case until the MOD internal review process has been completed. Further details of the role and powers of the Information Commissioner can be found on the Commissioner's website, http://www.ico.gov.uk.
Extract from the Mull of Kintyre Review

3. Previous Reviews and Inquiries

3.1 Introduction

3.1.2 The RAF Board of Inquiry immediately convened to investigate the accident and following extensive investigation delivered its report to the RAF Higher Authority on 3 February 1995. The findings were reviewed and signed off by the Higher Authority (the Reviewing Officers) on 3 April 1995. The report was then passed to the RAF Inspectorate of Flight Safety and the Ministry of Defence. On 15 June 1995 specialist officers from the RAF, who were able to discuss and explain the Board's findings, handed over the report to most of the next of kin. The then Secretary of State for Defence, the Rt Hon Malcolm Rifkind MP, made a statement to the House of Commons announcing the Board's findings and the placing of the Military Aircraft Accident Summary in the House of Commons Library. As an unclassified document it did not detail the comments of the chain of command.

3.1.2 A Board of Inquiry was an internal process convened for Armed Services reasons to determine how a serious incident happened and why, and to make recommendations to prevent a recurrence. The Board of Inquiry was not a substitute for a legal inquiry into the cause and circumstances of a death. So on completion of the Board the Ministry of Defence discussed with the Lord Advocate (the chief law officer in Scotland) and Solicitor General for Scotland (responsible for the Procurator Fiscal Service who were the public prosecution service and carried out functions broadly equivalent to a coroner) the need to hold a public Fatal Accident Inquiry under Section 1(l)(a)(i) of the Fatal Accident and Sudden Deaths Inquiry (Scotland) Act 1976. Shortly before publication of the Board of Inquiry report the Lord Advocate concluded that a Fatal Accident Inquiry was necessary because some of those on board at the time of the crash were engaged in the course of their employment and, while not mandatory in respect of all of the deaths, the inquiry should relate to all on board. The Inquiry was held over 18 days in Paisley Sheriff Court from 8 January to 2 February 1996 and heard from 38 civilian and military witnesses. The Sheriff found that he could not determine the cause of the accident and did not agree with the determination of gross negligence by the Reviewing Officers.

3.1.3 Following the Sheriff's determination questions were raised about the inconsistency between the two inquiry findings and particularly the difference of opinion between the Board and the Reviewing Officers. In the intervening years the accident has been debated in and outside Parliament and a number of articles have been written and broadcast.
3.1.4 The concerns raised prompted the House of Commons Defence Committee to investigate the lessons to be learned from the accident with the Committee reporting in May 1998. The Committee was clear from the outset that it was not a further "court of appeal" but sought to clarify the conflicting messages about the possible cause of the accident. This investigation was followed by the Parliamentary Public Accounts Committee in November 2000, who investigated the Ministry of Defence's acceptance into service of the Chinook HC-2.
Justice Committee

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

Supplementary written submission from Flt Lt James Jones, RAF (Rtd)

I understand that the taking of evidence officially concluded on 26th May 2015, but I respectfully ask that I be afforded the opportunity, granted to others, to raise observations on past evidence which I believe should be brought to the attention of the Justice Committee. Only now do I have a copy of the transcript of the evidence given on 26th May, and a copy of Mr Stephen McGowan’s important letter. I think that it is worth noting that had the COPFS evidence been presented on 12th May, as originally planned, I would have been making these comments earlier. I confine my observation to “errors in fact”.

The reference in Mr McGowan’s letter to the 3rd Edition of Carmichael on Sudden Deaths and Fatal Accident Inquiries is a misquote. Paragraph 2-07 actually states, “It must be borne in mind that deaths of police officers on duty and deaths of members of the forces, regular or part-time and including visiting forces, while on duty, do not count as deaths in the course of employment for the purpose of s.1(1)(a)(i)” No explanation is given as to why it should be borne in mind. So if Carmichael is an authoritative book on the law of Scotland, then any FAI Bill amendment needs to cover more than just the military. Having said that, paragraph 2-55 of Carmichael claims that a discretionary FAI was held for the Mull of Kintyre accident because all those on board were members of the armed forces. This is not correct as there was a mixture of civilian and military personnel. According to Lord Philip’s 2011 review the FAI was held because the Lord Advocate concluded that some on board were engaged in the course of their employment. The accuracy of Carmichael therefore becomes questionable.

Mr McGowan’s reference to section 1A of the 1976 Act is a further misquote. This section refers to a referral being made under section 12 of the Coroners and Justice Act 2009 by the Secretary of State, or Chief Coroner, because it is thought that it may be appropriate for the circumstances a death to be investigated under the Fatal Accident and Sudden Deaths Inquiry (Scotland) Act 1976. The paragraph in question actually states “Subsection (4) applies where the Lord Advocate decides it would be appropriate in the public interest for an inquiry under the Act to be held in the circumstances of the death, and does not reverse that decision”. The Act, in this case, refers to the Coroners and Justice Act 2009, and the Lord Advocate, who is always acting in the public interest, has a choice of accepting the referral or “reversing it”; in other words rejecting it and sending it back under section 13 of the 2009 Act (see attached). The Lord Advocate exercises his discretion in determining whether or not the case should be held in Scotland or not; this is not the same as a discretionary FAI referred to in section 1(1)(a)(ii) of the 1976 Act. It is noted that Section 7 of the new Bill does not comply with section 50 of the Coroners and Justice Act 2009, in its entirety. It removes mandatory requirements on Procurator Fiscals, subsection (4), and inserts the word “if”, which gives the impression of a discretionary FAI.
Finally, I would like to address the Lord Neuberger issue. Yes it is true that Lord Neuberger did not actually draw up the Judgement that was done by Lord Justice Moses. However, all three judges agreed with the judgement and because Lord Neuberger was the senior judge he was given the credit by the media. But who drew up the judgement is not the issue it is the confirmation of the employer/employee relationship between members of the armed services and MoD. I attach extracts from the 2012 agreed ruling for perusal by committee members. There was no need for consideration in detail by the Supreme Court because the relationship was historically well established for UK forces deployed in the UK. I sense from Mr McGowan’s letter that the Crown Office seems to accept the employer/employee relationship in terms of duty of care and negligence, but is that not what section 1(1)(a)(i) is about? Isn’t that the reason why the employer is invited to attend the inquiry; section 4(3)?

Having brought this issue to the table I firmly believe that the problem simply exist because the interpretation of “employee”, adopted by the Crown Office, is not in keeping with that of a “reasonable person”, in the legal sense. Any future FAI bill should try and incorporate the phrase used by Lord Cullen in his recommendations, namely “work related deaths”, with a clear definition of intent as to what that means.

James Jones
30 May 2015
Court of Appeal

Hearing dates: 25th-27th June, 2012

Before

LORD NEUBERGER, MASTER OF THE ROLLS
LORD JUSTICE MOSES
and
LORD JUSTICE RIMER

Judgment, As Approved by the Court

38. It is beyond dispute, and the MOD did not purport to dispute, that it owed a duty of care at common law to members of the armed forces as their employer. Nor was it disputed that health and safety provisions contained in Sections 2-4 and 6-7 of the Health and Safety Act 1974 and in Regulations made under Section 15 imposed statutory duties on the MOD. For example, it is required to secure suitable personal protective clothing and adequate information, instruction and training about such equipment under the Personal Protective Equipment at Work Regulations 1992, to construct or adapt work equipment so that it is fit for purpose under the Provision and Use of Work Equipment Regulations 1998, to make a suitable and sufficient assessment of risks to health and safety, and to secure adequate health and safety training on recruitment, or when exposed to new or increased risks, under the Management of Health and Safety Regulations 1999. The territorial scope of those Regulations is limited to Great Britain (Section 84(1), extended to Northern Ireland by Order in Council under Section 84(3) of the 1974 Act).

39. The employer’s duty of care, at common law and statutory duties imposed under Regulation, have been deployed against the MOD in numerous previous cases: in Chalk [2002] EWHC 422 (QB) (injury caused by avalanche to member of a RAF rescue team on training exercise), Fawdry [2003] EWHC 322 (QB) (ill-fitting helmet causing injury on exercise to trainee at Sandhurst), Hanks [2005] EWHC (injury to neck caused by breach of the 1992 Regulations during naval flight training exercise), Hopps [2009] EWHC 1881 (QB) (electrical engineer, working under the protection of the MOD in Iraq, injured by IED due to failure to provide suitable armoured vehicle). Most of these cases failed on their facts, but their significance lies in the MOD’s acceptance of the duties alleged.

46. But in the instant cases, the claimants have no need to make any such assertion. The duty of care owed by the Ministry of Defence, as employer, to the members of the armed forces, as employees, does exist and has been recognised, without demur, by the courts. It includes a duty to provide safe systems of work and safe equipment, as I have demonstrated. There was no suggestion that the courts were ill-equipped to deal with such issues, or that the resolution of the claims would be detrimental to the troops. The question whether a duty of care owed by the MOD to armed forces should be recognised has long since been answered. There is no basis for asking it in the instant appeals.
52. The fact that policy considerations and the scarcity of resources will arise in relation to allegations of negligence against the Ministry of Defence provides no basis for distinguishing the MOD from any other public body in relation to the duty it owes to its employees. That no such distinction is to be drawn is further underlined by the absence of any statutory prohibition against making claims for negligence.

55. It is not possible to distinguish consideration by the courts of the duty of care owed by the MOD to its employees, the armed forces, from the duty owed by other public authorities, save in one well-recognised respect: combat immunity. But the very existence of that immunity fortifies the view that in respect of actions or omissions outside its scope there is no reason to preclude an action in negligence.

Coroners and Justice Act 2009

13 Investigation in England and Wales despite body being brought to Scotland

(1) The Chief Coroner may direct a senior coroner to conduct an investigation into a person's death if—

(a) the deceased is a person within subsection (2) or (3) of section 12,

(b) the Lord Advocate has been notified under subsection (4) or (5) of that section in relation to the death,

(c) the body of the deceased has been brought to Scotland,

(d) no inquiry into the circumstances of the death under the Fatal Accidents and Sudden Deaths Inquiry (Scotland) Act 1976 (c. 14) has been held (or any such inquiry that has been started has not been concluded),

(e) the Lord Advocate notifies the Chief Coroner that, in the Lord Advocate's view, it may be appropriate for an investigation under this Part into the death to be conducted, and

(f) the Chief Coroner has reason to suspect that—

(i) the deceased died a violent or unnatural death,

(ii) the cause of death is unknown, or

(iii) the deceased died while in custody or otherwise in state detention.

(2) The coroner to whom a direction is given under subsection (1) must conduct an investigation into the death as soon as practicable.

This is subject to section 3.
Justice Committee

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

Written submission from the National Union of Rail, Maritime and Transport Workers

RMT welcome the Scottish Government’s Fatal Accident Inquiries and Sudden Deaths Etc. (Scotland) Bill and the opportunity to contribute to the formulation of legislation to improve and modernise the Fatal Accident Inquiry process. We are also particularly grateful for the opportunity to submit evidence to the Justice Committee as part of its essential role in scrutinising Scottish Government legislation.

We note that the Bill’s provisions are largely based on the recommendations emanating from Lord Cullen’s 2009 Report into the FAI system and elements of Patricia Ferguson MSP’s Inquiries into Deaths (Scotland) Bill. As such, the union agrees with the general direction and most of the aims of the Bill, particularly on flexibility over location and accommodation of an FAI, the preliminary inquiry process, FAIs into deaths that occurred abroad and extending the categories of death to which a mandatory FAI will apply.

In the following areas, however, we either disagree with the Government’s proposals or seek further clarification of the implications of the Bill’s provisions as they stand. Therefore, we would like to bring the following concerns to the attention of Justice Committee members:

- **Requirements to respond to an FAI determination** – We are concerned that the requirement to respond to a determination is not sufficiently compelling. RMT accept the arguments made by the Scottish Government against making determinations legally binding but still regard the current proposals as lacking regulatory teeth. In our view, one of the major shortcomings of the FAI process under the 1976 legislation (as amended) is this lack of statutory compulsion and sanction around the sheriff’s determinations. We do not see any significant changes in the Bill which would give determinations greater force, in terms of compliance.

  Under the future FAI process envisaged by the Bill, witnesses are compelled to appear at an FAI under threat of criminal sanction. Yet those persons to whom a sheriff’s determination or determinations are directed at the end of an FAI merely have to respond, explaining why they have or have not complied with the determination(s). We see no sanction on those who do not even respond and this must be addressed if FAIs are to become more relevant to the families of victims of fatal incidents at work and for the industries in question to learn any available lessons.

- **Start of an FAI** – as RMT stated in response to the Scottish Government’s consultation last year on its draft proposals for FAI reform, we support statutory timeframes between the death of a worker and the start of an FAI. We note the arguments made against timeframes in the Policy Memorandum issued by the Scottish Government but continue to believe that the most effective way of reducing the time lag in the overall FAI process would be to...
impose a statutory timeframe for the start of an FAI. We also contend that the fact that an FAI is usually mandatory is undermined by the lack of statutory certainty over the timeframe within which the FAI must start.

In RMT’s experience, criminal proceedings into the circumstances of deaths at work do not necessarily guarantee justice for the families of victims or meaningful lessons for the industry over the safety of its future operations. For example, the FAI into the deaths of two offshore workers, Keith Moncrieff and Sean McCue on the Brent Bravo platform on 11 September 2003 only took place after concerted trade union pressure. This campaign was necessary because the employer, Shell pleaded guilty to all charges at the criminal trial. Although Shell was fined (£900,000, reduced because of an early guilty plea) and corporate culpability for the deaths of the two workers was established, the trial itself did not provide meaningful justice for the families, so an FAI was the only alternative.

However, Sheriff Harris’s determinations, issued July 2006 were necessarily limited to the circumstances that led to the deaths of the two workers in question but provided clear grounds for action to improve the safety of repair operations on aging offshore hydrocarbon extracting platforms. Yet the lack of compulsion on Shell to respond makes it difficult to see how effective these determinations were in making the necessary operational and safety improvements, at that company and across the industry. We do not see the Bill as a means of substantially reducing delays in the FAI process or improving the overall effectiveness of determinations issued by the sheriff.

We acknowledge that this is a difficult area and we withdraw our previous proposal for a three month timeframe. FAIs should not, of course impede the full and detailed investigation of workers’ deaths, particularly in complex circumstances like offshore helicopter incidents. However, we believe that the Bill as framed does not strike an effective balance between investigatory processes, the needs of victims’ families and the adoption of new working practices or other changes to avoid potentially fatal industrial circumstances being repeated in the future. In our view, addressing the time lag between the death of a worker and the start of an FAI must be the focus of any legislation that seeks to make the FAI process more effective and efficient.

- **Clarity on the input of trade unions into the FAI process** – RMT continue to seek clarity on the role trade unions can play in the reformed FAI process envisaged by the Bill. Trade unions play a vital role in supporting and advising the families of victims of workplace deaths and in assessing workplace safety standards, both existing ones and those that may be introduced in response to a sheriff’s FAI determination. As such, we believe that trade unions need to be named in the Bill as organisations that are entitled or likely to be entitled to submit evidence as part of an FAI.

- **Extension of the Bill to cover deaths caused by industrial illnesses** – We believe that this would be an effective means of requiring companies to maintain employer liability insurance records, in order to avoid any repeat of the tragic and unjust situation faced by mesothelioma sufferers who cannot
trace liable parties, having been diagnosed with an aggressive, terminal illness caused by the industry the worker was employed in.

- **Status of determinations in re-opened FAIs** – We support the proposal to permit re-opening of an FAI in light of new evidence and would simply compare this provision with the UK Government’s recent and dangerous decision to abolish the duty on the Secretary of State for Transport to re-open a maritime accident investigation in light of new evidence. However, it is unclear whether or not existing determinations will be completely wiped from the record in the event of an FAI being re-opened in light of new evidence and we are concerned that a re-opened FAI can only issue one determination.

In our view, the existing determinations and any responses to them should remain valid, with no limit on the number of determinations that a sheriff can make following the re-opened FAI.

- **Jurisdictional issues** – RMT support the proposals on extending the FAI process to cover deaths abroad but we remain unclear over the status of the FAI process in the context of seafarer deaths in Scottish waters or in international waters off the Scottish coast. The union is especially concerned by the specific example of the tragic sinking of the *Cemfjord* in the Pentland Firth on 2nd January 2015 with the loss of all eight crew. The Maritime Accident Investigation Branch report is not expected until the end of this year, at the earliest and the flag state, Cyprus where the *Cemfjord* was registered will be responsible for conducting any subsequent safety investigation into the incident. The Cypriot register is an ‘open’ register, or Flag of Convenience (FoC) which attracts vessels by applying minimum international standards of safety and crewing levels. RMT believe that there is a moral duty on the Scottish and UK Governments to ensure that lessons are learnt from the sinking of the *Cemfjord*, as FoC registers are no guarantee that this will happen.

The *Cemfjord* tragedy also bears disturbing similarities to the sinking of another bulk carrier off the UK coast, the Cook Island registered *MV Swanland* in the Irish Sea on 27th November 2011 which resulted in the deaths of six Russian seafarer ratings. The MAIB investigation found a catalogue of structural problems going back over a decade and a failure of the Cook Islands register to conduct a structural survey since the vessel was registered with them in 2009 up until the vessel’s loss. However, the legal limitations on MAIB investigations and subsequent reports prevented any compelling recommendations, despite the considerable evidence supporting the view that the *Swanland* was not seaworthy and should never have been in service. The Cook Island Register (which, bizarrely, is not classified as a FoC) has only provided general reassurances in response to the MAIB’s Report into the *Swanland* in June 2013 which highlighted serious problems with the condition of the vessel. We do not wish to see a repeat of this disgraceful and immoral dereliction of duty in the case of the *Cemfjord*.

RMT
29 April 2015
Introduction

The STUC is Scotland’s trade union centre. Its purpose is to co-ordinate, develop and articulate the views and policies of the trade union movement in Scotland; reflecting the aspirations of trade unionists as workers and citizens.

The STUC represents over 627,000 working people and their families throughout Scotland. It speaks for trade union members in and out of work, in the community and in the workplace. Our affiliated organisations have interests in all sectors of the economy and our representative structures are constructed to take account of the specific views of women members, young members, Black/minority ethnic members, LGBT members, and members with a disability, as well as retired and unemployed workers.

As an organisation, the STUC believes that where individuals lose loved ones through work related injury or occupational disease our justice system is woefully inadequate in delivering the answers they deserve within a reasonable timescale, denying them the opportunity to reach a position where they can perhaps begin to move on.

The STUC welcomes the opportunity to provide this written submission and would wish to make the following comment:

1. Timescales

1.1. The STUC believes more needs to be done to ensure that decisions to hold Fatal Accident Inquiries are taken at the earliest opportunity and with transparency. The length of time from a fatal injury occurring, potential criminal prosecution and a Fatal Accident Inquiry being held neither serves the interest of bereaved families nor the need for lessons to be learned to prevent similar tragedies in future.

1.2. In our experience of working with bereaved families including the majority of families who lost loved ones in the ICL factory explosion in Maryhill their sole priority is to be provided with answers in relation to the circumstances of their loss and, commendably, to try to ensure that others do not suffer similar tragedies.

1.3. While we accept that delivering decisions whether to prosecute or not at an earlier stage was not the main driver for the COPFS Health and Safety Prosecution Division being set up we had hoped closer working between the COPFS and the HSE would have resulted in such decisions, criminal proceedings and inquiries taking place within shorter timeframes than previously. The STUC does not believe there has been any noticeable change in this regard.

1.4. Current timescales lead to increased anxiety for those families and frustration for trade unions seeking to support loved ones of a deceased member. The STUC is
disappointed that the Scottish Government Bill does not adequately address the issue of delays.

1.5. The STUC believes that providing timescales would help to provide families of the deceased with a reasonable expectation of when an inquiry is likely to be held in both circumstances, where no criminal or other investigation is taking place and where such investigations are necessary.

1.6. We believe that the timescales proposed by Patricia Ferguson MSP in her Inquiries into Deaths (Scotland) are necessary in order to address one of the most significant failures in the current system.

2. Families' role in fatal accident inquiries

2.1. The STUC supported moves to set up the COPFS Health and Safety Prosecution Division in order to provide a more consistent and effective approach to prosecuting health and safety offences.

2.2. Notwithstanding the comments in para 1.4 above we believe the new prosecution division has improved communication between the COPFS and bereaved families during the investigation stage through a dedicated Victim Information and Advice Officer.

2.3. However, in our experience, families have no opportunity to make submissions or representations on the scope of any inquiry into the loss of their loved ones.

2.4. Therefore the STUC believes that prior to the full hearing taking place should have the right to make representations to the Sheriff for his or her consideration. This is not in any way detrimental to the integrity of the inquiry or the independence of the judiciary but would provide greater transparency and confidence in the system by giving bereaved families the right to make submissions on matters important to them.

2.5. We also believe that the role of trade unions when supporting the families of deceased members should be taken into account and provision should be made for trade unions to make similar representations.

3. Sheriff's recommendations

3.1. The STUC believes that recommendations arising from Fatal Accident Inquiries could play an important role in improving workplace health and safety but this can only be done by making such recommendations legally binding.

3.2. We are not convinced that proposals to ensure that any participant in an inquiry to whom a recommendation is addressed responds to the Scottish Courts and Tribunals Service outlining compliance, or otherwise, with recommendations will make any significant change in changing behaviour or preventing similar tragedies in future.
3.3. Widespread dissemination of findings and recommendations through appropriate industry bodies is welcome although we would doubt whether this alone will encourage change in the absence of legally binding recommendations.

4. **Extending the range of mandatory fatal accident inquiries**

4.1. The STUC supports the extension of mandatory inquiries to include deaths resulting from occupational disease subject to appropriate safeguards being on place to avoid overloading the system.

4.2. We continue to believe that deaths resulting from disease or exposure from substances hazardous to health should be treated in the same way as other work related deaths and to continue to ignore the potential effects of emerging technologies and the chemicals involved in new manufacturing processes is wrong.

4.3. Inclusion of occupational disease within the mandatory inquiry could allow essential lessons to be learned and, as a result of proper examination as part of an improved inquiry process, potentially identify risks to health and life at the earliest possible stage.

4.4. The STUC believes that appropriate tests have been put in place in the proposals being out forward by Patricia Ferguson MSP to ensure the Lord Advocate has adequate powers to rule such an inquiry unnecessary where no further lessons can be drawn from the death. This would ensure that in the case of long latency disease where the nature of the disease and material exposed to are known and, in the absence of any further lessons to be learned, then an inquiry could be ruled out by the Lord Advocate.

5. **Deaths occurring abroad**

5.1. We would support the Lord Advocate having discretionary powers to instruct inquiries where sudden unexplained deaths occur abroad and the body is repatriated to Scotland.

5.2. Of particular interest to the STUC and our affiliated trade unions would be where such a death is related to an individual’s work.

5.3. Many workers have to look abroad for work as evidenced by the recent downturn in the offshore industry. In such cases workers are often going to countries with less established occupational health and safety legislative or enforcement regimes.

5.4. Holding inquiries into fatal accidents, with or without the co-operation of the state in which the death occurred would provide answers for the bereaved family and, at the same time, inform the wider public including employers of potential dangers of working in particular jurisdictions.
6. Funding

6.1. The STUC believes that families of those who lose loved ones in a sudden and unexplained nature should have the right to independent legal representation and should not have to have the procurator fiscal imposed upon them as the sole inquisitor in the Fatal Accident Inquiry process.

6.2. We support the view of Lord Cullen that legal aid should be available for families wishing to be represented at inquiries and we also agree that it should not be incumbent on them to justify the reasonableness of any such request.

STUC
5 May 2015
Justice Committee

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

Written submission from the Health and Safety Executive

Health and Safety Executive Response to Scottish Government Consultation Questionnaire:

Mandatory categories of FAIs

Question 1:
Do you think that the current mandatory provision for work-related deaths is sufficient?

Yes. HSE is content with the current mandatory category provisions for work-related deaths.

HSE supports the opinion expressed in the consultation document under the heading ‘Work-related Deaths’ that it is not clear what purpose would be served by extending FAIs to include industrial diseases. The resultant increase in the numbers of FAIs would also put further pressure on HSE’s resources.

In cases of death resulting from occupational diseases, HSE supports, where applicable, the greater use of the discretionary powers by the Lord Advocate, provided by section 1(b) of the Fatal Accidents and Sudden Deaths Inquiry (Scotland) Act 1976.

Question 2:
Do you agree that a death which occurs when a person is ‘arrested or detained by police’ should be subject to a mandatory FAI?

This category of incident should be mandatory. The HSE already investigates appropriate cases in accordance with the Work-related Deaths Protocol Scotland (WRDPS). In cases where a death was in police custody, the investigation would be in conjunction with the Police Investigations and Review Commissioner (PIRC). HSE agrees that the definition of “legal custody” requires updating.

Question 3:
Should the death of a child in ‘secure care’ be subject to a mandatory FAI?

HSE has no view on this issue.

Question 4:
Do you agree that any other categories of residential childcare, which are not defined as ‘secure care’, should not result in a mandatory FAI?

HSE has no view on this issue.
Question 5a:
Do you think the aim of an independent investigation into the death of a person subject to compulsory detention by a public authority, that retains the traditional role of the Lord Advocate, should be met by an investigation by the procurator fiscal and exercise of the Lord Advocate’s discretion on completion of that investigation?

HSE has no view on this issue.

Or

Question 5b:
Alternatively, do you think the option of a case review by a public authority such as the Mental Welfare Commission could be combined with a discretionary power to hold an FAI?

HSE has no view on this issue.

Question 6:
What impact do you think that the proposals in relation to the mandatory categories of FAIs will have on you, your organisation or community?

The proposals, should they be adopted, will increase the number of FAIs to which HSE gives evidence, thereby increasing pressure on HSE’s resources (see answer to Q1).

Deaths abroad

Question 7:
Should the Lord Advocate have discretion to hold an FAI into the death of a person domiciled in Scotland who dies abroad where the body is repatriated to Scotland?

Yes. This may be a very useful way of accessing information on situations that have arisen elsewhere, but may have direct implications not only in Scotland, but in GB as a whole. One example is a death abroad involving an adventure activity, in which lessons could be identified and learned via an FAI. The same is true for other work areas such as offshore worker deaths.

Question 7a:
If you answered ‘yes’ to question 7, should the criteria to consider include:

(i) Whether there had been circumstances which called for investigation
Yes

(ii) Whether there had been a satisfactory investigation (in the country where the death took place)
Yes

(iii) Whether there was a prospect of an FAI yielding significant findings
Yes
Question 7b:
*If you answered ‘no’ to any of the criteria in question 7a, please provide reasons for your answer.*

N/A

Question 8:
*What impact do you think this proposal will have on your, your organisation or community?*

Assuming that HSE’s view would be sought in such cases, it is likely that there will be an increase in FAIs where HSE might be expected to give evidence.

**Delays**

Question 9:
*Do you agree with Lord Cullen’s view that “it is plainly not practical or realistic to make it mandatory that an FAI must open within a certain period of the date of the death of the deceased… because of the diversity and potential complexity of the cases” which may mean that an incident is not properly investigated?*

Yes. The complexities of many investigations preclude the use of a fixed timetable for the opening of an FAI. That said, the question of delay in investigation is real and this should be minimised, wherever possible. However, HSE believes that it is possible to achieve this without resorting to the inflexibility of a fixed timetable. The text on page 18 does not quite reflect the reality of joint working between HSE, police and COPFS under the Scottish Work-related Deaths Protocol (WRDPS) where the pace of investigation is a factor. COPFS, via its Health and Safety Division and SFIU, direct the police and do have more control of the process than is suggested. HSE believes that, in some instances, it is possible to speed up the process. To achieve this, an early formal investigation review process, by the police, HSE and COPFS, should be introduced. This should include, amongst other matters, consideration of how to minimise delay. This tripartite approach is encouraged by the WRDPS. HSE believes that some delay in its investigations arises because of the need for the police to exclude breaches of the Corporate Manslaughter and Corporate Homicide Act 2007 (CMCH Act). The police retain “primacy” for the investigation in such cases and it can be difficult for HSE to influence the pace of the investigation effectively.

Question 10:
*Do you agree that preliminary hearings should be held to help speed up the process of FAIs?*

Yes. HSE supports Lord Cullen’s recommendation and the Scottish Government position that the introduction of preliminary hearings in Glasgow and Edinburgh Sheriff Courts is good practice, beneficial, and should be extended. Agreement of evidence and issues enables the FAI to concentrate on areas of disagreement and, consequently, to speed up the hearing process. However, there is a risk that preliminary hearings may increase the amount of HSE resource required (there is some evidence that this has been our experience in England and Wales) and, as
such, HSE would suggest that there needs to be some control on their timing and content.

**Question 11:**
**Will having pre-hearing meetings of experts speed up FAIs?**

Yes. This is a key issue. Some FAIs require expert input from HSE, and identifying areas of agreement and disagreement will not only assist the FAI process, but will improve the quality of evidence presented to the Sheriff. This proposal may also help to reduce further the adversarial nature that has crept into the system. The HSE view is that the Fiscal should manage the meeting.

**Question 12:**
**Will hearing some business in sheriffs’ chambers help speed up FAIs?**

Yes. As the FAI is not designed to be adversarial, but in some cases has become so, steps such as this would reduce opportunities to introduce an adversarial approach (for example, rehearsing civil claims and attempts to apportion blame). This may speed up FAIs.

**Question 13:**
**Do you agree the proposal of permitting the submission of statements to the sheriff in advance of the FAI?**

Yes. This proposal should require that statements are circulated to all participants to enable scrutiny of all witness evidence. HSE’s view is that this is a move towards a more inquisitorial approach, which we would support.

**Question 14:**
**Should the sheriff principal be able to transfer the case to a different sheriffdom (area) if this is thought appropriate and if it may speed up the holding of the FAI?**

Yes. HSE supports any procedural means of speeding up FAIs.

**Question 15:**
**What impact do you think that the proposals to speed up FAIs will have on you, your organisation or community?**

Improving FAI efficiency will potentially have an impact on HSE and result in savings of staff time and public money. This resource could be redirected to HSE’s other regulatory work, including inspections.

**Fatal Accident Inquiry accommodation**

**Question 16:**
**Do you agree with the proposal that the majority of FAIs should be dealt with in ad hoc locations, but FAIs which relate to deaths in rural or remote areas should still be dealt with in local sheriff courts?**
Yes. HSE supports this view, not least because of the pressures on courtroom availability in the major population centres, and it also recognises the needs of bereaved families.

Question 17:
Do you think that all FAIs in Scotland should be held in three bespoke, dedicated centres?

No. HSE agrees with the position suggested in question 16.

Question 18:
What impact do you think that the use of FAI centres, or taking FAIs out of sheriff courts, will have on those attending FAIs?

HSE can see a benefit to families. However, there is insufficient information for HSE to have a view on the impact on witnesses. HSE experience is that the current adversarial court setting does mean that witnesses are not relaxed and this can affect the quality of their evidence. Again, HSE’s position is provided in its response to question 16.

Sheriffs’ recommendations

Question 19:
Should it be mandatory for all FAI determinations, subject to redaction, to appear on the SCS website and be fully searchable?

Yes. As significant HSE and public resource goes into FAIs, HSE believes that lessons learned need to be made more accessible and searchable for regulators and the public. The additional transparency of the system will help engender further confidence in it.

Question 20:
Do you think that sheriffs should instruct the dissemination of their recommendations (if any) to the parties to whom they are addressed and any appropriate regulatory bodies?

Yes. Provided that the implementation of recommendations is not mandatory, HSE supports the Scottish Government view on this. Given HSE’s GB wide remit, adopting this position would align England and Wales with Scotland. There are benefits to HSE in this.

Question 21:
Do you agree that parties to whom sheriffs’ recommendations are addressed should be obliged to respond to the sheriff who presided over the FAI indicating what action had been taken? This would be on the basis that those parties would not be obliged to comply with the sheriff’s recommendations, but if they have not complied, they would be obliged to explain why not.

Yes. HSE feels that anyone to whom a recommendation is directed, whether represented or not, should be consulted by the Sheriff ahead of its release. HSE also
supports the introduction of a mandatory report back to the Sheriff. HSE agrees that, in cases of non-compliance, this should include detailed reasoning. Advance notification of the recommendation to the party concerned would be important from the Sheriff’s point of view as implementation may result in further risk being created elsewhere. HSE would assume that Sheriffs would not want to be in that position.

**Question 22:**
What impact do you think that the proposals regarding sheriffs’ recommendations will have on you, your organisation or community?

HSE does not foresee any significant impact, as it already reacts positively to determinations.

**Legal aid for bereaved relatives**

**Question 23:**
Do you agree that the existing arrangements for legal aid for bereaved families at FAIs should remain?

HSE has no view on this issue.

**Question 23a:**
If you answered ‘no’ to question 23, in what ways would you change the arrangements for legal aid for bereaved families?

HSE has no view on this issue.

**Question 24:**
What impact do you think this proposal will have on your, your organisation or community?

HSE has no view on this issue.

Health and Safety Executive
29 April 2015
Justice Committee

Inquiries into Fatal Accidents and Sudden Death etc (Scotland) Bill

Written submission from the Mental Welfare Commission for Scotland

1. The Mental Welfare Commission for Scotland is a statutory body established under the Mental Health (Care and Treatment) (Scotland) Act 2003, with powers under that Act and the Adults with Incapacity (Scotland) Act 2000 to protect and promote the human rights of people with mental health problems and learning disabilities, particularly if subject to detention or other compulsory care and treatment.

2. Those powers include a power to conduct investigations where we consider that a person with mental disorder may have been subject to ill-treatment, neglect, or deficiency in care or treatment. In some cases, we will formally investigate deaths of people subject to detention under this power. We expect to be notified of all deaths by suicide of detained patients.

3. Our response specifically concerns recommendation 6 of the Cullen report, that there should always be an independent investigation for the death of a person subject to compulsory detention by a public authority within the meaning of section 6 of the Human Rights Act. This recommendation is not being taken forward in the Bill.

4. The Policy Statement for the Bill states at para 78 that: The Mental Welfare Commission Scotland and the Royal College of Psychiatrists both oppose mandatory FAIs for patients who are subject to compulsory mental health detention orders and have commented that deaths of this category of patient give rise to no more concern than deaths of other mental patients.

5. It is correct that the Commission does not advocate a mandatory FAI for every death of a patient who has been subject to detention at the time of death. However, our position is more nuanced than the above comment would suggest. (We mention in passing that we also would not use the phrase ‘mental patients’, which is an old fashioned term and perceived as derogatory).

6. We investigated the deaths of detained patients in 2012/13. Our report is available at http://www.mwcscot.org.uk/media/175822/death_in_detention_final.pdf

7. That report did indeed find that patients subject to detention were no more likely to die than other people being treated for mental illness, learning disability or related conditions, and that it was important to maintain a policy focus on the much wider issue of the huge inequality of life expectancy between the general population and people with mental health problems.

8. It also found that, of 73 deaths about which we had information, 39 died from natural causes where death was expected, and 14 died suddenly from natural causes not related to mental health treatment. So in at least 2/3 of these deaths, it is difficult to see what value would have been added by an FAI.
9. Eleven cases were suicides, and we would certainly argue that suicide while a patient is detained merits careful review. But even there, we are not persuaded that every such case should result in a FAI.

10. We responded to the Government’s consultation on its response to the Cullen report. See http://www.gov.scot/Resource/0046/00460923.pdf at File 039. We favoured a middle ground between the Cullen recommendation of an FAI in every case, and maintaining the status quo (which involves COPFS investigations leading to a small number of discretionary FAIs; a separate process of critical incident reviews by local services; and some investigations by the MWC.)

11. Our preference was for a streamlined, transparent, and proportionate investigatory framework, with a proper hierarchy of investigation for all cases, including an independent element of oversight into local reviews. Under this model, FAIs would be reserved for particularly troubling or difficult cases which require full public scrutiny. The details of our proposal are outlined at the response to Questions 5A and 5B of the consultation.

12. The analysis of the consultation responses suggested that the majority of responses favoured the status quo, and some had concerns about a new approach. See http://www.gov.scot/Publications/2014/11/2861/0 at paragraphs 2.38 to 2.52. However, it is not easy to follow the reasoning of some of these responses, and it may be that they had not had an opportunity fully to consider what might be proposed. We maintain our preference for this new model, for a number of reasons.

13. Firstly, while we have said that we have no reason to suppose that detained patients are more at risk of death than other patient, and certainly not that the process of detention might be a cause of death (unlike, for example, some of the concerns about restraint in police custody), we agree with the basic point that society should be particularly concerned about people who die when their liberty has been removed by the state.

14. We are also doubtful that the current system lives up to the expectations of Article 2 of ECHR, as developed by caselaw. We refer the Committee to the Equality and Human Rights Commission report on Preventing Deaths in Detention of Adults with Mental Health Conditions; particularly pages 25 and 26 which set out the responsibilities of the State to make sure there is an effective investigation into every death from non-natural causes in state detention. http://www.equalityhumanrights.com/publication/preventing-deaths-detention-adults-mental-health-conditions

15. The deficiencies of the current system, judged against these standards, include:
   i. Independence is not guaranteed. Some suicides will be investigated by a local review without an independent element
   ii. Most reviews are not open to public scrutiny, even in an anonymised form
   iii. The involvement of next of kin is variable
iv. The fact that there are potentially three different modes of investigation (local review, FAI and MWC review), sometimes compounded by other investigations by bodies such as the Care Inspectorate and the Health and Safety Executive, means that investigations do not always ‘begin promptly and conclude as quickly as is reasonable’. We are aware of cases where a decision on whether to hold an FAI is outstanding, many months after the death.

v. Although Healthcare Improvement Scotland make efforts to share learning from suicides across the NHS, this is dependent on the quality and focus of local reviews, which can be highly variable.

vi. The process of investigation is unnecessarily confusing and stressful for services and families, since it can involve different agencies investigating in different ways, with a lack of overall co-ordination.

16. This picture is not universal, and we commend the efforts of HIS, COPFS and many local health boards to improve the quality and impact of investigations into suicides and other unexpected deaths. Nevertheless, we believe that more needs to be done to make the process efficient, effective and co-ordinated in every case, and to ensure compliance with Article 2 obligations.

17. We are open-minded about whether this requires to be enshrined in primary legislation or developed through protocols and joint working between the key agencies (COPFS, HIS, MWC etc.). But we urge the Justice Committee to take steps to ensure that such a system is put in place.

Colin McKay, Chief Executive
Gary Morrison, Executive Director (Medical)
28 April 2015
Justice Committee

Inquiries into Fatal Accidents and Sudden Death etc (Scotland) Bill

Written submission from the Scottish Human Rights Commission

The Commission welcomes the opportunity to comment on the Inquiries into Fatal Accidents and Sudden Deaths etc. (Scotland) Bill. We welcome the implementation of Lord Cullen’s recommendations, which have the potential to increase human rights protection. In particular, the issue of investigations into deaths in mental health detention is a matter on which we have called for action\(^1\). We take this opportunity to comment on the proposals in relation to this issue. Therefore we direct ourselves towards the question of whether the circumstances for mandatory FAIs provided for in the Bill are sufficient.

Legal Framework

- European Convention of Human Rights (ECHR)
- Scotland Act 1998
- Human Rights Act 1998
- UN Convention on the Rights of Persons with Disabilities (UNCRPD)

1. Article 2 ECHR provides that “Everyone’s right to life shall be protected by law”. This includes positive obligations to protect individuals from real threat to life. These positive obligations include a procedural element which requires effective domestic investigation of deaths to ensure the protection of life.

2. The procedural obligation has particular weight in circumstances where there is potential for State responsibility. The European Court of Human Rights (the Court) has found that “Where lives have been lost in circumstances potentially engaging the responsibility of the State, Article 2 entails a duty for the State to ensure, by all means at its disposal, an adequate response – judicial or otherwise – so that the legislative and administrative framework set up to protect the right to life is properly implemented and any breaches of that right are repressed and punished”\(^2\).

3. The essential purpose of investigation is to secure the effective implementation of the domestic laws which protect the right to life and, in those cases involving State agents or bodies, to ensure their accountability for deaths occurring under their responsibility\(^3\). Within those bounds, the Court has allowed flexibility as to the form of investigation.


\(^2\) Öner yıldız v Turkey (2005) 41 E.H.R.R. 20 at para 91

\(^3\) Jordan v United Kingdom (2003) 37 E.H.R.R. 2 at para 105
4. There are, however, certain essential requirements:

- **Independence**: The investigation must be carried out by a body with both institutional or hierarchical independence, and also practical independence from those implicated in the events.\(^4\)
- **Effectiveness**: The investigation must be effective in the sense that it is capable of leading to a determination as to whether or not the behaviour or inactivity was justified and to the identification and punishment of those responsible. The authorities must take reasonable steps to secure the evidence concerning the incident including, amongst other things, eye witness testimony, forensic evidence and, where appropriate, an autopsy which provides a complete and accurate record of injury and an objective analysis of clinical findings, including the cause of death.\(^5\)
- **Promptness and reasonable expedition**\(^6\)
- **Public scrutiny**: there must be a sufficient element of public scrutiny of the investigation or its results to secure accountability in practice as well as in theory.\(^7\)
- **Involvement of next of kin**: The next of kin must be involved to the extent necessary to safeguard their legitimate interests.\(^8\)
- **Initiated by the State**: The authorities must act once the matter comes to their attention rather than leaving it to the next of kin to instigate.\(^9\)

5. In considering when the procedural obligation of Article 2 arises, there is a particular obligation to provide explanations for deaths in custody or detention, in recognition of the fact that people in custody are in a vulnerable position and the authorities are under a duty to protect them.\(^10\) The Court has also recognised that the position of inferiority and powerlessness which is typical of patients confined in psychiatric hospitals calls for increased vigilance in reviewing whether the Convention has been complied with.\(^11\)

**Comments on the Bill**

6. The Bill does not take forward Lord Cullen’s recommendation that mandatory FAIs should extend to cases where the deceased is subject to compulsory detention by a public authority within the meaning of Section 6 of the Human Rights Act, such as those subject to mental health detention. The Commission considers that a gap remains in the investigation of deaths in mental health detention, in respect of which a clear system requires to be set up to adequately meet the procedural requirements of Article 2, set forth by the Court.

7. The policy memorandum expresses the view that the current system, of a graduated scale of investigations,\(^12\), is broadly sufficient. The Commission, however,

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\(^6\) *McKerr*, supra at footnote 3
\(^7\) Ibid
\(^8\) *Güleç v Turkey* (1999) 28 E.H.R.R. 121
\(^10\) *Salman v Turkey* (2002) 34 E.H.R.R. 17
\(^12\) Graduated scale of investigations:
concurs with the MWC who, in their response to the consultation preceding this Bill, said “there needs to be a clearer set of arrangements which provides appropriate assurance in all such deaths, with a proportionate hierarchy of investigations. The current system is confusing, with gaps, overlaps and uncertainties.”\textsuperscript{13}

8. The policy memorandum also explains that “Article 2 is realised in Scotland by systems of general application such as an effective criminal and civil justice system (for example damages actions for wrongful deaths), the regulation of dangerous activities, and high ethical and professional standards in the field of medicine”. These systems do not, however, address the obligation (highlighted above) to provide explanations for deaths in custody or detention, nor do they meet the Article 2 requirements set out earlier, such as independence, public scrutiny or initiation by the state. In addition, these systems do not serve the same purposes as an FAI, in that they would not provide a forum to consider what precautions or improvements might be taken or made to prevent other deaths in similar circumstances in the future.

9. The Commission appreciates the concern that there would be little public interest in holding a mandatory FAI in all situations of detention, without distinction, given that many of those deaths will occur from natural causes. We do not therefore propose such a blanket requirement. We do, however, believe that steps need to be taken, to ensure that systems of investigation meet the Article 2 requirements outlined above and to remedy the current gaps and confusion. In responding to the consultation\textsuperscript{14}, we expressed the view that a case review by a public authority such as the MWC, combined with a discretionary power to hold an FAI, could comply with Article 2 requirements if implemented in the following form: an initial investigation by an independent public body to rule out deaths from natural causes; in all other circumstances, a mandatory FAI would be triggered. The Commission considers this a reasonable proposal which could meet Article 2 requirements while providing a degree of flexibility, as endorsed by the Court.

10. The Commission also considers that the proposals by the MWC in their response to the consultation merit further consideration, as a means of addressing Article 2 requirements and meeting the goals of an FAI, as follows:

“We propose that there should be a statutory requirement to notify any death of a patient subject to a compulsory order under the Mental Health (Care and Treatment) (Scotland) Act 2003 to the fiscal and the Mental Welfare Commission. Following such notification, the Commission would undertake a review of the case notes by a medically qualified person, to determine if there are any factors requiring more detailed investigation. If there are, a Commission investigator would initiate a more formal review, which would be in a form consistent with the

- adverse incidents (an internal review);
- critical incident reviews (these involve a consultant from another Health Board area);
- significant adverse incident reviews (involving another Health Board);
- independent investigations by the Mental Welfare Commission Scotland;
- independent investigation by the procurator fiscal and possibly a discretionary FAI.

\textsuperscript{13} http://www.gov.scot/Resource/0046/00460923.pdf

\textsuperscript{14} http://www.scottishhumanrights.com/resources/policysubmissions/consultationonreformoffai
procedures for healthcare critical incident reviews. In more straightforward cases, that review might be run locally but monitored and quality assured by the MWC. Where there is significant concern, the review would be conducted independently by an investigator appointed by the MWC. The MWC would keep the fiscal advised throughout the process, and would advise the fiscal if it believed there were grounds for an FAI, either instead of or following the review overseen by the MWC. The Lord Advocate would retain full discretion to initiate an FAI at any stage.\textsuperscript{15}

11. There are various options to design a proportionate system in this regard. The Bill could, for instance, provide for mandatory FAIs in all cases where a person is subject to mental health detention, with an exclusion where the Lord Advocate is satisfied that the circumstances of the death have been sufficiently established during the course of an inquiry by the MWC (in the manner of Section 3 of the Bill).

12. However the specifics of investigations are designed, it is key that they result in a robust system which provides for the investigation of all deaths in mental health detention, and the triggering of an FAI where there are any factors of concern. Taking steps within the Bill to implement such a system would be a significant step in addressing Article 2 concerns.

13. If the Mental Welfare Commission is to perform an investigative role, the Commission considers that the following elements would be necessary in order to ensure Article 2 requirements are met:

- **Independence**: We would support the MWC as an appropriate body to carry out an initial investigation. The MWC appears to have the necessary degree of institutional and practical independence from the NHS and health boards.
- **Effectiveness**: Assuming any new system of investigation is in addition to the MWC’s existing investigatory powers, consideration should be given as to whether the MWC will require powers to aid their investigations, such as compelling witnesses and evidence gathering.
- **Promptness and reasonable expedition**
- **Public scrutiny**: Publication of reports of MWC inquiries could provide the necessary degree of scrutiny.
- **Involvement of next of kin**: Relatives and carers of the deceased must be involved with the investigation.
- **Initiated by the State**

14. The Commission notes that the MWC has raised the question of whether individuals subject to community-based compulsory treatment orders, suspension of detention and welfare guardianship orders may also fall within the definition of compulsory detention\textsuperscript{16}. The Commission recommends that further consideration be given to this point. While we recognise that a large number of individuals subject to these measures would not be regarded as in the custody of the state, there may still be a significant number who reside in specified accommodation and care

\textsuperscript{15} http://www.gov.scot/Resource/0046/00460923.pdf
\textsuperscript{16} “Death in Detention Monitoring”, Mental Welfare Commission (March 2014)
arrangements against their will, as a consequence of such orders. Those individuals should be afforded the same protections as those in the custody of the state in a hospital setting.

Scottish Human Rights Commission
28 April 2015
Justice Committee

Inquiries into Fatal Accidents and Sudden Death etc (Scotland) Bill

Written submission from Glasgow City Council

1. Glasgow City Council is pleased to respond to the call for written evidence on this Bill. Glasgow City Council supports the policy objective of the Bill to reform and modernise the law governing the holding of Fatal Accident Inquiries (FAIs) in Scotland. Glasgow City Council responded to the Scottish Government Consultation in Fatal Accident Inquiries legislation in September 2014. Glasgow City Council responded to the Scottish Parliament’s Finance Committee request for views on the financial implications of the Bill in April 2015.

2. Glasgow City Council believes that the circumstances for mandatory FAIs provided for in the Bill are sufficient. In our response to the Scottish Government Consultation, Glasgow City Council expressed the view that suitable and sufficient arrangements currently exist in terms of the reporting requirements of the Looked After Children (Scotland) Regulations 2009, as amended, and the discretion to hold an FAI in relation to the death of a child in residential establishment. Glasgow City Council expressed the view that as the majority of deaths of child in residential establishments are the consequence of life–limiting conditions, an FAI would not be both necessary and beneficial in every such case. Glasgow City Council queried the use of the term “secure care”. Glasgow City Council is pleased to note the use of the term “secure accommodation” in the Bill. Glasgow City Council agrees that the death of a child in secure accommodation should be subject to a mandatory FAI.

3. Glasgow City Council believes that the circumstances provided for in the Bill in respect of discretionary inquiries are appropriate.

4. Glasgow City Council believes that the provisions in relation to the dissemination of the Sheriff’s determination and compliance with the Sheriff’s recommendations are appropriate and reasonable.

5. Glasgow City Council believes that the provisions of the Bill are unlikely to have implications for Glasgow City Council’s existing practices. The policy memorandum states that there has been no death of a child in secure accommodation in the past 5 years, and that a discretionary FAI would usually be held for any death of a child in secure accommodation under the current legislation, unless the bereaved relatives were strongly opposed. The policy memorandum suggests that having this as a mandatory category will result in no more than an additional one or two FAIs every few years. On this basis, there are unlikely to be any practical or financial implications for Glasgow City Council as a consequence of this provision.

6. Glasgow City Council believes that all other provisions of the Bill are appropriate and reasonable. Glasgow City Council does not propose the consideration of any alternative approach.
7. Glasgow City Council will be happy to provide any clarification of this submission if required.

Glasgow City Council
28 April 2015
Justice Committee

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

Written submission from Police Scotland

1. Police Scotland has been invited by the Scottish Parliament Justice Committee to provide comments to specific questions in relation to the Inquiries into Fatal Accidents and Sudden Death etc. (Scotland) Bill.

2. Initially, a review of the current legislation was undertaken by the Rt Hon Lord Cullen of Whitekirk KT, who provide recommendations, most of which have been implemented through the proposed Bill. Police Scotland recognise that the remit of the review was to improve on the existing law governing the holding of Fatal Accident Inquiries (FAIs) in Scotland and the system by which this was undertaken, and that the recommendations were therefore addressed to the Crown Office and Procurator Fiscals Service (COPFS) and the Scottish Court System (SCS).

3. Police Scotland acknowledge that the suggested changes to the mandatory category and the extension to the definition of legal custody within the proposed Bill are likely to be of benefit in modernising the existing legislation and analogous to the current practices of the Coroner’s Office in England and Wales. This is also likely to be the case when looking at death abroad and the introduction of pre-inquiry procedures, where both are already part of the current Coroners remit.

4. The policy intent, within the legislation, of providing a consistent approach throughout Scotland is welcomed by Police Scotland. As a recently formed national organisation it is much more effective and efficient to work within consistent processes and practice where there is benefit in doing so, and FAIs would appear to be one such area.

5. Pre-inquiry procedures proposed may provide an extra layer of procedure but if implemented correctly could also preclude the need for an FAI as the evidence can be considered early to make such an assertion. Police Scotland is aware the requirement of such a provision would benefit the process in determining the need for FAIs.

6. In considering the discretionary inquiries and the proposal to provide discretion to the Lord Advocate to require an inquiry to be held when certain conditions are met, Police Scotland agrees this provision is adequate and proportionate.

7. The investigation of death abroad of both civilian and service personnel is an area of potential concern for Police Scotland. Whilst we support the intention of the Bill to ensure that FAIs can be held in a range of circumstances not currently catered for, and which from time to time have been issues of public concern, there is a lack of clarity about the police role in such cases. It is suggested these investigations will rely on information and reports provided from the investigating country and dealt with by the COPFS, however, there is a concern that Police Scotland may be required to have a more active involvement in gathering evidence, in partnership with
international Law Enforcement agencies. It should be noted that the level of investigation will differ from country to country and there is a possibility that problems could arise in the accessibility of material required. It may be that this type of investigation should be considered in not all, but some circumstances where there is dubiety in the determination received from the originating country and in these circumstances it is perhaps most likely that Police Scotland would be expected to perform a more active role.

8. Police Scotland has a concern that such investigations may require more than the proposed model of a paper exercise and should this be requested the burden of investigation may lie with Police Scotland as agents for the COPFS. Police Scotland has neither the range of capabilities nor the capacity to undertake a significant level of investigation abroad, within other jurisdictions. The cost of undertaking just one such enquiry would be substantial and are at this time not allowed for within ever constrained budget plans.

9. What is unclear and very difficult to determine, prior to the Bill being enacted, is the effect the Bill would have on the method of investigation and how much the proposals would impact on the nature of Police Scotland’s involvement in the investigation of FAIs.

10. Police Scotland is aware that it is stated within the Bill that the purpose of such an inquiry is not to establish civil or criminal liability; however experience suggests that some form of investigation is often instigated by Police Scotland, through COPFS, to determine the facts, which sometimes are not immediately apparent.

11. There are no alternative approaches that Police Scotland can provide for consideration to the committee, without explicitly amending the Bill to include more detail on circumstances in which Police Scotland would be, or would not be, expected to conduct investigations into circumstances abroad, and indeed travel abroad for those purposes, which at this time remains unclear.

12. The impact of the changes outlined is likely to be much more apparent when the Bill is implemented. Police Scotland are aware that certain aspects of the recommendations outlined by Lord Cullen have been implemented by the COPFS and have had a positive impact on the system of dealing with such inquiries to date.

Police Scotland
30 April 2015
Justice Committee
Inquiries into Fatal Accidents and Sudden Deaths etc. (Scotland) Bill

Written submission from the Faculty of Advocates

The Faculty of Advocates is Scotland’s independent referral bar. The Lord President has described the essential qualities of the Faculty in the following terms: “a commitment to excellence, a commitment to scholarship and learning, a commitment to the noblest ideals of professional conduct and, above all, a commitment to justice for all in our society”. The bar has great collective experience of conducting all types of hearings, including fatal accident inquiries.

As set out in paragraph 3 of the explanatory notes, the Bill seeks to modernise the legislative framework for Fatal Accident Inquiries (FAIs) in Scotland. The Faculty supports that aim. It is clear that the provisions of the Bill take forward many of the recommendations requiring primary legislation from Lord Cullen’s Review of the operation of the Fatal Accidents and Sudden Deaths Inquiries (Scotland) Act 1976 (“the 1976 Act”) which reported in 2009. Again, in the main, the Faculty favours those recommendations being taken forward and supports the Bill’s aim of making the process of investigating deaths quicker and more transparent.

Inquiries into certain deaths (ss. 1-7)

The Faculty supports these sections, subject to only one qualification. The Faculty considers that a mandatory inquiry should be held into the death of a child maintained in a residential establishment for the purposes of the Children (Scotland) Act 1995 or the Social Work (Scotland) Act 1968. The Faculty favours the inclusion of a death of a child required to be kept or detained in secure accommodation as an addition to the mandatory categories in the 1976 Act. However, the Faculty adheres to the view it has previously expressed that Lord Cullen’s recommendations on this issue ought to be implemented in full by including within the mandatory categories deaths of children being maintained in residential establishments. In its July 2014 consultation paper the Scottish Government drew a distinction in this context between children maintained in residential accommodation which is not secure accommodation and those in secure accommodation, namely that residential establishments cannot detain children against their will. We do not consider that distinction is sufficiently persuasive to justify departing from Lord Cullen’s recommendation. A child who is in a residential establishment provided or arranged for by the State is in the care of the State; if they are there under a supervision order made under the Children’s Hearings (Scotland) Act 2011, then they are subject to the coercive power of the State, even if they are not held in secure accommodation. Lord Cullen considered that the dividing line between cases where an FAI should be mandatory in relation to a child in care should exclude children in kinship or foster care, but include children in residential establishments. We share his view that this is the appropriate division.
Reasons where inquiry not held

The Faculty supports the requirement for reasons to be given on request for a decision not to hold an inquiry.

Procurator fiscal’s investigation

The Faculty recognises that it is important for the fiscal to have the power to cite witnesses, if necessary, for precognition as part of a death investigation.

Participants

The Faculty notes that the provisions in this section have been updated to capture modern relationships as the 1976 Act does not include civil or cohabiting partners: the Faculty supports this.

Location

The Faculty agrees that the Scottish Ministers should be able to make regulations, as provided by section 11, to designate places at which a sheriff court may be held for the purposes of holding an FAI.

Section 12(1) is an important new provision which provides that an FAI may be held in any sheriffdom in Scotland regardless of the place of the death or (if applicable) any accident causing death. The Faculty understands that the thinking behind this is to allow greater flexibility in the system of FAIs which may allow inquiries to be held more quickly. The Faculty supports this provision in the interests of avoiding delay in FAIs where possible but on the basis that the flexibility permitted by section 12 would still permit an FAI to be heard locally.

The Faculty notes that the expectation expressed in the explanatory notes to the Bill is that most inquiries will continue to be held in the sheriffdom connected with the death, and it may be that there should be a statement on the face of the Bill that an inquiry will take place in that sheriffdom unless there is a good reason for it to be held elsewhere. One reason for holding the inquiry in the sheriffdom local to the death is that this will usually (though not always) be the forum which is convenient for the family of the deceased, witnesses and other interested parties. The Faculty suggests that the views or interests of the family of the deceased should be taken into account when decisions are made about forum.

Inquiries into multiple deaths

The Faculty agrees that in certain circumstances it may be appropriate to hold a single FAI into multiple deaths even if they have not occurred in the same sheriffdom.

Pre-inquiry procedure

The Faculty supports the focus on the desirability of holding the FAI as soon as is reasonably practicable, the provisions in relation to preliminary hearings and the
agreement of uncontroversial evidence with a view to shortening the length of FAIs. It is suggested that section 17 should be amended, to provide that the act of sederunt mentioned will “prescribe the appropriate procedure for the agreement by …”. The word “about” could be read to suggest that the act of sederunt could go beyond procedural mechanisms.

The inquiry

The Faculty has no comment.

Findings and recommendations

The Faculty agrees with the approach which has been taken in the Bill to the sheriff’s findings and recommendations. The proposals strike an appropriate balance in relation to the effect of findings and recommendations.

Further inquiry proceedings

The Faculty notes that section 28 confers a new power on the Lord Advocate in connection with circumstances in which there may be further proceedings. The Faculty can see merit in such a provision in the public interest.

Inquiry procedure rules

No comment.

Specialist sheriffs and summary sheriffs

The Faculty considers that there is merit in the power to designate “specialist” sheriffs in FAIs. The Faculty has some concern about the use of summary sheriffs in FAIs. While this would allow for flexibility – and may assist in the aim of securing that inquiries will be held as quickly as possible, the use of summary sheriffs would appear to run counter to the proposal for “specialist” sheriffs. Given the limited jurisdiction of summary sheriffs, there may be a perception that an inquiry before a summary sheriff is being treated with less significance than an inquiry before a non-summary sheriff.

Faculty of Advocates
6 May 2015
In addition to the undernoted comments, reference is made to our response to the consultation document which preceded this Bill which was submitted on 9 September 2014 (a further copy of which will be supplied on request)

1. Places at which inquiries may be held – section 11/ Jurisdiction – section 12

Jurisdiction to hold an FAI is currently conferred on the procurator fiscal within whose district and the sheriff within whose sheriffdom, the circumstances of the death seem most closely related. (It will have been apparent from our response to the consultation paper that we consider that this should continue to be the case). The consultation paper posed questions in relation to the viability of setting up specialist FAI centres. We presume that section 11(1) of the Bill envisages inquiries taking place in such centres. Section 12(1) provides that proceedings may be held in a sheriffdom “whether or not there is a connection between the death, or any accident resulting in the death, to which the inquiry relates and the sheriffdom”. We are concerned about these provisions which may lead to the centralisation of FAIs and a move towards the use of specialist centres or particular designated specialist courts. In our view it is important to maintain a link between the inquiry and the local community where the death occurred. Further, the centralisation of cases will have a significant impact in relation to the cost of travel and accommodation for witnesses, relatives of the deceased and legal representatives.

While the vast majority of FAIs should be dealt with in the relevant sheriff court, we accept that the use of alternative accommodation may be appropriate in larger, more complex and long-running inquiries. It is important that the location identified is not only viable for witnesses and relatives but also that it is appropriately resourced in terms of security, clerking arrangements and information technology.

Section 12(2) of the Bill envisages that the Lord Advocate, after consulting the “Scottish Courts and Tribunal Service” will choose the sheriffdom in which proceedings are to be held. If it is the view of the executive that FAIs should, for example, be centralised in Edinburgh or Glasgow, there may be significant pressure upon the Crown to make applications to hold inquiries in only those locations. Section 12(3) attempts to introduce a safeguard in providing that the presiding sheriff “may make an order transferring the proceedings to a sheriff of another sheriffdom”. However in practice this can only be done with the consent of both sheriff principals involved. It is unclear how the sheriff concerned ought to make enquiries of the sheriff principals in such circumstances. In practical terms it is difficult to envisage how this procedure would operate to enable a sheriff to make an order ex proprio motu to transfer an FAI having first secured the consent of two relevant sheriff principals.

If the terms of section 12(1) are to remain notwithstanding our previous observations, then in our view applications for transfer of an inquiry should be made to the sheriff
and the Bill should provide a framework for the exercise of discretion to transfer FAIs with reference to factors such as the impact on the families of the deceased, witnesses etc. It also seems surprising to us that section 12(2) does not provide for the Lord Advocate to consult with sheriff principals as regards the initial choice of sheriffdom before an application to hold an inquiry is made, given the sheriff principals’ statutory responsibility for the management of business in their sheriffdom.

2. Initiating the Inquiry – Section 14/ Preliminary Hearings – Section 15

Section 14 of the Bill provides that a procurator fiscal must give the sheriff along with a notice that the inquiry is to be held “a brief account of the circumstances of the death so far as known to the procurator fiscal and any other information required by an Act of Sederunt (yet to be promulgated) under section 34(1)”. Based on that information the sheriff must make an order fixing a date and place for a preliminary hearing and a date for the start of the inquiry which should be “as soon as reasonably practicable”. In our view an application to hold an FAI should incorporate a proper narrative setting out the facts and circumstances of the case, and in particular where the application is a discretionary one, what the public interest issues are. Sheriffs have encountered difficulties with the narrow specification given under the existing rules and suggest that this issue could helpfully be addressed in section 14 and the Act of Sederunt which is to follow.

We appreciate that section 14 is qualified in terms of section 3(b) to provide that where the sheriff considers that it is “not appropriate” a date for the inquiry may not be fixed and further that the Act of Sederunt referred to under section 34(1) which will presumably provide significant detail in terms of procedural rules etc. will follow. It would be helpful to have a set of rules in relation to the content and format of such applications and also details of potential interested parties including relatives, employers etc. (We assume that we will be given the opportunity to comment on the draft Act of Sederunt in due course.)

Applications to hold an FAI should not ordinarily be granted unless or until the procurator fiscal’s investigations have been completed or are at an advanced stage of preparation. Effective judicial management of FAIs is crucial to the efficient progress and early focussing of cases. Preliminary hearings play an important part in that process. At the preliminary hearing sheriffs should be able to ascertain from the parties the likely length of the inquiry, the state of preparation of the parties or their representatives, the issues likely to arise, the nature of the evidence and availability of the witnesses, scope for agreement of aspects of evidence, the exchange of expert reports, arrangements for cross examination of experts, and the nature and arrangements for productions etc. Often preliminary hearings call at a stage where parties are not fully prepared and where many outstanding matters require to be addressed. There are material issues such the grant of legal aid for representation and related applications before SLAB in relation to sanction for experts. Solicitors may only fully investigate when legal aid is granted and expert reports undertaken. Late disclosure leads to adjournments and consequently early proactive management by the court is essential. This emphasises the need for careful consideration of the timing of the preliminary hearing, new rules and
procedures to enable the sheriff to undertake a meaningful management role throughout the proceedings and judicial continuity in dealing with cases.

We find it difficult to envisage any cases where it will be appropriate for the sheriff to fix a start date for the inquiry as soon as an application is lodged. Assigning a date before the Crown’s investigations are complete leads to problems. It is impractical to fix a date when the scope and complexity of the hearing, the number of witnesses and potential for agreement of evidence or use of affidavit evidence and the proposed input from experts has yet to be been identified and in consequence an informed estimate as to the likely length of the inquiry and the court time and accommodation required made.

3. Agreement of Facts before an Inquiry – Section 17

FAIs are independent public inquiries. Sheriffs may request further evidence on issues arising where appropriate. In this context concern has been expressed by some sheriffs about the court being bound by the terms of an agreement between the parties as to the scope of the inquiry which is a matter for the sheriff. The wording of section 17 of the Bill is not entirely clear and we may have misunderstood the policy intention.

4. Judicial Specialism in Inquiries/ Competence of Summary Sheriffs to conduct inquiries – Sections 35 and 36

We are very concerned about these sections of the Bill. It seems to be envisaged that sheriff principals will no longer conduct inquiries. FAIs involve the consideration of matters of significant public interest and importance which attract a significant media profile. The inquiries into the Glasgow refuse lorry accident and the Clutha helicopter crash are two examples of such inquiries which are likely to arise in the coming year. The public have a reasonable expectation that such cases will be dealt with by the most senior judicial office holder in the sheriffdom concerned.

There is an emphasis on sheriff principals designating one or more sheriffs as specialists in fatal accident inquiries. This was not a specialism envisaged in the Courts Reform (Scotland) Act 2014. The designation of specialist sheriffs is likely to lead to the centralisation of FAIs and the grouping of specialist sheriffs in only a small number of courts or specialist FAI centres. We would strongly oppose such a move.

We are also very concerned to note the proposal to extend the competence of summary sheriffs in relation to FAIs. FAIs were not envisaged as an area of work to be undertaken by summary sheriffs in the 2014 Act. Given the complexity of such cases and the importance of the subject matter we are of the view that they should remain within the privative jurisdiction of sheriffs.

Sheriff Derek O’Carroll
Honorary Secretary
Sheriffs’ Association
28 April 2015
Justice Committee

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

Written submission from the Lord President of the Court of Session

1. Thank you for inviting me to submit evidence to your committee. I welcome the Bill. It is essential that the process for investigating sudden and unexplained deaths operates in an efficient way and meets the needs of those who have lost a family member. I consider that the provisions of this Bill will update the Fatal Accident Inquiry process in a way that is appropriate for a modern legal system.

2. I offer some comments on certain sections of the bill which I trust the committee will find helpful.

Section 10: Persons who may participate in an inquiry

3. Section 10 allows a range of persons to participate in an inquiry. This could be the subject of abuse if not properly regulated. Unless the sheriff has power to curtail the extent of the participation of any of the parties to the inquiry, the length and cost of a FAI may simply escalate out of control. In my view, this Bill offers an opportunity to deal with this risk. I therefore suggest:

   (i) A further subsection should be added to section 10, conferring discretion on the sheriff as to the extent to which any person should participate. That subsection should be so drafted as to allow the sheriff to limit, in advance, the issues in a FAI upon which any participant should be entitled to adduce evidence and the issues that such a participant should address in making submissions.

   (ii) Section 10(1)(e), which entitles “any other person” to participate in an inquiry, should be so framed as to make it clear that the sheriff has a broad measure of discretion as to who should participate in a FAI. This could be done, for example, by providing that the sheriff must be satisfied that such a person has “sufficient interest” to make it appropriate that that person should be permitted to participate in the inquiry.

Section 17: Agreement of facts before an inquiry

4. In my view this provision, which allows provision to be made by Act of Sederunt for the agreement of evidence, is important. There has been uncertainty under the current regime as to whether evidence may be agreed by the parties. Rules made under section 17 can place the matter beyond doubt.

5. I suggest also that there should be added to section 17 a provision making it clear that a sheriff is entitled to require evidence to be lodged in written form where in his discretion he considers that to be appropriate. That would, for example, allow uncontroversial evidence to be lodged in the form of a report or an affidavit, with a significant saving in cost and time. It would also, where appropriate, allow a witness’
written evidence to be treated as his evidence in chief for the purposes of oral examination.

**Section 18: The powers of the sheriff**

6. Section 18 is in general terms and will no doubt be supported by rules contained in an Act of Sederunt. I suggest that a specific provision be added to the rules to the effect that in cases where oral evidence is to be taken, the sheriff has power require a participant to provide written notice of the topics upon which he wishes to examine or cross-examine any witness.

**Section 26: Compliance with sheriff’s recommendations**

7. Scottish Courts and Tribunal Service (“SCTS”) has continuing concerns about the requirements which would be placed on SCTS by these provisions. I share these concerns. There is a question of principle whether SCTS staff, whose primary role is to support the judiciary, should take on this task. However, I accept that there appears to be no alternative option. I therefore regard this as an exceptional situation and do not expect it to constitute a precedent. There is likely in most cases to be a requirement for legal advice about the content of such responses before publication on the SCTS website. In the event that these requirements are placed on SCTS the costs (which are unbudgeted) associated with these requirements should, in my view, be met by the Scottish Government.

**Section 34: Powers to make Rules to regulate procedure**

8. I strongly support making rules to modernise and update the procedures and practice of Fatal Accident Inquiries.

**Section 35 (Judicial specialisation in inquiries) and Section 36 (Summary sheriff: competence to conduct inquiries)**

9. I am content to support these provisions.

Brian Gill
Lord President of the Court of Session
27 April 2015
I would like to thank the committee for the opportunity to give evidence on behalf of the Society on 19 May. A number of matters arose on which I would like to elaborate.

1. **Different aspects of public interest** I mentioned that there were differences between the public interest in the enforcement of the criminal law by prosecution and the public interest in lessons being learned for the future by the holding of an FAI. The Lord Advocate presently has the responsibility for both of these issues and the tendency increasingly is to pursue the prosecution avenue at the expense of an inquiry. Indeed the whole thrust of the Crown’s response to the committee’s call for evidence is based on prosecution being given primacy.

The committee has been given a number of instances in other submissions, for example the FBU response, which show first that giving primacy to prosecution may delay for very lengthy periods the holding of an FAI and second that once a prosecution has been mounted and a plea of guilty tendered the Crown apparently considers there are no lessons to be learned.

The FBU submission, with its detailed account of the aftermath of the death of firefighter Ewan Williamson, gives a graphic example of the dampening effect the potential for a prosecution has on the ability even to begin to start the process of learning practical lessons for the future. It also shows that the agreed statement of facts given to the judge on the tendering of a guilty plea does not begin to address the type of systemic problems which an FAI would be able to consider. Other high profile cases, such as the Flying Phantom and the 2009 North Sea helicopter crash, demonstrate that putting decisions on prosecution ahead of an inquiry can lead to very lengthy delays. The committee will also be well aware of the thematic report of the Inspectorate of Prosecutions into the Health and Safety Division of COPFS ([http://www.gov.scot/Resource/0041/00418557.pdf](http://www.gov.scot/Resource/0041/00418557.pdf)). The public interest in learning lessons should, it is submitted be given greater priority.

2. **The position of the Lord Advocate** It is important to remember that the present role of the Lord Advocate in the holding of FAIs is not a part of the Lord Advocate’s prerogative as the head of the prosecution service, stemming from the Treaty of Union or the Scotland Act. The legislative history of FAIs and the role of COPFS and the Lord Advocate are set out in Lord Cullen’s report (paragraphs 2.1-2.22). There is therefore no constitutional reason for the current bill not to provide that the bringing forward of an inquiry for its purposes should proceed independently of any decision to prosecute or not. In practice the facts which will inform both the question of a prosecution or the holding of an inquiry will be the same but, as indicated, the uses to which those facts are put are quite different.

3. **Would an FAI inevitably prejudice a prosecution?** In our view the answer is no. It is rarely the case that an FAI is held where the death was the result of a crime
involving mens rea or criminal intent. There are exceptions – the Lockerbie case being one, where an FAI was held and, of course, many years before the prosecution. Most cases particularly of workplace accidents involve statutory breaches of health and safety law where an error or omission has had fatal consequences. It is difficult to see how an exploration of the factual background of such an incident in open court from witnesses under oath for the purpose of establishing the cause of death and preventing future accidents, so far as possible, would make the subsequent prosecution of an alleged wrongdoer impossible. So long as the determination of the sheriff could not be founded upon in criminal (or civil) proceedings, as at present, any subsequent court having to consider a breach of the criminal law would have a different task but would have the benefit that many of the facts would already have been explored and potentially agreed. Putting an FAI first would enable the lessons to be learned quickly and acted upon.

4. Making recommendations effective There respectfully appears to be a desire in the committee to arrive at a solution to the very real problem that a recommendation from an FAI currently has no teeth. Having given the matter further reflection there are a number of potential avenues. It is necessary to consider the nature of the recommendation. Does it involve purely practical matters; would it extend beyond the parties involved in and the circumstances of the inquiry in question; is there any need for any rule or law to be amended; how would the recommendation be enforced?

Taking the most simple situation, where a recommendation involved a practical step specific to a party to the inquiry, whether the approach was that under section 27 of the present Bill or the one in section 20 of Patricia Ferguson MSP’s proposed Inquiries into Deaths (Scotland) Bill, if the person to whom the recommendation was addressed accepted and acted on the recommendation, the matter would be closed. Even then, in either situation, if there was a subsequent failure in compliance and an accident occurred, what would be the status of the earlier recommendation and its acceptance? The earlier inquiry would be complete and any further action, as with the original fatality, would have to take the form of a further FAI, a prosecution, and claims for damages.

The situation would be more complex in the event that the recommendation (a) was of a more general nature affecting parties beyond the incident in question or industry more widely, (b) required action by professional or regulatory bodies, or (c) would need changes in Statute or Regulations (the Committee has been referred to the example of the absence of requirement for MOTs of mobile cranes). Ultimately, however, even if the recommendation was accepted and acted upon, any further accident would also be handled in exactly the same way as the most straightforward situation referred to in the last paragraph.

It is therefore compliance and ensuring so far as possible the likelihood of compliance that will be effective in reducing the prospect of further fatality.

At the meeting of the Committee on 19 May I suggested that one step to strengthen the proposed regime under the current Bill would be for the response to any recommendation to be made to the sheriff rather than to SCTS. This would mean that the inquiry procedure would not formally close until after the responses had
been received. This would also leave open the prospect that the sheriff could order a further hearing, if so advised, into any matter raised in a response. There are further steps which could be taken without altering the existing character of an FAI. Firstly, the Justice Committee itself could monitor recommendations and responses as part of Parliament’s policy of assessing the effectiveness of legislation. It could then make its own recommendations for amendments to Regulations or Statutes as appropriate.

Secondly, the Scottish Ministers could be given power to bring forward subordinate legislation under the Bill for the purpose of promoting compliance with recommendations made, including, if thought appropriate, the creation of offences to bolster such legislation.

Finally, there would be dissemination of recommendations to those who are relevant, together with professional or regulatory bodies, as envisaged by sections 25(5)(b) and 26(1)(b) of the current bill (subject to the amendment suggested above).

All of these measures collectively would give the greatest chance that recommendations would be heeded and acted upon without either altering the nature of the inquiry process or of judicial legislation.

5. Deaths abroad The question was posed concerning the necessity of repatriating the body as currently contained in section 6. An alternative would be to give the Scottish court power to deal with any case in which the deceased died domiciled in Scotland. Domicile in this instance would have the same meaning as in family law i.e. place of permanent residence even if the person was currently resident abroad at date of death. Removing the need to repatriate the body would avoid ruling out cases where repatriation was impossible.

6. I hope these additional suggestions are helpful. If the Society can be of any further assistance please let us know.

Tom Marshall
President
22 May 2015
Summary of Key Points

- The Crown Office and Procurator Fiscal Service (COPFS) welcomes the Inquiries into Fatal Accidents and Sudden Deaths etc. (Scotland) Bill which implements many of the recommendations made by Lord Cullen in his review of the operation of the Fatal Accident Inquiry legislation.
- Many of Lord Cullen’s recommendations were addressed to COPFS and those recommendations (recommendations 12 to 17) have been implemented with the launch of the Scottish Fatalities Investigation Unit (SFIU).
- COPFS considers the Bill strikes the right balance in extending the mandatory category in relation to deaths in legal custody and maintaining the power of the Lord Advocate to exercise his discretion to hold a FAI into the death of someone subject to detention by a public authority.
- COPFS are content that the current system in relation to discretionary inquiries is maintained and welcome the clarification on the face of the Bill that the purpose of such an inquiry is not to establish civil or criminal liability.
- In relation to the power to hold FAIs into deaths abroad COPFS recognises the limitations on this power.
- COPFS welcomes the flexibility that provision in sections 11, 12 and 13 will bring to the holding of FAIs and is of the view that the formalisation in statute of a preliminary hearing system will bring consistency of approach and assist in focusing the issues to be addressed in any Inquiry. All of these features of the Bill should assist in the overall speeding up of the holding and concluding of FAIs.
- Although it is anticipated that the provisions in relation to re-opening an FAI where fresh evidence comes to light will be used sparingly COPFS is of the view these provisions are desirable.
- COPFS welcomes the notice procedure provided for in section 14 of the Bill. Although Lord Cullen recommended that, in cases in which an FAI is mandatory, the Procurator Fiscal should apply for an FAI at an early stage after death, COPFS considers that this could add an unnecessary layer of procedure in many cases. In the majority (59%) of cases relating to deaths in the course of employment reported to the Health and Safety Division of Crown Office where there were criminal proceedings which had concluded in the last 4 years no mandatory inquiry was held because it was considered the circumstances of the death had been sufficiently established in criminal proceedings. Families may be further distressed if a FAI was formally opened but then did not take place because of the decision that criminal proceedings had fully established the facts. Presently COPFS provides a contact point for information to nearest relatives and ensures families are kept up to date with progress. Procurators Fiscal meet families and nearest relatives are given the opportunity to be fully engaged in the investigative process. If a FAI is not being petitioned for in such circumstances now COPFS do explain such
decisions as a matter of standard practice and, if requested, provide a written explanation to families.

- COPFS is aware of the issues that have been raised in relation to the time taken to hold a FAI from the time of death. COPFS are committed to investigating deaths timeously, but will not compromise thoroughness for speed as this could compromise a Sheriff’s ability to make proper findings and/or recommendations.

- The time taken for holding a FAI can be affected by many factors such as:
  (i) Time elapsed between death and it being reported to the Procurator Fiscal
  (ii) Criminal proceedings are required to take place (or at least be ruled out through a detailed investigation) before consideration can be given as to whether a FAI should take place all of which inevitably takes time.
  (iii) In many cases the Procurator Fiscal is dependent on investigations carried out by regulatory authorities before COPFS can complete its own investigations. In complex cases this can take a significant period of time and is not something the Crown can control.
  (iv) Many deaths investigations also require expert evidence and it can take time to identify the necessary expert and obtain all relevant reports.
  (v) Timing of the Inquiry is also dependent on the availability of suitable court time which is allocated by the Sheriff Principal.

- COPFS recognises the importance of holding an FAI as soon as possible once a decision is taken that an FAI is to be held. The Crown now petitions the court to hold a FAI within 2 months of the instruction to hold an FAI.

Submission

1. The Crown Office and Procurator Fiscal Service (COPFS) welcomes the Inquiries into Fatal Accidents and Sudden Deaths etc. (Scotland) Bill which takes forward many of the recommendations from Lord Cullen’s review of the operation of the fatal Accident and Sudden Deaths Inquiry (Scotland) Act 1976 which reported in 2009.

2. As outlined in paragraph 4 of the Explanatory Notes to the Bill, many of the recommendations from Lord Cullen’s review were addressed to COPFS and have been implemented. It may assist the Committee to provide details of how COPFS has implemented these recommendations.

3. The Scottish Fatalities Investigation Unit (SFIU) was launched in October 2010 and incorporated the recommendations contained in the review relating to the work of the Crown Office and Procurator Fiscal Service.

4. The SFIU took on responsibility for investigating all sudden, suspicious, accidental and unexplained deaths allowing death investigation to be carried out thoroughly and expeditiously by dedicated specialists. It became the central point for the provision of advice to Procurators Fiscal investigating deaths; for liaison with Crown Counsel regarding the direction and focus for deaths investigation; for liaison with the nearest relatives of the deceased’s family and for providing them with reasons where the Lord Advocate did not apply for a FAI. Such communication was
provided in person at a meeting, by telephone or in writing depending on what method of communication was considered most appropriate by the family in the circumstances.

5. With the introduction of a geographic Federation structure within COPFS from April 2012, the SFIU was reorganised to mirror the Federation structure. There are now three SFIU teams, one in each Federation (SFIU North, SFIU East and SFIU West) in addition to the National SFIU team which is the central point for the provision of advice to colleagues in the SFIU teams, for liaison with Crown Counsel and with primary responsibility on policy matters relating to deaths. The Heads of the three SFIU teams report directly to the overall Head of National SFIU who is a Senior Procurator Fiscal.

6. Building on this and in implementing the recommendations, SFIU have created a database of cases which differentiates between mandatory and discretionary FAIs and records relevant dates and detail in order to track the progress and timings of cases and to maintain statistical data.

7. SFIU have also captured details of suitable experts who have assisted in investigations previously and this will be updated on a regular basis.

8. Current cases have been prioritised to ensure that any cases which have been awaiting resolution for some time are being expedited.

9. The current structure of SFIU provides the necessary contact point in line with recommendation 15. There is a very experienced dedicated member of VIA (COPFS’ Victim Information and Advice service) working in SFIU who provides support to families.

10. All of these changes demonstrate a commitment by COPFS to deliver expert, thorough and timely investigation of deaths.

The Bill

11. In addition to ensuring that considerations of public interest are met, at the heart of any investigation by the Procurator Fiscal of sudden, suspicious, accidental or unexplained death is the need to try and obtain answers for the relatives as to the cause of death and why the person died. In the vast majority of deaths investigated by the Procurator Fiscal there is no requirement for a public hearing- the family can obtain the answers they need in private and, where the causes are not complex within a short period of time, without the formality and distress that formal court proceedings can bring. In all deaths which require further investigation, COPFS conduct the investigation and aim to advise the nearest relatives of the outcome within 12 weeks, in at least 80% of cases. In the year 2014/15 91 % of cases met that.

12. The opportunity has been taken in the Bill to modernise the system of Fatal Accident Inquiries based on Lord Cullen’s recommendations. The fundamental purpose of a fatal accident inquiry has been set out in the Bill as being to establish
the circumstances of the death and consider what steps if any might be taken to prevent other deaths in similar circumstances.

Mandatory category

13. COPFS welcomes the modernisation of the category for mandatory FAIs by the updating and extending of the definition of deaths in legal custody. We note that Lord Cullen recommended the mandatory category should include the death of any person subject to detention by a public authority but that the Royal College of Psychiatrists and the Mental Welfare Commission Scotland considered this was unnecessary in their responses to the Scottish Government consultation. COPFS considers the Bill strikes the right balance in extending the category for legal custody and maintaining the power of the Lord Advocate to exercise his discretion to hold a FAI into the death of someone subject to detention by a public authority. We also welcome the retention of the discretion of the Lord Advocate to decide not to hold a FAI where the circumstances of any death have been sufficiently established in criminal proceedings to the extent that an Inquiry is no longer necessary in the public interest.

Discretionary Inquiries

14. The holding of a discretionary inquiry will remain as a matter for the Lord Advocate acting in the public interest. It is important to underline the independence of the Lord Advocate in this role. All the facts and circumstances of the death will be considered, as will the views of the nearest relatives, in line with obligations under Article 2 of the European Convention on Human Rights, in taking the decision as to whether an inquiry in public is required. The decision of the Lord Advocate can and has been challenged by judicial review but it is notable that this remedy has only been used sparingly. An independent and objective investigation and assessment of the wider public interest by the Lord Advocate is required so that issues are appropriately considered and focussed. In this way competing interests in whether or not a FAI should be held are properly balanced. COPFS is content that this aspect of the current system is maintained and welcome the clarification on the face of the Bill that the purpose of an inquiry is not to establish civil or criminal liability.

Deaths abroad

15. With regard to the power to hold a fatal accident inquiry into deaths abroad it must be stressed that there will be limitations on what COPFS can actually act on and the Bill does not have retrospective effect. A FAI could only be held if it is considered that the circumstances of the death have not been sufficiently established in the course of a foreign authority's investigation and where there is a real prospect that those circumstances would be sufficiently established in an Inquiry. It is important to note that it is the power to hold the inquiry that is provided for, not the power to investigate the death which occurred abroad. There may well be limitations to what can be established by COPFS regarding deaths which occur abroad. COPFS has previously assisted relatives in obtaining information about investigations abroad on an informal basis only. Even in criminal proceedings it can take a significant period of time to secure evidence from abroad using Mutual Legal Assistance (MLA) treaties as the process relies heavily on the goodwill of the
requested state to provide the request with the relevant degree of priority. For instance the standard period to obtain evidence from the United States is six to eight months and in many cases it takes longer. However, MLA treaties could not be used to obtain evidence from abroad for a FAI as these treaties are restricted to criminal proceedings. Accordingly, COPFS will not have the power to compel the attendance of witnesses or the production of crucial evidence from foreign countries for FAIs within the scope of mutual legal assistance. If it is possible to obtain any evidence at all it is likely to take far longer than it does in criminal proceedings. As a result there may be little further that can be discovered by the holding of a FAI than was discovered by the local investigation, and this may only serve to prolong frustration and distress for the family, particularly where there is likely to be a considerable passage of time before a FAI can be held as a result of the lack of Crown investigative powers. Additionally, were a FAI to be held into a death that occurred abroad and a Sheriff made recommendations with a view to preventing other deaths occurring, it is hard to see how such recommendations could be taken forward with the relevant foreign authority involved.

Places at which Inquiries may be held and jurisdiction

16. COPFS welcomes the flexibility that the provisions in sections 11, 12 and 13 bring to the holding of FAIs. Some Inquiries have been held in venues other than sheriff courts. The removal of FAIs from formal court surroundings can improve the facilities available for the family of the deceased and witnesses. It is desirable to remove FAIs from a sheriff court which is busy with other civil and criminal business. In terms of jurisdiction, in many cases there may be little connection between the court house, place of death, the witnesses, or the nearest relatives and accordingly the place of death need not be the overriding factor in choosing the location for a FAI to be held. The ability to hold a FAI into multiple deaths whether or not they occurred in the same sheriff court jurisdiction ensures that the fullest evidence can be presented to one sheriff.

Pre Inquiry Procedure
Notice Procedure

17. CCOPFS welcomes the notice procedure provided for in section 14 of the Bill. We note that Lord Cullen recommended that, in cases in which an FAI is mandatory, the PF should apply for the FAI at an early stage after a death, so that the sheriff, relatives and other interested parties can be informed as to the state of investigation, the expected timescale and any factors likely to affect progress.

18. However, it is considered that this could add an unnecessary layer of procedure in many cases and that a much larger number of FAIs would then require to be applied for initially but the majority of these would not proceed because it is likely that criminal proceedings will be instigated and the Lord Advocate may ultimately consider that an FAI is not necessary as the circumstances of death have been sufficiently established in those criminal proceedings.

19. In relation to deaths in the course of employment which were reported to Health and Safety Division of COPFS, 27 cases were concluded in the last four years: of those, seven resulted in no criminal proceedings being taken and seven
mandatory inquiries were then held. In 20 cases a prosecution took place and 16 inquiries were waived by the Lord Advocate: four were instructed. In 59% of those cases relating to deaths in the course of employment which were reported to the Health and Safety Division and had criminal proceedings concluded, no mandatory inquiry was held because it was waived in terms of section 1(2) of the 1976 Act.

20. However, COPFS recognises that it is crucial that families are kept up to date with the investigation into a loved one’s death. COPFS provide a contact point for information to nearest relatives on the investigation of deaths by the Procurator Fiscal so that they can raise any concerns and issues directly with that person. Procurators Fiscal meet with the families to explain the process of the investigation and to keep the family up to date with progress. Whether or not a mandatory FAI is ultimately held, the nearest relatives are given the opportunity to be fully briefed on the investigative process. This process can sometimes lead to additional investigation being undertaken by the Procurator Fiscal to address further concerns raised by the family.

21. Families may become subject to further distress if a FAI was formally opened raising their expectation that there would be evidence led at a FAI, but then did not take place because of the Lord Advocate’s decision that the matter had been fully explored in criminal proceedings.

Preliminary hearings

22. The provision of the preliminary hearing system in FAIs is welcomed as this will aid early discussion once the decision has been made that a FAI is to be held. The practicalities of where and when the FAI will take place, the state of preparation of all parties, and which parties will be represented at the FAI can all be explored at the earliest opportunity. This improvement to the process has already been put in place. The Crown guidance requires that Procurators Fiscal seek a Preliminary hearing in every FAI when a petition is lodged with the court. The Sheriff Principal of Glasgow and Strathkelvin has issued a practice note providing that preliminary hearings should be fixed 4 weeks before the date fixed for an inquiry in all cases in his jurisdiction. COPFS welcomes the formalisation of the preliminary hearing system in statute to provide certainty and clarity to all who are involved in the formal proceedings in any jurisdiction about the issues which should be considered at the FAI, the timing, location and timescales.

23. We welcome the flexibility built into this process to allow the Sheriff to dispense with the requirement for the preliminary hearing, in relation to those FAIs where it is clearly not necessary. For instance, in many mandatory FAIs the facts are clear cut and are likely to lead to only formal findings of where when and why a death occurred. The notice procedure will allow considered decisions to be taken on whether the preliminary hearing should be fixed.

Ability to re-open a FAI: sections 28 to 33

24. It is desirable that there is provision to have further proceedings where fresh evidence comes to light which would materially affect a finding or recommendation in
a determination. It is anticipated that this would only be used very sparingly given the thorough investigations which take place.

**Timing of FAIs**

25. COPFS is aware of the issues that have been raised in relation to the time taken to hold an FAI from the time of death.

26. COPFS is committed to investigating deaths as timeously as possible, but will not compromise thoroughness for speed. Proceeding to FAI without carrying out the most thorough of investigations could result in incomplete evidence being put before the Sheriff who would then not be able to make a full determination.

27. The time taken for holding FAIs can be affected by many factors:
   - Time may have elapsed between the death occurring and it being reported to the Procurator Fiscal.
   - In some cases, criminal proceedings will require to take place before the FAI can take place. This inevitably takes time. Even when criminal proceedings do not take place, there can be considerable enquiries which need to be carried out to determine whether such proceedings are necessary and this requires to be completed prior to considering whether an FAI should be held.
   - In many of the deaths in which FAIs take place the Procurator Fiscal is dependent on the outcome of investigations carried out by the regulatory authorities which are bound by statute to carry them out. For example, the Air Accidents Investigation Branch (AAIB), the Health and Safety Executive (HSE), the Marine Accident Investigation Branch (MAIB) and the Rail Accident Investigation Branch (RAIB). These can be required in the most complex of cases. The Crown currently has no power to direct agencies such as these but cannot complete its own investigation until the safety investigation which establishes the cause of any fatal accident or work related incident has been completed by the relevant regulatory authority. This can hamper progress in the Crown investigation significantly and can cause delay in the holding of a FAI. For instance, representations had to be made recently by the Solicitor General and the First Minister to UK Ministers at Westminster regarding the time taken to see information being provided to the Crown by air accident officials investigating the Clutha helicopter crash and concern in relation to the time being taken to complete that AAIB investigation.
   - Many of the deaths which result in discretionary FAIs are complex and require COPFS to obtain expert evidence. Identifying the necessary expert can take time but it is very important that the most appropriate experts are requested to provide reports. The timing of the provision of reports is not something that COPFS can control and we cannot compel experts to provide them within set timescales. It can also be the case that the experts themselves raise further issues which require additional time for further investigation or instruction of further experts to provide reports.
• The timing of the hearing is also dependent on the availability of suitable court time which is the domain of the Sheriff Principal.

28. COPFS recognises the importance of holding an FAI as soon as possible once a decision is taken that an FAI is to be held. To this end, the Crown now petition the relevant court for FAI within 2 months of Crown Counsel instruction to hold a FAI.

**Practical implications of the Bill**

29. The Bill, in large part, implements those recommendations made by Lord Cullen that have not thus far been implemented. The Bill provides a more flexible approach to where FAIs can take place which will assist families and shorten the time taken for holding a FAI, allowing for greater use of alternative accommodation rather than Sheriff courts. The formalisation in statute of a preliminary hearing system will allow for consistency of approach across Scotland to focusing issues in advance of an inquiry. It is hoped that this will shorten the duration of Inquiries and reduce the occurrence of adjournments which can impact on the length of time taken to conclude a FAI. The Bill also extends the category of mandatory FAIs in an appropriate and proportionate way and now allows in certain limited circumstances for there to be a FAI into a death which occurred abroad.

Catherine Dyer
Crown Agent & Chief Executive
28 April 2015
Evidence relating to deaths of service personnel

During the oral evidence given by the Solicitor General and Stephen McGowan, Procurator Fiscal of Major Crime and Fatalities Investigation on 26 May 2015 the Convener asked if COPFS had held any discretionary Fatal Accident Inquiries for service personnel and an undertaking was given that this would be checked by COPFS. In addition, Christian Allard, MSP, asked that information also be provided to the committee on whether COPFS had been asked to hold a discretionary FAI for service personnel.

I have now had an opportunity to look into this issue.

It has not been possible to find the information you have requested from our database, which is a live operational database not designed for statistical or research purposes, as the specific criteria you have asked about is not recorded. This means that a manual search of all FAI cases would be required. However, members of the Scottish Fatalities Investigation Unit have been able to provide some information from their knowledge and experience in dealing with deaths investigations and conducting FAIs which may be of assistance to the committee.

Firstly, I would like to clarify that the death of an army cadet which was mentioned by Mr Finnie, MSP, as a possible example of such a discretionary FAI would not fall under that category. Although a discretionary FAI was indeed held into that death, the army cadet force is a youth organisation and does not form part of the regular armed forces.

A FAI was held into all the deaths of the 29 people killed in the 1994 RAF chinook crash at Mull of Kintyre and the determination was issued on 26 March 1996. Those killed included police officers and members of the security service who were employed at the time they died and service personnel. The Lord Advocate concluded a FAI was necessary because some of those on board at the time of the crash were engaged in the course of their employment and, while not mandatory in respect of all deaths, the inquiry should relate to all on board.

There have been 2 occasions where COPFS has been asked to hold a FAI into the deaths of service personnel.

The first involved the fatal crash of a Tornado aircraft on 2 July 2009 at Glen Kinglas. The aircraft had been involved in a low level training exercise when it crashed killing the pilot and navigator on board. The service inquiry which was conducted concluded the crash was caused by controlled flight into terrain and did not apportion blame. No FAI was held into the deaths. It is the recollection of those working in SFIU that initially a member of one family had expressed the wish that an FAI be
held with a view to a sheriff recommending certain restrictions and controls be implemented on low-level flying in Scotland. However records available reflect that at the time Crown Counsel issued the instruction that a FAI was not to be held it was understood that there was no longer a wish on the part of bereaved relatives for an FAI to be held as the matter they wished recommendations in connection with would have been outwith the powers of the Sheriff.

The second involved the collision of 2 RAF Tornado aircraft whilst on a routine training exercise over the Moray Firth on 3 July 2012 where the pilots of both aircraft and the rear seat instructor in one aircraft were killed. Crown Counsel instructed that there was to be no Fatal Accident Inquiry into the circumstances of the deaths. Written evidence has already been provided to the committee explaining the legal basis for the decision that these deaths did not fall under the mandatory category for holding a FAI and Crown Counsel considered there was no basis for a discretionary inquiry, there already having been a comprehensive service inquiry.

One of the three families expressed an interest in an FAI being held prior to the decision being taken not to hold such an Inquiry, however, when reasons were provided for the decision these appeared to be understood and accepted. When the decision not to hold a FAI was provided a member of one of the other families expressed surprise at the decision however they did not indicate that there was any matter which they considered could have been subject to the findings of a Sheriff in a FAI, which had not been covered by the information with which they had already been provided.

I hope that you find this information helpful.

Catherine Dyer
Crown Agent & Chief Executive
18 June 2015
When I gave evidence on the Inquiries into Fatal Accidents and Sudden Deaths etc. (Scotland) Bill on 26 May, I undertook to provide some further information to the Committee and also some further clarification on issues which were raised during the session about fatal accident inquiries (FAIs).

Mandatory Fatal Accident Inquiries

I understand that a number of respondents to the Committee’s call for evidence have proposed expanding the circumstances in which a mandatory FAI should be held. This was specifically suggested in the areas of industrial disease deaths, those of mental health patients and of children who are compulsorily detained by the State. The Committee has also heard views on the proposals consulted on by the Scottish Government for dealing with deaths of those detained by a public authority and the application of the European Convention on Human Rights (ECHR). I undertook to provide clarity on these matters.

European Convention on Human Rights

Let me deal with ECHR first. As stated in paragraph 255 of the Policy Memorandum, the Bill makes a significant positive contribution to realising in Scotland the procedural element of Article 2 of the ECHR (right to life), by continuing to provide for mandatory FAIs in certain cases and discretionary FAIs in others. The Scottish Government and the Presiding Officer have both certified the Bill as being compliant with the ECHR. The longstanding authority of the procurator fiscal to investigate deaths in Scotland as well as investigations by other public authorities (such as the Health and Safety Executive, the Mental Welfare Commission Scotland (MWCS) or the Air Accident Investigation Branch) plus the discretionary power of the Lord Advocate to hold an FAI meet the requirements of Article 2.

As the Solicitor General told the Committee, the “final safeguard” under the Scottish system is the Lord Advocate’s discretionary power to hold an FAI where article 2 compliance has not been secured by another authority’s investigation. The Solicitor General emphasised in this regard the independence of investigations by the Crown Office and Procurator Fiscal Service (COPFS) from those that may be carried out by other public authorities. There is also the additional safeguard that the Scottish Ministers may establish an inquiry under the Inquiries Act 2005, and that possibility is explicitly recognised in section 3(2)(d) of the Bill.

Industrial diseases

The Scottish Trades Union Congress have proposed that the mandatory category of deaths as a result of an accident in the course of employment should be extended to cover deaths caused by industrial disease.
It is not clear what purpose would be served in the public interest by an FAI when the exposure causing the fatality from industrial disease may have been decades ago, at a workplace that no longer exists, and where in any event the risks and dangers of that exposure are now fully known and understood. Further, the exposure may have occurred wholly or partly outside Scotland.

Deaths caused by industrial diseases are unlikely to be sudden or unexplained and it is likely that in most cases the victim will be pursuing civil redress against the employer (before death occurs) or the family will do so after the death.

Any deaths arising in any new industry, which do not fall within the current types of death which require a mandatory FAI, could, however, rightly raise issues of public concern and would be addressed by the holding of a discretionary FAI. This was confirmed by the Solicitor General who said:

“[New industrial processes or diseases are] exactly the type of situation where discretion would be exercised on whether to have an inquiry because, irrespective of whether it was a new type of industrial process or a new disease, there would be public concern about the issues surrounding its not having been aired before. Our holding an inquiry would fall into the category of erring on the side of caution because there had not been previous public scrutiny, especially if there were serious concerns about a new industrial process. I do not feel that it would be necessary to have such cases in the mandatory category because there are all sorts of difficulties around definition, but those are exactly the types of situation that would lead to discretionary FAIs.”

Neither Lord Cullen nor the Health and Safety Executive supported mandatory FAIs into deaths caused by industrial diseases. Lord Cullen said that “it is quite difficult to find a form of words that would bring in what we want to bring in without bringing in things that we do not want to bring in”.

Tom Marshall, of Thompsons, Solicitors, and President of the Society of Solicitor Advocates, said: “It is unrealistic to have a mandatory inquiry in every case of industrial disease”.

Detained mental health patients

The Scottish Government specifically consulted on Lord Cullen’s recommendation that provision be made for the investigation into the death of any person who is subject at the time of death to compulsory detention by a public authority within the meaning of the Human Rights Act 1998.

As I have explained above, a full FAI is not required in all cases to meet the requirements of Article 2 of ECHR and it is not the only means to have a death investigated. Sudden, suspicious or unexplained deaths are the subject of investigation by the procurator fiscal (and/or by other public authorities) and the Lord Advocate has discretionary power to hold an FAI into mental health-related deaths when it is considered to be in the public interest.

In relation to the Government’s question on Lord Cullen’s proposal, some 74% of respondents to consultation favoured the retention of the investigation by the
procurator fiscal and the exercise of discretion by the Lord Advocate on completion of the investigation to instruct an FAI.

Investigations are already carried out by the independent MWCS (in the case of mental health patients) who liaise with COPFS in cases which they feel may merit an FAI. Neither the MWCS nor the Royal College of Psychiatrists support having mandatory FAIs for detained mental health patients for the reasons set out in their submissions and consultation responses.

Many families of detained mental health patients may not want an FAI in the event that their loved one dies in compulsory detention. Many deaths of mental health patients will be from natural causes, which are nothing to do with their mental health condition, and it is difficult to see what would be achieved by an FAI in such cases.

Some witnesses drew attention to the fact that mandatory FAIs are held into all deaths in legal custody in prison or police custody and compared this with other forms of compulsory detention by the State. But prisoners are detained securely by the State for reasons of punishment and rehabilitation. Mental health patients are detained by the State – for the safety of the patient and of society – in a caring, healthcare environment. The Scottish Government would submit that this is fundamentally different from legal custody in prison or police custody. As the Solicitor General said:

“The balance in the legislation is appropriate. The purpose of mental health detentions is care of individuals. There would therefore not be the same public concern about, for example, people who are in police custody or prison, for whom there is an element of punishment as well as care.”

Further, the Lord President said in his evidence: “I think that we can rely on the good judgement of the Crown to identify exactly the cases in which such issues arise and cases in which they plainly do not”. He went on: “I think that we are in danger of imposing unnecessary rigidity on the system. The system by which the Crown makes investigations and forms judgements is, I think, the best model”.

To the extent there is any perception of “gaps” or lack of clarity in terms of practical working arrangements, I repeat my call for the relevant authorities to collaborate to produce any flow diagrams, protocols or Charters that might set out the optimal working practices in this field and secure greater confidence that everything is in order.

**Looked after children**

I note that Glasgow City Council recommended against widening the circumstances for mandatory FAIs for all deaths of looked after children and was content with the provision in the Bill which provides for mandatory FAIs for deaths of children in secure accommodation.

I would add to their view, however, that FAIs can be held in wider circumstances if it considered to be in the public interest by the Lord Advocate.
The law already provides for the investigation of deaths of looked after children through the reporting requirements of the Looked After Children (Scotland) Regulations 2009, (which require local authorities to notify the Scottish Ministers and the Care Inspectorate of a death within 1 working day).

Deaths of children in residential establishments are investigated and reviewed by the Care Inspectorate and many (half) are as a result of health issues. It is difficult to see how the public interest would be served by having a FAI for every such case.

The Care Inspectorate identifies any lessons to be learned and makes recommendations for review of legislation, policy or guidance.

The Centre for Excellence for Looked After Children in Scotland did not recommend making this a mandatory category because it said there was no certainty it would lead to improvements in services for looked after children and those leaving care.

COPFS liaise with and refer to Care Inspectorate reports to inform its decisions on whether to hold an FAI.

The legal definition of “looked after” children includes some who remain living at home with parents, or live with relatives, foster or adoptive parents. Lord Cullen specifically advised against bringing all looked after children within the mandatory grounds.

Finally, I would suggest that a mandatory FAI into the death of a child in wider circumstances than those specified in the Bill may cause the bereaved family unnecessary distress. As with mental health-related deaths I invite the relevant stakeholders to reflect on whether they might produce flow diagrams or other materials to make clearer the proper working practices in this field and more clearly demonstrate circumstances and decision making process as to when an FAI might be considered.

Military deaths in Scotland

The Committee has received concerns that currently the deaths of service personnel in Scotland are not investigated through mandatory FAIs because they are not considered to be employees, though the Lord Advocate may exercise his discretion to hold an FAI. I undertook to provide further information on this.

The Coroners and Justice Act 2009 introduced arrangements for FAIs to be held into deaths of Scottish military service personnel abroad. The 2009 Act amended the terms of the previous Coroners legislation and the Fatal Accidents and Sudden Deaths Inquiry (Scotland) Act 1976 to allow an FAI to be carried out in Scotland where appropriate into deaths of service personnel abroad. The spirit of the legislative change was to give a choice to affected nearest relatives as to whether a coroner’s inquest or an FAI be held if the deceased had links to Scotland. The provisions of the 1976 Act are proposed to be re-enacted without policy modification.

As the Committee will be aware, there was no FAI into the deaths of three RAF airmen following the collision between Tornado jets over the Moray Firth in 2012. I
am aware that COPFS has provided a detailed letter of legal reasoning to the Committee on why service personnel are not in the same legal position as civilian employees, in terms of mandatory FAIs under the 1976 Act.

No discretionary FAI was held in relation to the 2012 Tornado collision because "all the relevant issues have been comprehensively examined in the course of the Military Aviation Authority report and could not have been better considered in any FAI." COPFS also said an FAI "would only duplicate the months of thorough work undertaken by the Military Air Accident Investigation Branch and the Military Aviation Authority in preparing the service inquiry".

The Bill has been introduced on the basis that FAIs will be mandatory in cases of death as a result of an accident in the course of employment – a restatement of the 1976 Act.

The position of deaths of service personnel in Scotland was not raised in Lord Cullen's review or by any respondents to the Government's consultation on its legislative proposals. This issue only came to light during evidence given to the Committee by former Flight Lieutenant James Jones.

Mr Jones seeks to have mandatory FAIs into military deaths in Scotland. He and other campaigners have criticised the apparent inconsistency between how FAI legislation is applied and the system in England and Wales under the 2009 Act. For example, an FAI was held into the RAF Chinook helicopter crash in the Mull of Kintyre because civilian staff were also on board, which triggered a mandatory employment FAI. A coroner’s inquest would be held for any death resulting from a military accident that occurred in England and Wales.

Having reflected on the evidence at Stage 1, the Government believe that it is inconsistent to have discretionary FAIs into military deaths abroad (but only if the death is notified to the Lord Advocate) and coroners’ inquests into such deaths in England and Wales, but not when the death occurs in Scotland. Crown Office have confirmed to the Committee that they would not have difficulty with a change to the law which would permit FAIs to be held into deaths of military personnel in Scotland. This issue clearly involves the reservation of the naval, military or air forces of the Crown to Westminster. Any legislative action would have to be in the Westminster order which is proposed under section 104 of the Scotland Act 1998.

The latest position is that the Scottish Government is seeking the view of the Ministry of Defence on having mandatory FAIs into service employment deaths in Scotland. I will update the Committee on the response from the UK Government, when a response is received.

FAIs into deaths abroad

I am aware that COPFS has indicated that it is prepared to accept that death investigations may in exceptional circumstances have to be carried out without the body being repatriated to Scotland. The Government will consider a Stage 2 amendment to remove the need for the repatriation of the body. Death
investigations and FAIs into deaths abroad would remain at the discretion of the Lord Advocate.

**Representation of the family and legal aid**

The Committee has suggested that the Scottish Government was not implementing Lord Cullen’s recommendations regarding legal aid on cost grounds. That is not the only reason why the Scottish Government is not proposing that Lord Cullen’s recommendations should be implemented, though it is a significant one.

In his Review, Lord Cullen recommended that (i) relatives of the deceased should not have to justify the reasonableness of the granting of legal aid for their representation at an FAI; (ii) the Scottish Ministers should consider increasing the limit for legal aid in FAIs and the extent to which legal aid is available within that limit; and (iii) legal aid should, as a matter of course, be granted in any case where the participation of the relatives is necessary in order to comply with Article 2 of ECHR.

In its response to Lord Cullen’s Review, the Scottish Government responded as follows:

“The Scottish Government does not agree with this recommendation, and believes that existing statutory tests should continue to apply. While we regard it as important that relatives should be able to participate appropriately in FAIs, we do not accept that this requires automatic legal representation in every case.”

This view is reinforced by the fact that, in the current financial climate, it has been necessary to manage legal aid expenditure more effectively. Ministers are determined to do this in a way which maintains access to justice as far as possible, and do not believe that removing a test of reasonableness specifically for FAIs would contribute to this aim. All civil legal aid applications need to meet the statutory tests of probable cause and reasonableness.

Since it is for the procurator fiscal to investigate the circumstances of a sudden death, there must be a clear basis for a relative of the deceased requiring their own publicly funded legal representation. The basis of this approach is rooted in the function of the inquiry itself, namely that it is a fact finding exercise, and not one which seeks to apportion blame or fault.

Notwithstanding, the reasonableness test is likely to be met if a relative can demonstrate that they have a discernible interest that is unlikely to be subject to investigation by the procurator fiscal, necessitating that they have their own legal representation.

When an inquiry is investigating a potentially unlawful killing by agents of the State, or as outlined above, a death in legal custody, then we accept that it will be generally appropriate for relatives of the deceased to secure independent legal representation.
Accordingly, the tests of probable cause and reasonableness should be easy for an applicant to satisfy.\(^1\)

The Scottish Legal Aid Board (SLAB) has published guidance explaining the current approach taken when assessing reasonableness in these applications. Where a death occurs in legal custody, SLAB accept that it would be generally reasonable for relatives of the deceased to have independent representation, given that the investigation is being conducted by an agent of the State. This is the practice for legal aid applications. The Scottish Human Rights Commission indicated that there was no ECHR issue with the current provision of legal aid.

The Scottish Government does not believe that there have been any changes in circumstances which would cause it to revisit its attitude to the provision of legal aid for FAIs. In particular, the severe restraints on public expenditure imposed by the UK Government largely remain in place, and could indeed get worse in the forthcoming July 8\(^{th}\) Budget Statement and in these circumstances it would be inappropriate to extend legal aid availability for FAIs as this would reduce the amount available for other proceedings.

Notwithstanding that the function of an FAI is not to seek to apportion blame or guilt in civil or criminal sense, it is clear that some firms of solicitors continue to try to use FAIs as a method of trying to establish grounds for subsequent civil action. My officials have previously drawn the attention of the Committee to the website below which clearly sets out how some solicitors view FAIs as an opportunity to glean information which may support a civil claim.

http://www.lemac.co.uk/resources/guides/The_Fatal_Accidents_and_Sudden_Death_Inquiry.htm [Link no longer active]

In particular this site suggests that “any gaps or inadequacy in your civil claim should become clear or be capable of being dealt with”.

This is not the purpose of FAIs, which are inquisitorial judicial inquiries held in the public interest and not preliminary hearings for adversarial actions for civil reparation. Section 1(4) of the Bill makes it clear that the purpose of an inquiry is not to establish civil or criminal liability. I must emphasise this point robustly.

When I gave evidence to the Committee, I undertook to provide to the Committee the costs to the legal aid fund of supporting families at FAIs in the past three years, which totals £2,472,600 between 2011 and 2014.

\(^1\) http://www.gov.scot/Publications/2011/03/18150120/3
### FAI - Total Legal Assistance Paid inc VAT

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* estimated figures for 11-12 & 14-15
** provisional figures

These are the annual report figures for FAI costs, including Advice & Assistance (A&A), which was not included in the breakdown for the Financial Memorandum. The annual report figures are the summed effect of accounts from many FAI cases from the past few years. They represent what FAI cost as a subject area in any particular year. The figure for 2011-12 is higher as that includes representation for the Rosepark Care Home FAI that concluded in 2010.

The figures provided in the Financial Memorandum were constructed differently in that lifetime costs of cases were summed back on to the year the FAI case started. This allowed more detailed analysis of FAI case cost to demonstrate what the potential impact could be of a small increase in case numbers.

Please note that the figures for the last financial year are provisional. Legal aid costs for FAI cases may be payable over a number of financial years. SLAB emphasise that case numbers for FAIs are typically few, but case costs are potentially high and also very variable. Therefore any change to the provision of legal aid or the number of FAIs could have a disproportional affect on the Legal Aid Fund.

### Location of Fatal Accident Inquiry

I understand that the Committee heard concerns that the best location for an FAI was usually the sheriffdom in which the accident occurred. The Committee has asked whether the Scottish Government would consider including in the Bill an assumption that an FAI should be held in the local sheriffdom in which the accident occurred unless there was a good reason not to.

The Scottish Government agrees that FAIs should normally be held in the sheriffdom in which the death or deaths occurred (or the accident which caused the death(s)) and it is expected that this will continue to be the case in the vast majority of cases. Particularly in remote and rural parts of the country, it is right that an FAI should be held in the local sheriff court so that the bereaved family and/or witnesses do not have to travel significant distances. Section 12(3) of the Bill does, however, permit a sheriff to transfer proceedings to another sheriff of another sheriffdom, as recommended by Lord Cullen.

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2 Pages 25 and 26 of the Financial Memorandum
http://www.scottish.parliament.uk/S4_Bills/Fatal%20Accidents%20(Scotland)%20Bill/b63s4-introd-en.pdf
The Bill removes the link between the location of a death and the local sheriff court district. This will provide more flexibility in the system and should mean that court capacity will not delay FAIs being held since it will be possible to hold the inquiry where there is capacity. This may mean that the FAI is held in another sheriff court district within the sheriffdom or in another sheriffdom.

Lord Cullen recommended that FAIs should, where possible, not be held in a sheriff courtroom but elsewhere in other appropriate premises. The greater use of ad hoc premises as well as sheriff courts will provide maximum flexibility for accommodating FAIs as well as providing alternative accommodation as envisaged by Lord Cullen. The FAI into the 2009 North Sea Super Puma crash was held in the Council Chambers in Aberdeen City Chambers. Other FAIs have been held in Maryhill Community Centre, which was originally adapted for inquiry use for the ICL Stockline Inquiry headed by Lord Gill, and in a gospel hall in Motherwell.

The use of such premises may well permit FAIs to be held quicker than might be the case if capacity had to be found in a local sheriff court.

The Lord President gave evidence to the Committee in the following terms: “I think that in most cases it will be pretty obvious that the inquiry should take place in the jurisdiction in which the accident happened, but there will be cases in which it is more appropriate that inquiries take place where the families are. That gives us the necessary degree of flexibility”. He specifically disagreed that there should be a presumption on the face of the Bill that the inquiry be held locally. The Scottish Government agrees that the appropriate authorities can be entrusted to exercise their discretion sensibly on a case-by-case basis.

The ability to choose to hold an FAI in a different sheriffdom would permit, for example, an FAI in relation to a death in Glasgow to be held in, say Paisley or Dumbarton Sheriff Courts, rather than the very busy Glasgow Sheriff Court within the geographically small sheriffdom of Glasgow and Strathkelvin.

There is, however, no intention or expectation that an FAI into a death most closely connected to the sheriffdom of South Strathclyde, Dumfries and Galloway would be held in the sheriffdom of Grampian, Highlands and Islands, for example.

Centralisation of FAIs

The Committee asked what assurances could be given that the proposals in the Bill to enable FAIs to be held outside courts and away from the local sheriffdom would not be used by the Scottish Courts and Tribunals Service (SCTS) to centralise FAI hearings at some point in the future.

The Government consulted on the proposal that all FAIs would be held only in bespoke, dedicated centres, with specialist sheriffs, with one in the North of Scotland, one in the East and one in the West. This option was, however, rejected by 72% of consultees who responded to the questions on FAI accommodation who mostly cited the expense of providing such centres, the likelihood that they would be under-employed (since there are only around 50-60 FAIs per annum) and the cost and inconvenience to bereaved families who would have to travel to such centres.
The Lord President, to whom SCTS are responsible and who is statutorily responsible for the efficient disposal of business in the Scottish courts, specifically disagreed with a suggestion that the creation of specialist sheriffs for FAIs could lead to a possible centralisation of the FAI process. Lord Gill said in evidence to the Committee: “I do not think that that will happen. There is no immediate prospect of there being a centralised FAI system with a national FAI venue. It is not being contemplated at the moment and it is not even on the far horizon. I do not see any need for it, either”.

He went on: “The Courts Reform (Scotland) Act 2014….broke down the rigid barriers in sheriffdoms; sheriffs now have the flexibility to sit wherever they are sent. If a small group of specialist FAI sheriffs were to emerge, they could be deployed anywhere in Scotland as need arose. That would be a much better solution than a centralised venue”.

The Government does not therefore envisage any possibility of the centralisation of FAIs in the foreseeable future.

Expenses

Section 24 of the Bill expressly removes any power of the court to award legal expenses at an FAI. The Committee asked if I believed these should be retained as a tool to prevent abuse of process by parties to an FAI.

The Scottish Government does not believe that the award of legal expenses in FAIs is appropriate or necessary to prevent abuse of process by participants at an FAI. This is unconnected with the payment of the expenses of any witnesses etc.

FAIs are inquisitorial judicial inquiries held in the public interest. They are not civil proceedings which typically end with an award of expenses for or against one party. The policy of the Bill is that no expenses should be capable of being awarded against either the Crown or another participant at a judicial inquiry.

In relation to awarding expenses against the Crown, the issue of allowing such expenses to be awarded was considered in the case of Global Santa Fe Drilling (North Sea) Ltd v. Lord Advocate (2009 CSIH 43) where, in proceedings for judicial review, an award of expenses made by the sheriff at Aberdeen Sheriff Court was upheld in the absence of statutory direction on the point. If permitted, awards of expenses against the Crown would undermine the principle of the Bill that the decision to hold an FAI is for the Lord Advocate alone acting in the public interest. Section 14(1) of the Bill provides that an FAI is initiated by the procurator fiscal simply notifying the sheriff that an inquiry is to be held.

In relation to other participants at an inquiry, if a participant behaves veraciously, then the sheriff has case management powers to deal with that. The rule making power in the Bill will permit rules to be made to give sheriffs sufficient case management powers to be able to deal with vexatious behaviour as it arises without the need to award expenses. For example, FAI rules will greatly empower the sheriff to control proceedings through the use of minutes of agreed evidence, powers to regulate the conduct and management of proceedings and the regulation of witnesses and evidence. This approach is in line with the reforms introduced by the
Courts Reform (Scotland) Act 2014 to permit greater judicial control of the pace and
direction of court proceedings.

**Sheriffs’ recommendations**

Having read the official report for the 26 May session, I would like to take this
opportunity to clarify one point.

The Committee asked if I would expect SCTS to monitor compliance with sheriffs’
recommendations. When responding I said it would probably give more credibility to
the process if responses are made to the sheriff. As you are aware, the provision in
the Bill is for the response to be made to SCTS and not the sheriff, but I was keen to
emphasise that this would strengthen the authority of the inquiry process and the
sheriff’s recommendations in that responses would be sent to SCTS rather than
Scottish Government or another body. The Government’s consultation sought views
on responses going directly to the sheriff, however the Lord President, SCTS, the
Sheriffs Principal and the Sheriffs’ Association raised serious concerns as the
sheriff’s role in the FAI is ended (functus officio) once the determination has been
issued.

I understand that Patricia Ferguson has proposed a continuing involvement in the
enforcement of recommendations by the sheriff. Presumably a sheriff would be
required to call a party back to court if another party complained that the
recommendation had not been implemented. This causes us significant concern, in
that this would have major implications for shrieval and court resources if such a
proposal were to be adopted, since FAI proceedings would effectively continue,
possibly indefinitely, while interested parties complained to the sheriff – with
justification or not – that recommendations had not been implemented.

Section 26 of the Bill provides for the dissemination of the sheriff’s determination to
(a) each person to whom a recommendation is addressed and (b) any other person
whom the sheriff considers has an interest in the recommendation. This was a point
discussed during my evidence to the committee and dissemination could clearly
include any regulatory body with power to implement change, possibly on a UK
basis. This is how lessons from FAIs will be disseminated and learned. The Health
and Safety Executive’s evidence was that the relevant authorities review
determinations carefully and take recommendations very seriously indeed.

It would be inappropriate for the Scottish Government, SCTS or the Lord Advocate to
actively monitor compliance because this would place them in a quasi-judicial role.
Recommendations, made for a specific set of circumstances, often refer to working
practices which require interpretation on the ground and it is hard to see how the
Scottish Government could assess compliance in such circumstances. Many
recommendations, particularly in for example medical and aviation FAIs, are
technically complex and it might be a matter of opinion as to whether the
recommendation had been implemented. There may also be very legitimate reasons
not to implement a sheriff’s recommendation such as unintended consequences.
There may be better ways to achieve the desired result. Moreover, it would be
highly undesirable to expect devolved authorities to action changes to reserved
areas of regulation – health and safety at work being the most obvious one – where under current devolved responsibilities they would have no power to do so.

The Bill therefore proposes that SCTS would be the most appropriate body to receive and publish responses to sheriffs’ recommendations, particularly as the sheriff’s determination is published on the SCTS website. This was agreed by as being logical by the Chief Executive of SCTS. In this way, as stated earlier, the Bill will foster accountability on the part of those to whom sheriffs’ recommendations are addressed and responses to them will become more transparent by providing a public record.

What is proposed in the Bill broadly replicates what happens under the system of coroners’ inquests and the Ministry of Justice believe that this is a proportionate response which fosters compliance by those to whom coroners’ reports are sent.

The Committee also asked about consideration of legal sanctions against those who fail to respond, such as contempt of court. The Scottish Government does not believe that this is necessary as COPFS have indicated that parties to whom recommendations are addressed usually take them very seriously and there will be an incentive to respond in that the fact that a party has not responded will be noted next to the determination on the SCTS website. The Chief Coroner’s Office has indicated that there was a 100% response rate in the first six months of 2014 under regulation 29 of the Coroners (Investigations) Regulations 2013 (which mirrors what is proposed in the Bill) with no threat of legal sanction. I would expect that the media and public interest groups would seek to expose respondents who fail to produce a response, or an adequate response. Thus, in the words of the Health and Safety Executive, there will be a “strong steer” towards compliance in the Bill as it stands.

I hope the Committee finds this further clarification helpful. I will be replying separately about Patricia Ferguson’s Inquiries into Deaths (Scotland) Bill which was introduced on 1 June.

Paul Wheelhouse
Minister for Community Safety and Legal Affairs
4 June 2015
We are very pleased to respond to the call for written evidence on this Bill. The Royal College of Psychiatrists in Scotland has considered the Bill and has also been involved with this issue for some time, responding both to the review of Fatal Accident Inquiry Legislation carried out by Lord Cullen in 2009 and to the Scottish Government Consultation on Fatal Accident Enquiries Legislation in September 2014.

In response to the Lord Cullen review of 2009 the RCPsych in Scotland expressed strong views that the recommendation involving mandatory FAIs for all persons who die whilst subject to Compulsory Detention by a Public Authority should not be accepted. This would of course have covered all patients detained under the Mental Health (Care & Treatment) (Scotland) Act 2003, the Adults with Incapacity Legislation, Children’s Act and the Criminal Procedures Act who are cared for by our members and the services they work in. We believed that this would have been a backward step and would have done nothing to address the stigma and discrimination that people with mental health problems have to deal with. In addition the numbers of patients who would fall under the category would have imposed large numbers of elaborate, expensive and drawn-out judicial procedures on families, clinicians and services with no discernible benefit to justify it.

We are therefore very pleased that that this Bill does not include extending the categories of those who should be subject to a mandatory FAI to all those detained under mental health legislation.

We believe the rest of the content in the Bill is reasonable and we have no further comments to make at this time. We would be happy to be consulted again if there relevant issues pertaining to mental health raised during the passage of the Bill in the Parliament.

Dr Alastair Cook
Chair, RCPsych in Scotland
14 April 2015
Justice Committee

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

Written submission from Stuart Graham

Background

1 In writing this submission of an alternative that should be considered with consideration of FAI’s I should stress that it is not really an alternative but something that should be regarded as a proposal to sit alongside FAI’s.

2 I also write this as an individual with a very personal experience of FAI’s through having two carried out for family members. Through this I have witnessed very different issues being dealt with and resulting in very different degrees of satisfaction.

3 In the first of these cases there was an FAI carried out for the fatalities from the Chinook crash in the North Sea in 1986, my brother William was on this. The second was far more recent in the FAI looking at the circumstances of death for my stepson Colin Marr who died in very suspicious circumstances.

4 The outcome for the former was very important not only to the families but also for removing the possible risk for similar events to occur. The latter was far removed from providing any kind of satisfaction and in fact it was impossible to do so. Not only did the Sheriff comment on his belief that it should not be in his court but in fact we had also asked for its cancellation.

5 Unfortunately we had to agree to an FAI in the first instance to gain access to the investigation files as there was no other mechanism available to allow us to analyse and answer the many issues our family had.

6 If anyone has followed Colin’s case they will see that there has since been many complaints upheld and further actions taken. None of this would have happened without full access to documents. Furthermore, even if our concerns had been ill founded we would undoubtedly have achieved effective closure. This is an opportunity that many families have requested but have never been given. In fact we are one of only two families in recent history to have such an opportunity.

The problem with FAI’s for most families with fatalities

7 The fundamental issue for most families suffering fatalities in Scotland is that they are not held for the benefit of families. This can be found in paragraph 43 of the policy memorandum.

8 “It is worth bearing in mind that FAIs are judicial inquiries which are held in the public interest to establish the time, place and cause of a death and to identify reasonable precautions which may be taken to prevent deaths in similar circumstances. They are not held specifically for the benefit of the families.”
9 Although there is a process for COPFS to work with families through investigations, nevertheless, annually there are many families unhappy or uncertain with aspects of the investigation who request FAI’s. They do this as there is no other vehicle available to give them such answers and without realisation that the type of deaths their loved one has suffered does not fit in with the remit of a Full Judicial hearing as within the format of an FAI.

10 While it accepted that COPFS do seek inputs from families during investigations, they also have the right to ignore these inputs. This is a valid stance as it is critical that COPFS maintain their independence and impartiality throughout an investigation.

11 Furthermore, it is stated that investigation findings are shared with families. This is only a partial truth as many have found, in that, what is invariably presented is the information that supports the declared outcome. In our personal experience this is way short of what was actually found.

12 It should always be remembered that the primary purpose of COPFS and Police is the pursuit of criminals. It has to be reasonable that there may be borderline cases that exist that get by them and do not get their full attention. Once deemed to probably not be a crime they cannot demand the same attention as maybe families would wish. This is only right with limited resource but does not nor cannot remove the concern of the family.

13 This is a major demarcation from the manner that accused criminals are allowed access to findings from an investigation. Not only are the findings shared fully with the accused, they also have to be assessed by senior counsel before even attempting to execute a prosecution. Even here the success rate for conviction between 1997 to 2007 was only at 68.4%. (Difficult to find data beyond this period) This does not even account for those cases that did not make it to prosecution. (http://www.gov.scot/Topics/Statistics/Browse/Crime-Justice/Datasets/Homicide2009-10Datasets)

14 This data is not meant as a criticism of the investigation capability of the police but to highlight that it is feasible that they have not got enough evidence available. If this is the case for deaths that are incredibly scrutinised, is it not reasonable to assume that errors can be made when such scrutiny is not available and thus would it not be reasonable that some families may have many questions about the investigation? Is it right that deaths can be subject to what is called a short report and deemed to be conclusive without a family’s right to fully check or challenge?

15 Is it right that individuals that are not obvious cases of homicide are not deserving of having their family members assess the whole truth and in some cases defend their last right?
16 I believe that the FAI would not be the correct vehicle for these families as the basis of the FAI is to look at cause of death and the ability to prevent such deaths in the future. What we found, in Colin Marr’s FAI, was that the police investigation itself was out of bounds for questioning or challenging and this was the crux of our issues.

17 When there are doubts about cause of death and experts cannot be sure, the final outcome is invariably decided through the findings of the police investigation and yet there is no comprehensive way to see this and thus challenge any aspect of the finding, save hiring your own investigator. (An action we took to good effect.) It seems quite absurd that all other experts can have their findings shared and challenged but somehow the police investigation is sacrosanct.

18 Many families are left with many unanswered questions, doubts and worries that actually may have been addressed by the investigation but this lack of compassion in allowing access to material after an investigation is complete leaves a bitter taste and an open wound forever. The biggest shame would be that this pain exists when there is no need other than that we have not thought to put a mechanism in place to allow effective closure.

How to move forward

19 In developing our petition (PE1501) we have sought to comprehend how things are carried out in England and were astounded that they were already dealing with this through their Coroner system and had 30000 inquests a year to our 60 through our FAI system.

20 While this showed the marked disparity between the way people are treated across the UK, it also served hope that it was achievable to allow more access within Scotland. Also, talks with an ex head of CID from West Yorkshire confirmed that for many people they did get a higher degree of closure, helped bridge trust with the police and in some cases they actually found cases of homicide that were previously being dismissed as self-inflicted.

21 This Coroner system though is not a panacea as many families are dragged into a hearing that they do not wish for and as we have no Coroner system it would be likely to be of high cost to implement taking many years.

22 This brings us to the principle of our thoughts on what is needed to close an enormous gap in allowing families to be more central to the Justice Process. Rather than demanding that all deaths are subject to a public review we believe that upon what is deemed to be a successful closure of an investigation and seen as accident or self-infliction (Outwith FAI parameters), families should have the right to have access to the entire investigation findings if so required.

23 This would ensure that any family that does not want to be exposed to any more pain or suffering, need not be (except FAI’s and Prosecutions). Also, those families wanting more information receive it.
24 This could be managed through release of full packages from the investigation via the family Lawyers or an organisation such as Victims Support. The essence within these proposals has been supported by Victim Support Scotland and The Law Society of Scotland through the Petitions process. Precedent for such scale of release has been set.

25 It is believed that the majority of cases when reviewed by families and their advisors would finish with a satisfactory outcome allowing closure for many. In the few that may result in challenges it is envisaged that any new investigation would be driven and agreed with COPFS.

26 If a significant change in outcome has been derived from these investigations or it has been found that there has been a significant failure to investigate in line with protocols then there should be some form of public review to learn and implement effective corrective actions.

Benefits of suggested changes

27 The introduction of a system allowing families full access to fatal investigation findings will allow the Justice system to place families at the heart of the system.

28 In doing so, it will be done at the lowest possible cost with the ability to satisfy family needs without major judicial changes or hearings.

29 This will also result in random testing and inspection of investigations at little extra costs, which in turn will help drive robustness into these investigations that in turn should drive greater certainty of public support and trust.

30 This would sit alongside FAI’s in providing a comprehensive review of cause of death in Scotland.

(Greater detail provided through Petition and Justice Committee)

Stuart Graham
20 April 2015
SCID welcomes the opportunity to respond to the Justice Committee’s call for written evidence on the Inquiries into Fatal Accidents and Sudden Deaths (Scotland) Bill (“The Bill”).

From SCID’s point of view; “The most fundamental requirement: families need to understand what happened to their loved one, why it happened and, most important of all, to know that lessons have been learned from their loss to ensure that no other family will suffer as they have.” This statement epitomises the post-crash trauma of families bereaved by road crashes. SCID welcomes the majority of proposals in the Bill but would ask the Justice Committee to consider the following:

1. Are the circumstances for mandatory FAIs provided in the Bill sufficient?

1.1 It is current COPFS policy there will be no need for an FAI where criminal proceedings has taken place; however there can be circumstances which merit an FAI following criminal proceedings.

1.2 Following a fatal road crash a mandatory FAI will only be granted when a driver is killed whilst driving in the course of his/her employment. Paradoxically when another road user is fatally injured by a driver, driving in the course of his/her employment, then an FAI would be at the discretion of the Lord Advocate.

1.3 SCID applauds the Lord Advocate’s decision to hold a timely discretionary FAI into the “bin lorry” incident in Glasgow on December 2014 which resulted in the deaths of the 6 people. This incident rightly gives cause for public concern, but equally there is great concern when a professional/commercial driver is involved in an incident in which even one innocent road user is fatally injured.

1.4 We ask the Committee to consider extending mandatory legislation to include an inquiry into road users’ deaths arising from collisions involving drivers driving in the course of their employment including emergency services\(^1\). In doing so the essence of the Bill is fulfilled; as stated in Section 25(b) and (c)\(^2\).

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\(^1\) Annex A - Freedom of Information requests on fatalities involving emergency vehicles (years 2008-2013prov 6 fatalities)

\(^2\) There are no similar statistics available for commercial, corporate or professional drivers.

\(^2\) Inquiries into Fatal Accidents and Sudden Deaths (Scotland) Bill: 25(b) the making of improvements to any system of working; 25(c) the introduction of a system of working.
2. **Are the circumstances provided for in the Bill in respect of discretionary inquiries appropriate?**

2.1 SCID welcomes steps already taken by COPFS and the inclusion in the Bill to provide bereaved families with written reasons when a decision is taken not to hold an FAI. This provision has been a long standing issue for SCID.

2.2 It is the case that the majority of bereaved families have no knowledge of the investigative process or of the purpose of FAIs. The procurator fiscal (PF) will explain the investigative and possible judicial process but as the PF acts in the public interest bereaved families have no input into the processes.

2.3 Many families bereaved by road crashes welcome a discretionary FAI as set out in section 25(2) of the Bill especially to get the facts ventilated in public and measures put in place to prevent a similar occurrence in future. It is also the first time that there interests can be represented in court.

2.4 SCID supports Lord Cullen’s recommendation that “relatives of the deceased should not have to justify reasonableness of the granting of legal aid; and the limit should be increased for legal aid for FAIs.”

2.5 There are approx. 50-60 FAIs in a year. It reasonable to request the Justice Committee, if they have not already done so, to commission SPICe to examine the legal aid cost of discretionary inquires in the last year with a view to reconsidering the Scottish Government’s position on extending legal aid.

3. **Should the Sheriff’s recommendations be binding?**

3.1 COPFS have reported that there is no evidence that the sheriffs recommendations are not being acted upon. SCID would put it to the Justice Committee that there is no evidence that sheriffs’ recommendations are being acted on.

3.2 It has been SCIDs experience that any recommendations made by the sheriff do not come to the attention of the Scottish Government. This is an opportunity missed. Road safety is a collective issue. The Scottish Government’s stated commitment in *Scotland’s Road Safety Framework to 2020* is “all interventions can play their part in saving lives, and each partner matters equally. This partnership approach relies on all of us working together to deliver the Framework commitments” yet at present the fundamental purposes of an FAI go unheeded by the Scottish Government.

3.3 From several studies presented in the Dundee Law School Report an independent multi-road collision investigation body carrying out in-depth safety

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3 No statistics available on legal aid applications for discretionary inquiries. From SCIDs experience an application for legal aid is not made in all cases.
6 University of Dundee School of Law Report: ‘Access in Europe by a bereaved family to information gathered during an investigation into a fatal road collision’
investigations of each fatal road collision working alongside the police investigation and publishing the results was recognised as best practice. Such a model is a core ingredient of road traffic safety policies and has been proven to lead to immediate improvements to the road environment and to road safety.

3.4 In the absence of such a model in Scotland, SCID supports Lord Cullen’s recommendation that there should be a “duty on bodies subject to recommendations to make a written response to the Scottish Government confirming steps taken to implement if any with reasons.” This recommendation is particularly relevant given the Scottish Government policy to reduce road deaths and injuries as in Scotland’s Road Safety Framework to 2020.

3.5 It is the duty of the Scottish Government to monitor and learn from the recommendations made by sheriffs. Any recommendations should require a written response from bodies concerned, within an agreed timeframe, confirming that recommendations have been applied. It would be for the Scottish Government to decide which Minister would be responsible for monitoring responses but consideration should be given to the Minister for Transport and the Islands in accordance with Scotland’s Road Safety Framework to 2020.

Scotland’s Campaign against Irresponsible Drivers
23 April 2014

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8 See Vagverket- In depth studies of fatal accidents help to save lives www.trafikverket.se

“Every death and every serious injury on the roads is one too many. We need to maintain the huge effort made by many people in Scotland towards making our roads safer. Indeed, we need to take stock and see what more we can do.”
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FOI request Police Service of Scotland 11th September 2013 Ref No IM-FOI-2013-1067
Ms Margarat Dekkor  
17 Scott Drive  
Cumbernauld  
G67 4LB

Dear Ms Dekker

FREEDOM OF INFORMATION REQUEST

Thank you for your email dated 10 September 2013 requesting information under the Freedom of Information Act Scotland 2002 which has been processed.

Detail

You asked for information for the years 2008-2012 inclusive on the number of Scottish Ambulance Service vehicles which have been involved in road casualties; a) injury only and b) fatal.

Response

We only hold information from April 2010. For this period the number of Scottish Ambulance Service vehicles involved with injury only accidents is 105 vehicles. The number of vehicles involved in fatal accidents for this period is 2 vehicles.

Prior to April 2010 we were recording all data in our ledger and as such we do not hold details at incident level. In April 2010 we appointed a claims handler who has the functionality to record all of this data.

Review Procedure

If you are dissatisfied with the way in which I have dealt with your request, you are entitled to require a review of this decision. Should you decide to request a review you must:

Apply for a review of our decision in writing within 40 working days of the date of this notice and include:

- An address for further correspondence
- A description of the original request and
- The reason(s) why you are dissatisfied with our decision

A Special Health Board of the NHS in Scotland
You should address your request for a review of decision to:

Sharon Hammelt
Head of Corporate Affairs and Engagement
Scottish Ambulance Service
National Headquarters,
Gyle Square
1 South Gyle Crescent,
Edinburgh, EH12 9EB
0131 314 0000
e-mail: sharon.hammelt@nhs.net or richard.walter@nhs.net

The request for a review will be passed to another manager who was not involved in the original decision to assess the application.

Following the review you will receive notice of the result as soon as possible but in any case within 20 working days of us receiving it. Our response will explain the decision of the reviewer as well as details of how to appeal to the Office of the Scottish Information Commissioner if you remain dissatisfied with the review decision reached by us.

If you wish to appeal to the Scottish Information Commissioner you may do so at the details below:

Scottish Information Commissioner
Kinburn Castle
Doubledykes Road
St Andrews
Fife
KY16 9DS
Telephone: 01334 454610
Fax: 01334 454611
e-mail: enquiries@itspublicknowledge.info

Should you have issues you would like to discuss about this process, please contact me.

Yours sincerely

Linda Nell
Administrator Claims/Corporate Affairs and Engagement
From: "Haddow, Debbie" <DEBBIE.HADDOW@firescotland.gov.uk>
Date: 23 October 2013 10:30
To: <mdssker@blueyonder.co.uk>
Subject: Freedom of Information Request No. 725 - Number of Scottish FRS Vehicles involved in RTCs
Dear Ms Dekker

Thank you for your request for information.

Your request has been processed in accordance with Freedom of Information (Scotland) Act 2002.

I have noted below the information you requested in regards to the number of Scottish Fire and Rescue Service vehicles involved RTC's which resulted in injuries and fatalities.

<table>
<thead>
<tr>
<th>Year</th>
<th>Injuries</th>
<th>Fatalities</th>
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<tr>
<td>2008/09</td>
<td>19</td>
<td>0</td>
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</table>

In line with the terms of the Freedom of Information (Scotland) Act 2002, Scottish Fire and Rescue Service has in place a procedure by which a review of the way in which we handle requests for information can be carried out. If you are dissatisfied by the way Scottish Fire and Rescue Service have dealt with your request or about any decision made by them in connection with your request, and wish a review to be carried out, please inform me of this by 18th December 2013. In doing so, it would be helpful if you could state the matter, which has given rise to your dissatisfaction.

Staff not involved in the original decision will handle any review.

Should you not be satisfied with the outcome of our review, you will then have the right to appeal to the Scottish Information Commissioner within 6 months. The Commissioner will decide whether your request has been dealt with properly, in accordance with the Act.

The Commissioner's contact details are as follows:

Scottish Information Commissioner
Kinburn Castle
Doublesdykes Road
St Andrews, Fife
KY16 9DS

Telephone: 01334 464610
Fax: 01334 464611

E-mail: enquiries@itspublicknowledge.info

For further details, please see the Commissioner's website at www.itspublicknowledge.info.

Please do not hesitate to contact me if I can be of further assistance.

Regards
Sharon Reid

Sharon Reid, Data Protection Officer/Freedom of Information Officer
Scottish Fire & Rescue Service, West Service Delivery Area, Bothwell Road, Hamilton, ML3 0EA
T: 01698 402627: Sharon.Reid@firescotland.gov.uk

23/10/2013
Summary of key points

- The Equality and Human Rights Commission (the Commission) welcomes the proposal to extend the legislation for mandatory Fatal Accident Inquiries (FAIs) to cover the death of a person in police custody irrespective of the location of the death.
- The Commission welcomes the extension of the legislation for mandatory FAIs to apply to children in secure accommodation.
- The Commission welcomes the requirement on those to whom sheriffs direct recommendations to respond.
- The Commission is concerned that the Bill does not propose to make any changes in relation to FAIs concerning the death of any person who is subject at the time of death to compulsory detention by a public authority within the meaning of the Human Rights Act 1998.
- The Commission has particular concerns about the investigation of the death of people detained in psychiatric care and children looked after under statutory orders, other than those in secure accommodation.
- The Commission is concerned that the current proposals set out in the Bill may not comply with the principles of Articles 2 and 14 of the European Convention on Human Rights.
- The Commission notes that Clause 3 of the Bill allows for exceptions to the mandatory FAI and proposes that, were mandatory FAIs relating to the death of any person in compulsory detention by a public authority introduced, similar exceptions could apply.

The Commission largely welcomes the increased flexibility of the system for designation of places where a FAI may be held, on the understanding that venues under consideration will have regard to the accessibility of the relevant premises for disabled people.

Submission

1. The Equality and Human Rights Commission (EHRC) is the National Equality Body (NEB) for Scotland, England and Wales, working across the nine protected grounds set out in the Equality Act 2010: age, disability, gender, race, religion and belief, pregnancy and maternity, marriage and civil partnership, sexual orientation and gender reassignment. We are an “A-status” National Human Rights Institution (NHRI) and share our mandate to promote and protect human rights in Scotland with the Scottish Human Rights Commission (SHRC). We welcome the opportunity to comment on the Inquiries into Fatal Accidents and Sudden Deaths etc. (Scotland) Bill.

2. The Commission’s response to the Consultation on proposals to reform FAIs focussed on issues surrounding the circumstances for mandatory and discretionary FAIs and we intend to follow this approach in this submission.
Proposed system of mandatory FAIs: specific concerns

3. One of the options in the Consultation was for a case review by a public authority such as the Mental Welfare Commission to be combined with a discretionary power to hold a FAI. 59% of respondents supported this option as did the Commission, on the understanding that the proposal was to meet the aim of an independent investigation into the death of a person subject to compulsory detention by a public authority. It is noted however that this option has not been fully adopted by the Bill.

4. The Commission welcomes the proposal to extend the legislation for mandatory FAIs to cover the death of a person in police custody irrespective of the location of the death, as well as the death of children in secure accommodation (clause 2). The Commission welcomes the requirement on those to whom sheriffs direct recommendations to respond in writing as this would address the issue of accountability raised in para 12 (h) below (clause 27). The Commission largely welcomes the increased flexibility of the system for designation of places where a FAI may be held, on the understanding that venues under consideration will have regard to the accessibility of the relevant premises for disabled people and others with access needs. (clauses 11-12)

5. The Commission is concerned however, that the Bill does not propose to make any changes in relation to independent inquiries into the death of any person who is subject at the time of death to compulsory detention by a public authority within the meaning of the Human Rights Act 1998, in terms of Lord Cullen’s Recommendations at para 4.20.

6. Specifically, the Commission has concerns regarding the death of children who are not in secure care but who nonetheless may be compulsorily living away from home under the authority of a Child Protection Order or a Compulsory Supervision Order (consultation question 4). Similarly, the Commission has concerns regarding the death of adults and children who may be under compulsory detention, or living in the community and subject to an order under the Mental Health (Care and Treatment) (Scotland) Act 2003, or subject to detention under the use of legal guardianship or other powers under the Adults with Incapacity (Scotland) Act 2000 (for example with a requirement to attend day care or take certain medication).

7. The Commission recently completed research in Scotland which contributed to our report on “Preventing Deaths in Detention of Adults with Mental Health Conditions”. The report notes that the number of non-natural deaths of detained patients remained constant in 2010, 2011 and 2012; there were 6, 7 and 6 respectively. All were recorded as suicides. In contrast, in the same period in a prison setting there were 10, 6 and 8. In police custody the figures were 4, 2 and 0. (see table on p68).

8. In 2012-13, 78 deaths were reported to the Mental Welfare Commission in Scotland where people had died while subject to compulsory treatment. Information on 73 of these deaths was provided. Over half (53) were from natural causes, 6 had no explanation or relation to mental health, 11 were suicides and 3 recorded as delirium. Of the 11 suicides, 5 individuals were in hospital at the time, 3 were subject to compulsory community treatment and the remaining 3 were in the community under suspension of detention (see page 68).

9. In contrast, when the Commission looked at the FAI Judgements on the Scotcourts website, we found only two relating to a suicide in detention (both 2007) one where the person had absconded from the ward (2007) and one suicide in a day unit (2005).

10. These figures demonstrate that under the current system of discretionary investigation, a very small proportion of deaths in mental health detention lead to a FAI whereas all deaths in police custody and prison would lead to a FAI, although deaths in both contexts engage the responsibility of a public authority.

Human Rights approach

Article 2

11. Article 2 of the European Convention on Human Rights ("the Convention"), which safeguards the right to life, ranks as one of the most fundamental provisions in the Convention. Strasbourg has emphasised that the purpose of the Convention is such that it must be applied in a way that makes its safeguards practical and effective. Article 2 creates a positive obligation on States to take appropriate steps to safeguard the lives of those within their jurisdiction. Where lives have been lost in circumstances potentially engaging the responsibility of the State, there is a duty on the State to ensure, by all means at its disposal, an adequate response – judicial or otherwise – so that the legislative and administrative framework set up to protect the right to life is properly implemented and any breaches of that right are properly dealt with. In this connection, the Court has held that criminal proceedings are not required in every case and civil, administrative or even disciplinary remedies can be sufficient.2 The essential purpose of such investigation is to secure the effective implementation of the domestic laws which protect the right to life and to ensure the State is held accountable for deaths occurring under their responsibility.3

12. The Commission therefore reiterates the importance of an independent investigation into the death of any person where the responsibility of the state is potentially engaged. In the Commission’s view the following are required for a review to be compliant with Article 2:
   a. The body must have authority to initiate that investigation itself
   b. It must be carried out promptly and as quickly as is reasonable
   c. All reasonable steps to secure the relevant evidence relating to the death must be taken

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2 Oneryildiz v Turkey 48939/99
3 Paul and Audrey Edwards v UK 464777/99
d. All reasonable steps to uncover any discriminatory motive behind the
death must be taken
e. It must be carried out by someone who is independent of those
implicated in the events
f. The investigation and its results must be open to public scrutiny
g. The next of kin must be involved to ensure their interests are protected
h. Anyone found to be at fault as a result of the investigation must be held
to account
i. Lessons learned from the result of the investigation must be put into
practice to ensure, so far as possible, that the risk of similar deaths in
the future is minimised.

These requirements have been developed into a ‘Human Rights Framework
for the EHRC Inquiry on Preventing Deaths in Detention of Adults with Mental
Health Conditions.’

13. The Commission’s Inquiry Report noted at page 71 that “patients who die
while subject to compulsory treatment under the “Mental Health (Care and
Treatment) (Scotland) Act 2003 are reported to the Mental Welfare Commission
(MWC) by the health board. If the MWC have concerns that a person may not have
had the appropriate care or treatment, they may investigate further. Internal reviews
into deaths and near misses are conducted across all settings. The reports relating
to these are rarely published, making it difficult to ensure public scrutiny. A lack of a
standardised approach to conducting and recording critical incident reviews across
health boards in Scotland was a concern as a potential barrier to sharing learning.
However it is clear that there has been, and continues to be, significant efforts to
improve the review and learning culture. Healthcare Improvement Scotland is
leading this work and a National Framework was published in 2013.”

14. Amongst the Scottish recommendations of the report, were the following:
(page 73):

   a. The investigative structures for the deaths of detained patients in NHS
      Scotland mental health wards should be strengthened in line with our
      Human Rights Framework and clarified,

   b. To ensure adequate scrutiny of deaths in detention, responsible agencies
      should systematically collect, analyse and make available data by
      protected characteristic.

   c. Lessons learned in relation to deaths in detention are not being shared
      across settings. Responsible agencies should consider how this could be
      achieved and put this into practice.

15. It is noted that at paragraph 114, the Policy Memorandum states that the
MWC did not favour mandatory FAIs for the death of every person subject to
compulsory detention by a public authority. Whilst this is correct, the MWC did
support the second Consultation option; supporting the principle of some form of
investigation into the deaths of detained patients whilst retaining the independence
of the role of the Lord Advocate in relation to deaths. The MWC also went on to
express concern that not every death in compulsory detention is notified to the fiscal.

4http://www.equalityhumanrights.com/sites/default/files/uploads/Pdfs/ADI/formatted/Human%20Rights
%20Framework.pdf
The current system is confusing eg Crown Guidance to medical practitioners specifies that deaths in legal custody should be notified but does not specify that deaths under mental health detention should be notified. There is a separate system of notification for Health Improvement Scotland and a local case review for clinical services (Analysis of Consultation Responses para 2.47). The MWC proposed a solution whereby all deaths under compulsory orders would be reported to both the MWC and the PF followed by a system of review by the MWC who would liaise with the PF and advise if it was considered there were grounds for an FAI. The Lord Advocate would retain final discretion. In addition, it is noted that all deaths in prison trigger an FAI, regardless of whether they are of natural causes, unless one of the proposed exceptions apply.

16. It is the Commission’s position that the current disparate system in relation to the investigation of the death of people detained by a public authority, in particular those detained in mental health detention, is confusing and may lack sufficient procedural safeguards to meet the requirements of Article 2 as outlined above.

**Article 14**

The European Court of Human Rights has emphasised that persons in custody are in a vulnerable position and that the authorities are under a duty to protect them. It is incumbent on the State to account for any injuries suffered in custody. The Commission is particularly concerned that people under compulsory measures of psychiatric care and children in compulsory supervision are amongst the most vulnerable in society and that there must be a robust, clear system for investigation into their deaths, where lives have been lost in circumstances potentially engaging the responsibility of the State, in order to comply with the State’s obligations in terms of Article 2.

17. The Scottish Human Rights Commission stated in their response: “The Court has (also) recognised that the position of inferiority and powerlessness which is typical of patients confined in psychiatric hospitals calls for increased vigilance in reviewing whether the Convention has been complied with.” The Commission supports this view.

18. Where states have a general obligation to conduct an effective investigation in cases of deprivation of life, that obligation must be discharged without discrimination, as required by Article 14 of the Convention. The Court has held that discrimination can mean treating differently, without any objective and reasonable justification, persons in relevantly similar situations. It applies, for instance, to situations where different rules for early release apply to sentences of different types. It is capable of extending to discrimination in the enjoyment of the Convention rights on the grounds of physical or mental capacity.

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5 Paul and Audrey Edwards v UK 464777/99  
6 Herczegfalvy v Austria (1993) 15 E.H.R.R. 437  
7 Nachova v Bulgaria 43577/98  
8 D.H. and Others v. the Czech Republic [GC], no. 57325/00  
9 Clift v United Kingdom, Application No 7205/05 and Laduna v Slovakia App 31827/02  
10 (Pretty) v DPP [2002] 1 AC 800
19. The Commission is therefore concerned that the proposed system whereby there would be a mandatory FAI for a person in the custody of the police/in prison but not for a person detained by a public authority in other contexts could be discriminatory.

20. It could be argued that there is an objective and reasonable justification for treating people in other forms of state detention differently. It is noted for example that the Royal College of Psychiatrists expressed the view that there would be little public interest in having an automatic FAI for a patient who dies an expected death from an unrelated physical health problem. However RCPsych did support independent case review by another body such as the Mental Welfare Commission (Analysis of Consultation Responses para 2.45).

21. Clause 3 of the Bill sets out exceptions to the mandatory FAI, allowed at the discretion of the Lord Advocate, where satisfied that the circumstances of the death have been sufficiently established in the course of certain prescribed other proceedings, which include; criminal proceedings, health and safety proceedings and public inquiries. It is respectfully proposed that if there were to be mandatory FAIs for any person detained by the state, the categories of exceptions could be expanded eg where the Lord Advocate is satisfied that the circumstances of the death have been sufficiently established in the course of other prescribed proceedings such as an investigation by the MWC. Such a system of statutory exceptions might provide a less discriminatory means of meeting the policy objective whilst still putting in place a robust system of investigation into the deaths of people detained by a public authority, in pursuit of the aim of compliance with the principles of Articles 2 and 14 set out above.

Conclusion

22. In conclusion, whilst the Commission welcomes the proposal to extend the provisions for mandatory FAIs to other categories of people in custody, the Commission has particular concerns about the position in relation to the death of people detained in psychiatric care and in relation to children looked after under statutory orders other than those in secure accommodation which have not been addressed. The Commission would welcome further consideration of the issues set out in this submission.

Equality and Human Rights Commission
24 April 2015

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11The Commission notes that HSE also has a role in investigation of suicides in hospitals but that there has been only one prosecution in recent years (2014)
Justice Committee

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

Written submission from the Forum of Scottish Claims Managers

About the Forum of Scottish Claims Managers

The Forum of Scottish Claims Managers exists as a representative organisation on behalf of its members, working to improve the handling of insurance claims to deliver a better service to claimants, and seeking to promote the interests of the Forum members in civil justice matters covering the handling of insurance claims. The Forum aims to be actively engaged, with all interested parties, in discussions and debate relating to Third Party claims in Scotland including Pre and Post-litigation. A membership list and more information on the Forum are appended below.

General comments

We welcome the policy objective of the Bill to reform and modernise the law governing the holding of fatal accident inquiries in Scotland. We note that Patricia Ferguson MSP has proposed a Members' Bill to reform fatal accident inquiries; we consider that the Scottish Government's proposals, as currently set out in the Inquiries into Fatal Accidents and Sudden Deaths etc. (Scotland) Bill, provide the more workable, flexible and effective reform package.

Mandatory fatal accident inquiries (Sections 2 - 3)

We support the circumstances provided for in the Bill for mandatory fatal accident inquiries and do not believe that alternative approaches should be considered.

Discretionary fatal accident inquiries (Section 4)

We support the circumstances provided for in the Bill for discretionary fatal accident inquiries and do not believe that alternative approaches should be considered.

Inquiries into deaths occurring abroad (Sections 6 - 7)

We support the circumstances provided for in the Bill for inquiries into deaths occurring abroad.

Pre-inquiry procedure (Sections 14 - 17)

We consider that a fatal accident inquiry should not take place where criminal proceedings are being considered or are still underway, as competing investigations would not be in the public interest. We note that this is not explicitly provided for in

1 Personal Injury or damage to Property arising out of a party's negligence – be it a personal (Consumer) matter or a Commercial (Business) matter, Road Traffic Accidents and accidents in the Workplace.
the Bill and whilst we understand that the decision to launch both criminal proceedings and fatal accident inquiries rests with the Lord Advocate, it may be appropriate to have an express provision to this effect within the Bill.

**Expenses (Section 24)**

We consider that section 24 requires amendment as we are of the view that a Sheriff should retain the power to make an award of expenses against the Crown, where the Inquiry is deemed unnecessary or vexatious by the Sheriff, in line with current legal precedent as outlined in the case of *Global Santa Fe Drilling (North Sea) Limited and others v The Lord Advocate.*

Calum McPhail  
Chairman of the Forum of Scottish Claims Managers  
27 April 2015

**Further information on the Forum of Scottish Claims Managers (FSCM)**

1. The Forum aims to promote improvements to the law to enable consumers easier and quicker access to justice.

2. The Forum membership covers a number of major insurers, financial institutions together with claims handling companies and Local Authorities.

3. The individual members of FSCM are all senior professionals being Claims Managers or equivalent within their respective organisations with a wealth of experience in Insurance claims matters.

4. To provide some context of the size and scale of our membership:
   
   - We directly employ approximately 5,550 people in Scotland, solely in insurance
   - We generate over £1.9 billion annually in respect of insurance premiums collected in Scotland (Personal and Commercial business premiums)
   - Solely on claims, we spend £1.257 billion annually in Scotland
   - Glasgow is the largest insurance centre in the UK, outside London and is seen as core pool of talented resources

5. Insurance companies exist to provide financial protection for consumers and businesses in the event that the unforeseen happens.

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### Membership:

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By way of introduction, Zurich is one of the world’s largest insurance groups and one of the few to operate on a truly global basis. Our mission is to help our customers understand and protect themselves from risk. We have over 60,000 employees serving customers in more than 170 countries worldwide, including 11,000 in the UK. We offer a wide range of general and life insurance products and services for individuals, small businesses, mid-sized and large companies and multinational corporations.

As a leading UK employer’s liability insurer in the UK, a major insurance service provider in both private and fleet motor insurance and of risk management and insurance solutions to Britain’s public services, we very much welcome the opportunity to respond to the request for submission of views in relation to this Bill.

Zurich supports the creation and maintenance of fair, effective and efficient procedures which will enable swift investigation and assessment of circumstances and support involved parties throughout. We believe it is essential that Inquiries are undertaken only in appropriate circumstances and that there should be no potential for duplication or conflict between investigations, Criminal Proceedings or Inquiries.

Our views on the areas highlighted are noted below and are restricted to those areas where we have specific expertise, knowledge and involvement, based on a genuine attempt to provide clear insight.

1. General comments

We welcome the policy objective of the Bill to reform and modernise the law governing the holding of fatal accident inquiries in Scotland. We note that there is a proposed Members' Bill to reform fatal accident inquiries but consider that the Scottish Government's proposals, as currently set out in the Inquiries into Fatal Accidents and Sudden Deaths etc. (Scotland) Bill, provide a more workable, flexible and effective reform package.

2. Mandatory fatal accident inquiries (Sections 2 - 3)

We support the proposed circumstances provided for in the Bill for mandatory fatal accident inquiries and do not believe that alternative approaches should be considered.

3. Discretionary fatal accident inquiries (Section 4)

We support the proposed circumstances provided for in the Bill for discretionary fatal accident inquiries and do not believe that alternative approaches should be considered.
4. Inquiries into deaths occurring abroad (Sections 6 - 7)

We support the proposed circumstances provided for in the Bill for inquiries into deaths occurring abroad.

5. Pre-inquiry procedure (Sections 14 - 17)

We consider that a fatal accident inquiry should not take place where criminal proceedings are being considered or are still underway, as competing investigations would not be in the public interest. We note that this is not explicitly provided for in the Bill and whilst we understand that the decision to launch both criminal proceedings and fatal accident inquiries rests with the Lord Advocate, it may be appropriate to have an express provision to this effect within the Bill.

6. Expenses (Section 24)

We consider that section 24 requires amendment as we are of the view that a Sheriff should retain the power to make an award of expenses against the Crown, where the Inquiry is deemed unnecessary or vexatious by the Sheriff, in line with current legal precedent as outlined in the case of Global Santa Fe Drilling (North Sea) Limited and others v The Lord Advocate 2009 CSIH 43.¹

We would be happy to discuss any of the above areas further. If the Justice Committee wishes to discuss any aspect in our response, please do not hesitate to contact us.

John Latter  
Director of Technical Centre  
UK Claims  
27 April 2015

¹ [http://www.scotcourts.gov.uk/opinions/2009csih43.html](http://www.scotcourts.gov.uk/opinions/2009csih43.html) [Link no longer active]
As the trade union and professional body that represents around 39,000 nurses and nursing staff in Scotland, the Royal College of Nursing (RCN) Scotland welcomes the opportunity to submit evidence on the Fatal Accidents and Sudden Deaths etc (Scotland) Bill. We have views on particular aspects of the proposed legislation, set out under headings below.

The RCN supports moves to ensure Scotland's fatal accident inquiries (FAIs) are a clear and transparent mechanism for the investigation of deaths that occur in a health care setting. A high level of transparency allows the families of those who have died to establish the circumstances around the death of their loved one and to have confidence in the resulting recommendations. The better the FAI system, the better chance organisations have to put in place measures to minimise the risk of such an event again. Problems with staffing, training and equipment are some examples of the issues that can emerge at an FAI.

The following sections set out our views on particular aspects of the Bill.

Discretionary FAIs

We are of the view that clear and robust investigation procedures should be put in place for all deaths that are likely to meet the criteria for an FAI, resulting in a more efficient, effective and transparent system which may ultimately reduce the number of discretionary FAIs. Such a formalised and transparent investigation could be carried out sooner, with lessons learned sooner. This would not only reduce costs to all parties, it would result in the same outcome as an FAI.

Location of FAIs

We recognise the need to cut the link between the location of the death and the geographical closeness of the sheriff court to allow greater flexibility and minimise delays, as the Bill would do. However, this needs to be balanced with the fact that the location of the sheriff court can be important. There may be different procedures, pressures, nursing and other practices in different parts of the country, so taking an FAI in a different location may lose this context. The circumstances of the particular community in which the death took place may also be relevant. The RCN therefore believes that an FAI should be carried in the local sheriff court wherever possible.

Efficiency of FAI system

We support the Bill’s intention to introduce rules that will govern the agreement of evidence in advance of an FAI. This already happens in many cases, but not consistently. When agreement is not made in advance it can result in participants in FAIs not having the information they need in response to questions put to them
during an FAI hearing. Where agreement is made, it leads to a more transparent and efficient system which benefits all parties.

It is now standard practice that preliminary hearings are held for FAIs and the Bill would implement this across the board. We believe that when the ‘note of proposed issues to be explored’ is lodged for an FAI, the preliminary hearing(s) should be fixed. The intention behind this would be to avoid preliminary hearings being held shortly before the FAI itself and new issues being raised at this point. When this occurs, it can result in the FAI being discharged and is not only stressful for all involved but is also inefficient and costly.

**Outcomes of FAIs**

While the Bill places a new obligation on any person or body who was as an FAI participant to submit a written response to outline their action, or not, in response to an FAI’s recommendations, the sanction is only to name people or bodies who do not respond on the Scottish Court and Tribunal Service website. To strengthen this sanction we would suggest a lack of response is made more public, such as being published on the Scottish Government’s website. The RCN also believes the system would benefit from appointing someone specifically to review the FAI recommendations to ensure effective action has been taken by all participants.

We hope these points are useful to the Justice Committee as it considers the Fatal Accidents and Sudden Deaths etc (Scotland) Bill at Stage 1.

Royal College of Nursing Scotland
28 April 2015
Justice Committee

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

Written submission from the Fire Brigades Union

1 The Fire Brigades Union (FBU) is the professional voice of firefighters and other workers within the Fire and Rescue Services across the UK. The FBU has been representing firefighters, at all levels, for over 90 years. One of our main roles is to seek improvements in the health, safety and wellbeing of our members. We provide our members with training to participate in health and safety functions throughout the Service, from workplace reps to our national health & safety advisors. Using the provisions contained within the Health & Safety at Work Act we investigate workplace accidents. The FBU also campaigns for improvements in health & safety provision for all workers through the good offices of the TUC and STUC.

The case of firefighter Ewan Williamson

2 Firefighter Williamson was a member of Green Watch based at Tollcross Fire Station, Edinburgh. On the morning of 12th July 2009 the watch were mobilised to a fire in a basement of the Balmoral Bar, Dalry Road, Edinburgh. Firefighter Williamson was part of a breathing apparatus team who were recommitted to the bar and during that deployment Firefighter Williamson became trapped and was killed before the fire could be brought under control or rescue teams could reach him.

3 Following the fire a multi-agency investigation (Police, Health & Safety Executive and Strathclyde Fire & Rescue Service) was instigated under the direction of the Crown Office’s Health & Safety Division. The investigation progressed as follows:

- Accident date 12th July 2009
- Police investigation instigated immediately
- Civil Case raised by Williamson family on 8th March 2012
- Civil Case cited on 23rd October 2013 pending criminal prosecution
- Indictment served on Scottish Fire & Rescue Service on 8th October 2013
- Case first called on 7th November 2013. Plea to the competency and relevancy of charges made by the Scottish Fire & Rescue Service
- Continued preliminary hearing 6th December 2013. Plea to competency was withdrawn and not guilty plea entered. Case continued until 18th March
- Continued preliminary hearing on 18th March 2014 postponed until 26th May 2014 due to ongoing discussions and investigations
- Continued preliminary hearing 26th May 2014. Case called and continued for further discussion and investigations
- Continued preliminary hearing on 28th July 2014. Continued to allow time for a trial diet to be allocated
- Continued preliminary hearing on 9th September 2014 discharged and reassigned to 3rd October 2014
- Continue preliminary hearing 3rd October 2014
- 23rd October – Continued preliminary hearing. Case called and continued again for further investigation and discussion. Trial diet set for 26th January
5th December 2014 – Case called and continued until just before trial diet
21st January 2015 – Case called and Lord Uist wanted indictment changed to Scottish Fire & Rescue (from LBFRS). Trial discharged and new date set 3rd February 2015
3rd February – Trial discharged without calling. New date set 9th February 2015
6th February 2015 – Family informed of guilty plea
9th February 2015 – Trial date discharged case to call 23rd February 2015
23rd February 2015 – Scottish Fire & Rescue Service plead guilty to amended and reduced indictment. Defence plea of mitigation
20th March 2015 – Sentencing Scottish Fire & Rescue Service fined £60000 with 10% reduction for good previous history.

4 The trial diet was set down for 3rd February 2015 but postponed until Monday 9th February 2015 when the Scottish Fire & Rescue Service pleads guilty to a much reduced set of charges. A lengthy narrative of events was read out by the Advocate Depute after which the FRS Counsel made a plea of mitigation. The case continued further until 20th March 2015 where the judge sentenced to a fine of £54000. In doing that the Judge commented that the fine reflected the fact that the offences were towards the lower end of the scale. The initial indictment, served on 7th November 2013, was reduced to the charges that the Scottish Fire & Rescue Service pleads guilty to. The majority of the charges were dropped but the Crown was successful in achieving a guilty plea.

5 The fine set by the Judge was small in terms of the Scottish Fire & Rescue Service budget, but as a Public Authority, with limited resources, any fine could have the perverse outcome of damaging the SFRS and reducing the ability to improve the very areas the Scottish Fire & Rescue Service plead guilty to.

6 The time taken for the Crown Office to bring forward the criminal prosecution are completely unacceptable. During this time Ewan’s family, his friends and colleagues have had no explanation as to what happened. With the conclusion of the criminal proceedings they still have very few answers.

7 At present, the FBU are pressing the Lord Advocate to hold a mandatory FAI for this death at work. However, we are very conscious that the time passed since the incident and the likelihood that it may be another 2 years before a FAI is heard that the benefits may now not be limited.

Observations

8 During the five years and seven months it took for the death of Ewan Williamson to be investigated and prosecuted, Lothian & Borders Fire Board initially, and then their successor body, Scottish Fire & Rescue Service, refused to discuss the health & safety implications of this fire with the Fire Brigades Union. The Fire Service was an accused person in a criminal case so, to some extent, their unwillingness to engage with the FBU is understandable. However, there were serious and urgent lesson to be learned from this incident and what went wrong at the Balmoral Bar fire. These were not just restricted to the events which lead to
Firefighter Williamson's death but also in regard to other facts and circumstances surrounding operations at that fire and how they were dealt with.

9 Unfortunately, the nature of criminal proceedings is that they are adversarial. The burden of proof is one of beyond reasonable doubt.

10 It is not a process which lends itself to full discovery of all the facts and circumstances, nor is it a process that happens quickly. In this case, although the Advocate Depute read out a long and detailed account of what happened that night, there could be no forensic examination of the evidence and, in particular, no inquisitorial investigation into the full facts and circumstances on a "without prejudice" basis. The end result was that while the Crown secured a conviction against the Scottish Fire & Rescue Service, the prosecution itself did not really help in the process of addressing the lessons which still need to be learned from that fire and improving health and safety on the fire ground.

11 Much was made of Lothian & Borders Fire & Rescue Service's health and safety record prior to this fire by Scottish Fire & Rescue Service's Counsel and the fact that no Lothian & Borders Firefighter had died in their service before this case. The impression sought to be given is that Ewan's death was a tragic "one off" and that he died a hero fighting a particularly dangerous fire. There is no doubt that basement fires present certain difficulties which are not always present in other fires but these dangers are known and when adequate training is combined with properly established systems of work informed by active dynamic risk assessments then the risks associated with basement fires can be minimised to the point that no Firefighter is required to unnecessarily risk their life.

12 Ewan's heroism, and that of his fellow Firefighters, is beyond question but the same cannot be said of the systems of work which he was required to follow that night nor the adequacy of training provided to his Officers.

13 Two of the main reasons why FAI's are mandatory for workplace deaths could not be addressed in a prosecution – namely the reasonable precautions which could have been taken to have avoided the death and, defective systems of work which lead to the death. Unlike an FAI, the criminal court is not required to make any recommendations to prevent similar deaths from happening in future.

14 The FBU report into the Balmoral Bar fire showed that there were serious failings in the way in which the fire was tackled and there are important lessons to be learned and improvements to be made in regard to command and control of incidents, Firefighters welfare, and training for both Officers and Firefighters.

15 Engagement between the FBU and the Fire & Rescue Service was put on hold for almost six years.

16 During that period, on 7th July 2010, at an incident a Lothian & Borders firefighter was seriously injured at a fire which involved the breakdown of command and control procedures on the incident ground. The issues that arose that night were very similar to the command and control issues which were apparent at the Balmoral Bar fire.
17 In February 2011, the FBU wrote to interested stakeholders detailing significant safety critical issues that we highlighted during our investigation. Because of the criminal proceedings there was no discussion with any of the stakeholders regarding the resolution of those issues, instead a lettered response was received which did not satisfy the FBU as a satisfactory outcome.

18 The Scottish Fire & Rescue Service has embarked on a process for ensuring that firefighter safety is embedded within the fabric of the organisation. Within that Firefighter safety project, through the FBU safety representatives and elected officials we have engaged with the Scottish Fire & Rescue Service and already we are seeing meaningful change which has begun to address the safety critical issue that were apparent at the Balmoral Bar fire. However, it must be noted that there was no compulsion on the Scottish Fire & Rescue Service to implement this course of action. We believe that as a public authority the lessons learnt from a death at work must be addressed at the earliest opportunity.

19 We believe that a FAI could, and should, have been held much earlier rather than matters necessarily proceeding to prosecution. This was not a case of wilful fire raising or murder and we believe that it should be clear to the Crown Office Health & Safety Division at a relatively early stage that they were going to be dealing with a health and safety prosecution. An option was to hold an FAI first then consider whether a prosecution was justified or required.

20 Our own investigations lead us to the conclusion that a Sheriff would have had to make certain recommendations which would then have been the focus for improving health and safety for firefighters, especially if the party whom these recommendations were being made (Scottish Fire & Rescue Service) were required to show that they had considered and acted upon them.

21 A more effective and faster system of holding FAI’s and requiring parties to address their recommendations would have been of benefit in this case.

22 The FBU would welcome an invitation to give oral evidence to the Justice Committee.

Fire Brigades Union
28 April 2015
1. In this response to the call for evidence on the Bill as drafted SCOLAG will highlight those areas of the Bill which in the Group’s view have fallen short of what the consultation respondents might have hoped for / expected. While it is anticipated that some other individuals or groups may wish to respond to the proposals in so far as they related to the provision of Legal Aid for bereaved families, the Group will focus instead on those matters not related to funding. The Justice Committee has welcomed views on a number of specific areas and some of these areas are covered in this response.

2. SCOLAG is supportive of the extension of the mandatory FAIs to cover the death of a child under 18 while kept in secure accommodation. However we are disappointed that the deaths of those subject to compulsory detention by a public authority (as defined by the Human Rights Act) have not been included in the mandatory category. We consider that it is entirely appropriate for the state to investigate the deaths of those, for example, detained under mental health legislation. We note that the Royal College of Psychiatrists in Scotland has welcomed such an exclusion on the grounds that there would be no benefit in there being such FAIs and that it “would have done nothing to address the stigma and discrimination that people with mental health problems have to deal with” (http://www.scottish.parliament.uk/S4_JusticeCommittee/Inquiries/FA1_RCPsych_in_Scotland.pdf). We respectfully disagree.

3. In order to foster and maintain trust in state institutions in which a high degree of trust and responsibility is involved, we believe that it is appropriate they should be subject to the oversight of the FAI regime. Even if many of these patients die from natural causes, this is no different from the current position in respect to many prison deaths. It is also often the case that these “natural causes” deaths can reveal unsafe conditions and poor practices which in turn can allow lessons to be learned. In the prison environment, there are several examples of “uncontroversial”, “natural causes” deaths which, because there was an FAI held, led to lessons being learned. One example was the FAI into the death of Scott Welch (March 2014, Dundee, Sheriff A Brown) where the use of handcuffs on a prisoner dying in hospital was of concern to the learned sheriff. It was not suggested that this contributed to the death in anyway, but it is, in our view, often only through evidence being adduced at FAIs and sheriffs making such observations that practices change. Furthermore, we do not understand the Royal College’s view that holding such FAIs can be said to impact one way or another on mental health stigma or discrimination. In fact FAIs often result in better practices which is surely to the benefit of those detained under mental health legislation.

4. Furthermore, if the death is unexceptional and no lessons can be learned, it is certainly open to the COPFS and other parties to tender a lengthy joint minute of
agreement at the bar and to have, effectively, an FAI in formal terms only with no oral evidence adduced. This occurs frequently in prison FAIs and sum total of the court “appearance” can sometimes be 15 minutes only.

5. SCOLAG is pleased with the proposed power of the sheriff to make “recommendations” at the conclusion of the FAI. Recommendations can include reasonable precautions, improvements to or the introduction of systems of working, or the taking of any other steps which might realistically prevent other deaths in similar circumstances. However, while we agree that these recommendations should not be obligations in a legal sense, we do not consider the system proposed for the monitoring of the responses to be sufficiently robust.

6. Effectively, the proposal for the Scottish Courts and Tribunals Service (SCTS) to publish the responses (or a notice stating that a party to whom a recommendation was made has not responded) requires the media to monitor the SCTS website and to report on the published responses (or lack thereof). However, we do not consider this to be a role which ought to be undertaken by the SCTS for two reasons: firstly, the role of the judiciary and its connected structures should, in our view, end at the conclusion of the FAI: neither sheriffs nor the courts administration ought to have involvement past that point; secondly, the SCTS website is unlikely, in our view, to attract “hits” from those outwith the legal profession and some print media. If the objective of the Bill is to make parties to whom recommendations are made account for what they have or have not done, then in our view it is the Scottish Government which ought to be reporting on compliance. As we said in our response to the consultation, this is unlikely to be too onerous a task given the small number of FAIs there are per year and the even smaller number at which recommendations are made. If the Government was to report on compliance, it is more likely, in our view, that members of the public and other forms of media will see the responses. It is more transparent.

7. We are supportive of the holding of preliminary hearings before all FAIs however we think the proposed case management could go further. We are of the view that a “note of issues” or “note of proposed argument / proposed findings” style document should be explored and that all parties should be required to submit such a document in advance of the preliminary hearing. We submit that without such a practice being adopted, it is likely that parties could turn up to preliminary hearings and inform the court that investigations remain ongoing without any substantive progress being made / evidence being agreed.

8. SCOLAG considers that more information needs to be given on how FAIs into deaths abroad would work in practice before comments can be provided. We would require to know much more about the procedure and what processes would be in place for the ingathering of evidence / citation of witnesses etc.

9. SCOLAG considers that more information needs to be given on the situations in which it is envisaged that an FAI would be re-opened / a fresh inquiry instructed. SCOLAG takes the view that a line should be capable of being drawn after which point
an inquiry cannot be re-opened / a fresh inquiry instigated. This is for the sake of the families as well as the other interested parties. We are not persuaded that this is necessary.

10. SCOLAG welcomes the fact that three FAI centres will not be introduced but the Group is concerned that FAIs can take place outwith the sheriffdom connected to the death. We agree that FAIs should when possible take place in buildings other than courts, but consider that the distance the family and witnesses have to travel must be a primary consideration when determining whether to hold an inquiry in a different sheriffdom. Local knowledge must be preserved.

SCOLAG
28 April 2015
Justice Committee

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

Written submission from the Scottish Civil Justice Council

The Scottish Civil Justice Council (SCJC) welcomes the introduction of the Inquiries into Fatal Accidents and Sudden Deaths etc. (Scotland) Bill and supports its general principles. In particular, we will be taking an interest in how the Bill progresses in relation to the development of the provisions around preliminary hearings and the sheriff’s determination.

Mandy Williams
Deputy Secretary to the Scottish Civil Justice Council
28 April 2015
Victim Support Scotland is the lead voluntary organisation in Scotland helping people affected by crime. We provide emotional support, practical help and essential information to victims, witnesses and others affected by crime in every Scottish local authority area, and in every Sheriff and High Court in the land. The service is free, confidential and is provided by volunteers. Victim Support Scotland welcomes the opportunity to provide our views to the Committee on the Inquiries into Fatal Accidents and Sudden Deaths etc. (Scotland) Bill.

Mandatory and discretionary FAIs

Victim Support Scotland supports the introduction of this Bill. In our opinion, all those bereaved by a sudden death will have similar questions regarding how the death occurred and why. In order to provide the answers necessary to facilitate recovery for families of the deceased, suitable processes should be developed irrespective of the circumstances in which a fatal accident has occurred; this may be through the criminal justice system or civil processes such as a Fatal Accident Inquiry (FAI). It is hoped that the ability of the Lord Advocate to hold a discretionary FAI should be sufficient to cover circumstances in which it is not mandatory to hold an FAI but where one should nevertheless be held.

Most crucially, family members should be provided with the opportunity to express their views on the holding of an FAI into the death of their loved one, and such views should be taken into account by the Crown Office and Procurator Fiscal Service when considering whether to hold a discretionary FAI. Although consultation with the family of the deceased is not provided for on the face of the Bill, VSS is reassured by the statement within the policy memorandum that, “Once death investigations are concluded, relatives are invited to discuss the findings with the procurator fiscal and, where an FAI is discretionary, their views as to whether there should be an FAI will be explored and taken into account.”

Where it has been decided that an inquiry will not be held, the reasons for this should be provided to the family of the deceased. We note that the practice of COPFS has been to inform the bereaved family of a decision not to hold an FAI, either in face to face meetings or in writing, and particularly hope that this practice continues, allowing the families an opportunity to meet with a representative of COPFS to discuss the decision in person.

1 Inquiries into Fatal Accidents and Sudden Deaths etc. (Scotland) Bill Policy Memorandum, p.10
http://www.scottish.parliament.uk/S4_Bills/Fatal%20Accidents%20(Scotland)%20Bill/b63s4-introd-pm.pdf

2 Inquiries into Fatal Accidents and Sudden Deaths etc. (Scotland) Bill Policy Memorandum, p.25
http://www.scottish.parliament.uk/S4_Bills/Fatal%20Accidents%20(Scotland)%20Bill/b63s4-introd-pm.pdf
Although the policy memorandum recognises that, “It can be the case that different parts of a family may have different views”, the possible variance in the needs and degree of engagement within a family does not seem to be reflected in section 8 of the Bill, which provides only for the spouse/partner or nearest known relative to be provided with written information on the reasons for a decision not to hold an inquiry, on request. VSS believes that such an approach could make it difficult for those who wish a more detailed, reasoned decision to be provided to them, as they would be forced to ask a particular person within the family to make the request; this may cause additional strain, whether on relationships within the family or on the specified person his or herself, who may not feel able to do this. It is the view of Victim Support Scotland that prescribed relatives of the deceased should be able to request written reasons for the decision not to hold an FAI, similar to the approach used within the Victims and Witnesses (Scotland) Act 2014\(^3\). Irrespective of who is eligible to make a request for written information, the relevant individual(s) should be made aware of their right to do so.

In general, it is fundamental that the family of the deceased is regularly kept up-to-date on the progress of the investigation and application, and support should be made available for them before, during and after an inquiry is held. Information and guidance must be given on the procedures involved so that the entire process is understood and the strain on the family is reduced to a minimum. It is important that the families involved are given enough time to digest the information provided to them, and to prepare for the next stage of the process.

We note the Lord Advocate’s ability to exercise discretion in holding an inquiry (within a mandatory category) if satisfied that the circumstances of the death have been sufficiently established during the course of other proceedings. We welcome this provision, as it is our view that an additional and unnecessary hearing would not be in the best interests of the family of the deceased and/or potential witnesses, as this may delay their recovery and deny them closure at an earliest possible stage.

**FAIs into deaths abroad**

Victim Support Scotland acknowledges that many practical jurisdictional problems may arise if FAIs are to be held into the death of Scots abroad, for instance regarding obtaining evidence and witness statements. However, it would still be useful to have the legal framework and ability to improve cross-border information sharing within the area of FAIs. The bereaved family will experience similar shock and devastation regardless of where the death occurs. Relatives of the deceased will want to have the circumstances around the death investigated, irrespective of where it happened, so we welcome the extended scope of FAIs within this area. Information regarding the range and capacity of the inquiry, including any practical problems which may occur in respect to cross-border cooperation, should be given to relatives and families engaging in FAIs

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\(^3\) Section 6(2)(b) of the Victims and Witnesses (Scotland) Act 2014 provides that prescribed relatives (defined by order) of deceased victims are able to apply for information on the progress of the case. [http://www.legislation.gov.uk/asp/2014/1/section/6](http://www.legislation.gov.uk/asp/2014/1/section/6)
to ensure that they have realistic expectations of what results will come from the inquiry process.

**Pre-inquiry procedure**

Victim Support Scotland believes the pre-inquiry procedures within the Bill to be reasonable, noting that they are intended to reduce delays. We support any measure that will speed up the FAI process, such as preliminary hearings and the agreement of facts before an inquiry, so long as it takes into consideration the needs of the family of the deceased and other witnesses involved. The sooner an inquiry is held, the faster bereaved relatives and friends can begin their recovery process. In addition to making the process more efficient, we believe that preliminary hearings will provide an early opportunity to assess whether there will be vulnerable witnesses involved, and therefore ensure support is provided for them.

We feel that it is reasonable that the sheriff should be able to transfer a case to a different sheriffdom if this is felt appropriate. In making this decision, the sheriff should consider the wishes and circumstances of the family of the deceased and other witnesses to the inquiry in relation to travel time and other practical arrangements.

**Practical implications of the Bill**

Expanding the categories for which an FAI is mandatory may result in an increase in the number of witnesses and bereaved friends and relatives who may require support through the process. Going to court to give evidence can be very confusing and traumatic for family members and other individuals close to the deceased, many of whom would greatly benefit from accessing support services throughout this demanding process.

Victim Support Scotland’s court based Witness Service provides practical information and emotional support to anyone being called as a witness in Scottish Sheriff and High Courts. Although Victim Support Scotland does not advertise our services to participants in FAI proceedings, our Witness Service does on occasion provide limited services to this group of witnesses if they are encountered upon during the Witness Service’s routine work. However, without a proper referral arrangement, the Witness Service cannot plan and provide any targeted support to this group of service users. In preparation of giving witness statements, many witnesses find it helpful to visit the court in a ‘familiarisation visit’. If a referral mechanism was put in place to inform the Witness Service of any witness called to participate in an FAI, familiarisation visits could also be offered to this group.

Furthermore, Victim Support Scotland’s community based Victim Service, located in each local authority area in Scotland, provides practical and emotional support and information to people affected by crime, including families bereaved by murder. They understand the reactions and implications of losing a family member and are in a good position to be able to expand their services to include family members taking part in an
FAI. Victim Support Scotland’s current funding does not include service provision to families taking part in FAIs, so if our remit should be extended, resource implications must be addressed.
RoSPA welcomes this opportunity to make a submission to the Scottish Parliament’s Justice Committee which is seeking views on the general principles of the Inquiries into Fatal Accidents and Sudden Deaths etc. (Scotland) Bill, which was introduced in the Scottish Parliament on 19 March 2015.

A registered UK charity, RoSPA has been at the heart of accident prevention in Britain and around the world for almost 100 years and is very active in Scotland. Our mission is to ‘save lives and reduce injuries’ (the latter encompassing prevention of work related ill-health). Our vision is ‘to lead the way in accident prevention’. In this context we are keen to contribute to debates about the improvement of safety, not only at work or on the road but in the home and in leisure pursuits where most fatal and serious injuries occur, affecting the young, the old and the socially disadvantaged disproportionately. RoSPA has continued to make significant contributions of views and evidence to public debates on this subject over many years and wishes this submission to be viewed that light.

The Society’s policy making in this area is underpinned by the work of our National Committees which are voluntary associations of people drawn from organisations representing a broad cross section of safety interests.

RoSPA is firmly committed to a proportionate, evidence and risk-based approach to safety and to approaches to the administration of civil and criminal justice which support this. Our evidence has been framed with this core value in mind.

Prevention must come first

We fully support the need for the rules and processes surrounding Fatal Accident Inquiries (FAIs) to be robust and transparent and to clearly meet the full range of considerations than comprise the public interest in the wake of sudden deaths. Establishing the facts surrounding a sudden death is necessary to serve a number of objectives: not only to determine what happened, how and why but to provide an evidential basis for any subsequent legal proceedings. In RoSPA’s view, the prime objective in any FAI must be to determine, ahead of any further mapping of evidence that might impinge later on questions of liability, the immediate and underlying causes of the events that led to the sudden death (or deaths) with a view to determining what steps might be taken in the future, not only to prevent recurrence of similar tragedies but to remedy any weaknesses in preventive or protective arrangements that ought to have been in place to prevent the tragedy in question. These questions are an important part of meeting the needs of friends and family who may be seeking ‘closure’ in the wake of an accidental fatality.
Scope and focus

FAIs are most frequently held to determine the facts surrounding deaths due to work related accidents, deaths in custody, deaths associated clinical malpractice, fires and so on. But because the power to hold FAIs is exercised sparingly, the majority of accidental deaths, particularly those that occur in the home or in leisure activities are not subject to inquiry in this way. This is a major failing.

Inequity in distribution of preventive effort

In the UK as a whole there are some 12,000 accidental deaths annually but there is a gross inequity in the distribution of preventive effort between the different domains within which deaths and serious injuries occur. For example, if an elderly vulnerable person is injured fatally as an employee or as a member of the public in a managed work setting, there will be official investigation to determine immediate and possibly underlying causes - as will also be the case if the death occurs on the public highway. Questions will be asked about the adequacy of preventive and protective services. But if the death of the same person occurs, for example, as a result of a fall at home or in a DIY accident, or in a leisure pursuit, it is much less likely that a comprehensive and disciplined investigation will occur. In part this may be due to the mistaken perception that these deaths are private tragedies, due, in the main, to the failure of victims. And those professionals dealing with these sorts of events may well have had much less training in understanding the aetiology of accidents, leading them to judge perhaps that serious and fatal injuries in such circumstances do not warrant in-depth investigation to see if and how prevention might be improved in future.

From investigation to prevention

RoSPA feels strongly that steps must be taken to remedy this inequality in Society’s preventive response in the wake of sudden deaths. It is self-evident that prevention is strongest in those safety domains that historically have had the strongest and most developed approaches to investigation (such as work, major hazards, nuclear, rail, civil aviation and so on). And it is weakest where approaches to investigation are superficial, underdeveloped or non-existent (such as in the home and in private sport and leisure pursuits).

It is in this context that RoSPA questions the criteria that are to be used to determine whether or not an FAI should be held. There are an estimated 1300 fatal injuries from all causes in Scotland annually, meaning that judgments have to be made about how to use limited time and other resources needed to undertake investigations and FAIs in an optimum fashion that best meets the needs of justice and the wider public interest. High profile disasters, particularly those involving multiple and simultaneous loss of life, obviously warrant the setting up of such inquiries - but where tragedies involving single deaths happen in isolation and do not attract widespread public attention, the need to assess the preventability of such events does not means that they should not be treated with equal priority.

RoSPA is not convinced that the arrangements for FAIs, as constituted under the new arrangements, will adequately address this issue.
Extension of FAI criteria

RoSPA urges that a review is carried out in Scotland to determine, review and compare the various responses which are made to all accidental deaths that have occurred over the last five years. This should be undertaken by a reputable and independent organisation that would have the necessary resources and access to data to assess how well the immediate and root causes of fatal accidents of all kinds were being determined and the extent to which findings were being fed back to improve the scope, delivery and effectiveness of preventive strategies and services. Investigation of individual accidents in all domains continues to show that the majority of these events are easily preventable. RoSPA believes that, in the light of serious and fatal accidents, it is the duty of all public authorities to determine the extent to which prevention has failed and to recommend any action needed to remedy such shortcomings in the future.

When the results of the review suggested here are known, the scope of FAIs should be extended as appropriate.

Dr Karen McDonnell
Occupational Safety Adviser
28 April 2015
Justice Committee

Inquiries into Fatal Accidents and Sudden Death etc (Scotland) Bill

Written submission from the Association of Personal Injury Lawyers

The Association of Personal Injury Lawyers (APIL) was formed by pursuers’ lawyers to represent the interests of personal injury victims. APIL is a not-for-profit organisation with 24 years’ history of working to help injured people gain the access to justice they need. APIL currently has around 4,000 members, 181 of whom are in Scotland. Membership comprises solicitors, advocates, legal executives and academics whose interest in personal injury work is predominantly on behalf of pursuers.

The aims of the Association of Personal Injury Lawyers (APIL) are:
- to promote full and just compensation for all types of personal injury;
- to promote and develop expertise in the practice of personal injury law;
- to promote wider redress for personal injury in the legal system;
- to campaign for improvements in personal injury law;
- to promote safety and alert the public to hazards wherever they arise; and
- to provide a communication network for members

Introduction

1. APIL welcomes the opportunity to respond to the call for evidence on the Inquiries into Fatal Accidents and Sudden Deaths etc. (Scotland) Bill from the Justice Committee of the Scottish Parliament. APIL has previously responded to the review of fatal accident Inquiry legislation led by the Rt Hon Lord Cullen of Whitekirk KT, the consultation on the Members’ Bill proposed by Patricia Ferguson MSP, and the recent Scottish Government consultation on the reform of fatal accident inquiries legislation.

2. While there have been some attempts by the Crown Office and Procurator Fiscal Service (COPFS) to address the delays in holding FAIs (through judicial education, and providing reasons for delays, for example) the state of the fatal accidents inquiry system is still deeply unsatisfactory.

Mandatory FAIs

3. Under clause two of the Bill, FAIs will be mandatory if someone dies in Scotland as a result of an accident at work, if they died while in legal custody, or if they were a child and died while being kept or detained in secure accommodation. We welcome these mandatory FAIs, which should hopefully ensure that answers are provided to bereaved families.

4. There have been previous suggestions from others that a FAI should be mandatory in every disease case. While we do not support this, as there would be limited value in holding repeated FAIs on the same subject matter, we think there...
should be some flexibility in holding FAIs in certain disease cases. It would be expected that a FAI into mesothelioma contracted while working in dockyards, for example, would almost certainly reveal the same answers as to similar FAIs, but it may well be worth holding a FAI into a death caused by mesothelioma which was contracted while in a school, or from working in a shop.

5. While we welcome the mandatory FAIs which have been included within the Bill, the Bill does not go far enough. The 2008 consultation paper published as part of Lord Cullen’s review of fatal accident legislation notes that “other countries provide for mandatory inquests into deaths of people detained under compulsory mental health powers; unresolved homicides; deaths from anesthesia; deaths of unidentified people; deaths in care (including children in care and patients in alcohol and drug assessment or treatment centers); and apparent suicides”.

6. We do not agree that FAIs should be mandatory in all the above cases, but FAIs should be mandatory in the deaths of people detained under compulsory mental health powers, deaths from anesthesia, and deaths in care. In general, deaths occurring in any situation where the state or an agent of the state was in a position of care and/or control over the deceased should be subject to a mandatory FAI.

FAIs into deaths abroad

7. We welcome the inclusion of clauses six and seven into the Bill, which cover inquiries into deaths occurring abroad. We have concerns, however, with the criteria included in clause six as to why a FAI might not be held into a death occurring abroad. The criteria could be used as loopholes, providing the Lord Advocate with justifications for not carrying out a FAI, where it may in fact be worthwhile doing so. The Lord Advocate may decide there is no need for an investigation because the circumstances of the death have been ‘sufficiently established’ in the course of an investigation in relation to the death. This should not be, by itself, a justification for a FAI in Scotland to be completely ruled out. Instead, the investigation which took place abroad could form part of the evidence for the FAI. This would ensure that answers are obtained for the bereaved family, lessons are learned and future accidents are prevented.

Pre-inquiry procedures

8. We support any proposals which will make FAIs quicker and more efficient, and we agree that preliminary hearings should be held to help speed up FAIs. Preliminary hearings will enable administrative and practical matters to be dealt with, and allow the sheriff to focus purely on the circumstances of the death at the FAI, which will be carried out with effectiveness, fairness and the minimum of delay. If a preliminary hearing is held, the issues can be identified in advance, and the actual FAI can then focus on the pertinent issues and will be much shorter and to the point. This will reduce delays and be much easier for the bereaved family to cope with.

1 Review of Fatal Accident Inquiry Legislation, a consultation paper. November 2008, page 11 paragraph 3.8
Sam Ellis
Parliamentary Officer
APIL
28 April 2015
Justice Committee

Inquiries into Fatal Accidents and Sudden Death etc (Scotland) Bill

Written submission from the Institution of Occupational Safety and Health

Introduction

1. The Institution of Occupational Safety and Health (IOSH) is the largest membership body for OSH professionals worldwide, with more than 44,000 members in 120 different countries. A Chartered body, we have charitable and international NGO status and our current President-Elect is a Scottish-based member. With over 4,000 members based in Scotland, of whom around 33% are Chartered members, we have four Branches and one District that meet regularly in Aberdeen, Edinburgh, Glasgow, Inverness and Tayside. IOSH volunteers also meet regularly with other OSH professional representatives and are active within the Health and Safety Executive-organised Partnership for Health and Safety in Scotland (PHASS).

2. IOSH welcomes the opportunity to comment on this important call for views from the Scottish Parliament’s Justice Committee on Inquiries into Fatal Accidents and Sudden Deaths etc. (Scotland) Bill. In the submission that follows, based on contributions from members in Scotland, we provide some general comments, followed by more detailed ones in which we address the Committee’s specific questions. We close with references and further information about IOSH. We have confined our responses to fatal accident inquiries (FAIs) for work-related accidents and exposures, as this is the aspect in which we have experience.

3. IOSH members’ primary competences and activities are advising on work-related health and safety hazards and effective methods to manage the associated risks. However, when things go wrong, they are typically also involved in assisting duty holders to investigate, identify and record what happened, including both the immediate and the underlying or ‘root causes’ of the failures to effectively manage risks, and to ensure that relevant lessons to prevent similar tragedies are communicated and understood by those who need to know. They therefore have experience of the aftermath of work-related accidents, including some fatal accidents – though of course relatively few now have much personal experience of these as, for most organisations and for most of the time, fatalities are prevented by the application of effective controls.

4. In terms of their types of deployment; most of our members work as in-house or contracted advisers, but some also work for local authorities and the Health and Safety Executive (HSE) in Scotland as regulators/enforcers and a few are specialist legal advisors.

General comments

5. IOSH very much welcomes the Inquiries into Fatal Accidents and Sudden Deaths etc. (Scotland) Bill and the accompanying Policy Memorandum and indeed,
we regret that decisions on how to implement Lord Cullen’s 2009 recommendations have taken several years to be reached.

6. The minority of our members who have personal experience of more recent fatalities have noted some beneficial effects from establishing the Scottish Fatalities Investigation Unit (SFIU) in respect of work-related fatalities, with improved consistency of approach and generally good links established with bereaved families. Our members experience is consistent with the findings of internal and external reviews of the enforcement activities of HSE, in conjunction with the Crown Office and Procurator Fiscal Service (COPFS). We note that the HSE briefing paper on prosecution of health and safety offences by HSE in Scotland, discussed at a recent PHASS meeting (February 2015), identifies similar benefits.5

7. We judge that both the Bill and the supporting Policy Memorandum are sound, clear and logical, and support the suggested reforms in the areas where we have relevant experience (see Introduction above). In particular, we welcome the emphasis in both documents on explaining that FAIs are held in the public interest and are not intended to consider criminal or civil liabilities. We are aware of examples where a party that was dissatisfied with aspects of the relevant enforcement body/ies investigation into a work-related fatality has then attempted to use the FAI process as a second opportunity to raise issues of liability. In our members’ experience that is not helpful – if there are perceived deficiencies in the way an enforcing body has carried out an investigation there should be suitable processes to examine these, but it is confusing and time-consuming to raise such concerns in the context of a separate legal process, which has a different function, such as an FAI. We suggest that the much improved liaison arrangements with families that COPFS now have in place should go a long way to minimise situations where families feel that an enforcing body investigation has not met their needs or expectations.

Detailed comments – IOSH response to the ‘call for views’ questions

8. **Whether the circumstances for mandatory FAIs provided for in the Bill are sufficient?** IOSH believes the circumstances that are provided for mandatory FAIs are sufficient, but make further comment in our next answer.

9. **Whether the circumstances provided for in the Bill in respect of discretionary inquiries are appropriate?** We note that a mandatory FAI is required only when the person(s) who died was “…acting in the course of the person’s employment or occupation.” [Bill, section 2(3)(b)]1 However, there can also be fatalities to members of the public from work-related accidents and illnesses e.g. 4 deaths from Legionnaires’ disease in Edinburgh, 2012 and 6 deaths in the Glasgow bin lorry accident, 2015.6, 7 Where there is no resulting prosecution, as in the examples cited, we suggest it should be normal practice (i.e. covered by the 'rules', Bill, section 34)1 to hold a discretionary FAI, unless there are very strong reasons not to do so. This could enable valuable health and safety lessons to be gathered in the public interest, if these have not already been learned.

10. We agree with the reasoning in the Policy Memorandum about FAIs for work-related fatal diseases (paragraphs 75-77)4 and suggest a further reason for not
making these mandatory could be the difficulty in certain cases of determining whether a specific health condition that resulted in death was in fact wholly or partially work-related. However, where there is a strong likelihood that it was work-related and where there is no associated prosecution, again, we suggest that a discretionary FAI should be normal practice, unless there are very strong reasons not to hold one.

11. Whether there are alternative approaches that should be considered? IOSH does not advocate alternative approaches. Evidence from our members’ experience, the HSE paper referenced above, and the background information detailed in the Policy Memorandum, suggests that the non-regulatory recommendations already implemented are making a positive difference. Also most alternatives of which we are aware seem to originate from parties who wish to see an alternative means of assessing blame or fault where they believe the existing enforcement processes have been unsatisfactory. As we note in paragraph 7 above, advocating an FAI as a possible remedy does nothing to change the enforcement processes, if they do indeed need improvements.

12. Whether the provisions in relation to FAIs into deaths abroad are appropriate? IOSH has no comment on this at this time.

13. Whether the provisions in relation to the pre-inquiry procedure are appropriate? IOSH has no comment on this at this time.

14. What are the practical implications of the provisions of the Bill? As outlined in our introduction, we are solely focused on work-related aspects, so in most respects we are not in a position to comment on the practical implications overall. For work-related deaths, to the extent that the different purposes of enforcement activities and FAIs are made even clearer, we believe there will be improved clarity for both duty holders and all parties directly affected by deaths, including families and co-workers. In practice, this will aid resolution of resulting issues, rather than allowing them to become potentially alienating, due to lack of clarity in the legal processes of which very few persons will have had any previous experience.

References
3. IOSH. Learning the lessons: How to respond to deaths at work and other serious accidents. Wigston: IOSH, 2010. www-iosh.co.uk/resources
About IOSH

Founded in 1945, IOSH now has over 44,000 members, with around 13,000 Chartered Safety and Health Practitioners worldwide and our vision is:

“A world of work which is safe, healthy and sustainable”

The Institution steers the occupational safety and health profession, providing impartial, authoritative, free guidance. Regularly consulted by government and other bodies, IOSH is the founding member to UK, European and International professional body networks. IOSH has an active research and development fund and programme, helping develop the evidence-base for health and safety policy and practice. Summary and full reports are freely accessible from our website. IOSH publishes an international peer-reviewed journal of academic papers twice a year titled Policy and practice in health and safety. We have also developed a unique UK resource providing free access to a health and safety research database, as well other free on-line tools and guides, including basic information for business start-ups; an occupational health toolkit; and a risk management tool for small firms.

IOSH has 35 Branches in the UK and worldwide including the Caribbean, Hong Kong, Isle of Man, Oman, Qatar, the Republic of Ireland, Singapore and UAE, 16 special interest groups covering aviation and aerospace; communications and media; construction; consultancy; education; environment; fire risk management; food and drink; hazardous industries; healthcare; offshore; public services; railways; retail and distribution; rural industries; and sports grounds and events. IOSH members work at both strategic and operational levels across all employment sectors. IOSH accredited trainers deliver health and safety awareness training to all levels of the workforce from shop floor to managers and directors, through a professional training network of almost 1,900 organisations. We issue around 160,000 certificates per year.

For more about IOSH, our members and our work please visit our website at www.iosh.co.uk

Richard Jones
Head of Policy and Public Affairs
28 April 2015
1. **Introduction**

1.1 On 19th March 2015 the Inquiries into Fatal Accidents and Sudden Deaths etc (Scotland) Bill was introduced to the Scottish Parliament. The Scottish Parliament's Justice Committee has issued a call for evidence in respect of that Bill in terms of which it seeks views on the Bill's general principles and on certain matters in particular. The submission on behalf of Pinsent Masons LLP is set out in this paper.

1.2 By way of background, Pinsent Masons is a global law firm with offices throughout the UK, in Europe, Asia and the Middle East. In Scotland, we have a litigation & regulatory practice in Glasgow, Edinburgh and Aberdeen and have several solicitor advocates, one of whom is a QC. The majority of our litigation & regulatory clients are business entities (of various sizes) or individuals engaged in business - we rarely act for private individuals. We have a large health & safety practice and regularly appear at Fatal Accident Inquiries (“FAIs”) in Scotland and Coroner's Inquests in England and Wales.

1.3 As we have indicated previously, we welcome the broad approach taken by the Scottish Government in its review of legislation in relation to FAIs and see this as an opportunity to modernise the system, making it more efficient, accountable and transparent, better able to meet the expectations and demands of a deceased's family and of the wider society in the 21st century.

2. **Question 1 - whether the circumstances for mandatory FAIs provided for in the Bill are sufficient?**

2.1 We consider that the circumstances set out in the Bill for mandatory FAIs are sufficient. We have previously advocated an extension to the exceptions for mandatory FAIs to make it clear that where there is no purpose to be served by holding a FAI, such as where the circumstances of death have already been established in relevant proceedings, the Lord Advocate should have a discretion to decide that one is not to be held. This is now contained in the Bill.

3. **Question 2 - whether the circumstances provided for in the Bill in respect of discretionary inquiries are appropriate?**

3.1 Section 4 of the Bill largely reproduces the effect of the previous provisions contained in the 1976 Act and there is no issue with that.

4. **Question 3 - whether there are alternative approaches that should be considered?**

4.1 Much of the criticism of the current system relates to the delay in the decision making process. Unfortunately the Bill does not address this. We
understand that there is often a need for extensive investigative steps to be taken before a decision on whether an FAI should be conducted can be taken. It is also understood that this process regularly and necessarily involves a third party Regulator such as the HSE, AAIB or the MAIB. We accept that criminal proceedings ought to be concluded before any decision is reached. That said, we remain of the view that, in the interests of all concerned, a time limit for a decision to be made in mandatory FAIs should be introduced. As a safeguard we would propose that the Lord Advocate has the ability to apply to the Sheriff Principal for an extension of that time limit on cause shown (such as ongoing criminal proceedings). This will allow for better case management of the FAI proceedings. Further consultation on the length of the proposed time limit ought to be undertaken.

5. **Question 4 - whether the provisions in relation to FAIs into deaths abroad are appropriate**

5.1 Whilst we can see benefits in these provisions, we remain concerned about practical difficulties in their operation. Witnesses and documentary productions will be abroad and powers to compel their attendance/production may be required. Interpreters may be needed to assist with translation issues. The Lord Advocate will need to rely heavily on the Regulator/Enforcing Authority of the country involved to secure this evidence. As we indicated in our response to the original consultation, clear guidance on the exercise of the Lord Advocate’s discretion will require to be produced if families are not to be given an expectation that an inquiry should be held here into the death of their loved one abroad.

Much of the publicity which accompanied the proposed extension of jurisdiction to deaths abroad was focussed on military deaths, where it may be that the assistance of MOD and other agencies is capable of ameliorating some of the issues we have highlighted. However the Bill is not restricted to such cases and we have a concern that it may raise in the public mind an expectation of an exhaustive investigation into other deaths abroad, where consideration has not been given to many of the practical difficulties which such an investigation may face. Quite apart from case-specific recommendations – which would have to be made against the background of a foreign jurisdiction, the need to focus on precautions and improvements is likely to mean that only in rare events would it be appropriate to have such an inquiry.

6. **Question 5 - whether the provisions in relation to pre-inquiry procedure are appropriate?**

6.1 We remain of the view that it would be in the interests of all concerned in a fatal accident for a time limit to be placed on the making of a decision to hold a FAI. See para 4.1 above.

6.2 We have previously indicated that we consider it should be made clear that topics such as the issues to be explored by the inquiry, the availability of witnesses, the exchange of productions and the order of questioning are fully covered at any preliminary hearing. The preliminary hearing should take place well in advance of the FAI. The Bill makes provision for such matters to be dealt with by act of sederunt.
7. **Question 6 - what are the practical implications of the bill's provisions?**

7.1 We have outlined concerns about the practical implications of deaths abroad in para 5.1 above. One of the key concerns about the current system is the delays involved in it. The Bill makes provision for procedure to be regulated by act of sederunt. Without knowing the details of those provisions it is difficult to assess the impact of the Bill and indeed if it is able to meet expectations. We believe it would be beneficial to have judicial involvement from an early stage and that rules are set out with the aim of ensuring transparency, efficiency and accountability at each step of the process.

Pinsent Masons LLP
28 April 2015
Justice Committee

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

Written submission from Together (Scottish Alliance for Children’s Rights)

Together (Scottish Alliance for Children’s Rights) is an alliance of children’s charities that works to improve the awareness, understanding and implementation of the United Nations Convention on the Rights of the Child (UNCRC) in Scotland. With over 260 members, our key aims include progressing children’s rights at a local and national level through the provision of support and expertise, and providing robust monitoring of UNCRC implementation in Scotland at a national and international level.

The UN Committee on the Rights of the Child recommended in its 2008 Concluding Observations to the UK that governments should “use all available resources to protect children’s rights to life, including by reviewing the effectiveness of preventive measures. The State party should also introduce automatic, independent and public reviews of any unexpected death or serious injury involving children – whether in care or in custody.”

In light of this UN Committee recommendation and consistent with statements included in Together’s annual State of Children’s Rights reports, Together submits the following comments and recommendations in response to the call for views on the Inquiries into Fatal Accidents and Sudden Deaths etc. (Scotland) Bill:

- **Undertaking a Child Rights Impact Assessment (CRIA):** A CRIA should be undertaken to ensure that the Bill is fully assessed in terms of its impact on the rights of children. This will help to predict, monitor, and if necessary, avoid or mitigate the impact of the Bill. It will also help the Committee to determine the extent to which the Bill can further protect children’s right to life and development (as set out in Article 6 of the UNCRC), including by reviewing the effectiveness of preventive measures and collecting evidence to influence policy and practice.

  The Justice Committee should refer to the CRIA model which the Scottish Government is currently developing in relation to the new UNCRC duties on Ministers introduced through the Children and Young People (Scotland) Act.

- **The EQIA on Bill states the following:** “Due to the limited evidence available to inform the EQIA, the implementation and review plan will include monitoring the policy to ensure it continues to comply with the public equality duty and UNCRC.” Together welcomes the commitment to use UNCRC compliance as a framework for the implementation and review plan for the Bill. Together recommends that a child rights approach is taken in monitoring and evaluation and could offer expertise and support in this area.

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1. CRC/C/GBR/CO/4 (29, page 7)
• **Mandatory inquiries into the death of a child:** The Lord Cullen (2009) review of fatal accident inquiry legislation recommends that an FAI should be mandatory in the case of the death of a child who was being maintained in a ‘residential establishment (including secure accommodation)’. The Bill proposes mandatory FAIs for children in secure accommodation. This proposal is welcomed by Together but should be widened to include all looked-after children. The Scottish Government has a direct responsibility for all looked-after children – regardless of whether they are in secure care, residential care or foster care – and as such any death of a looked-after child must be investigated, regardless of placement type.

• **Definition of a child:** Together welcomes the decision to update the definition of a child within the Bill, to a person who has not yet reached the age of 18. This is in line with Article 1 of the UNCRC and other related legislation such as the Children and Young People (Scotland) Act 2014.

Please let me know if the Justice Committee would like the support of Together to bring a child rights approach to scrutinising the Bill and furthering the recommendations included above.

Juliet Harris
Director
28 April 2015

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We act on behalf of the families of the late Laura Stewart and Mhairi Convy who tragically lost their lives following a road traffic collision on 17 December 2010. The circumstances of the collision were investigated at a Fatal Accident Inquiry held at Glasgow Sheriff Court. The determination of Sheriff Normand was published on 19 November 2014.

Our client’s have raised a number of concerns in respect of the investigation into their daughter’s deaths; the decision not to prosecute the driver and the holding and conduct of the Fatal Accident inquiry. The families responded to the earlier, wider, consultation on proposals for improving the system for Fatal Accident Inquiries in Scotland. In respect of the proposed Bill and accompanying memorandum the families would make the following observations.

**Timing**

There has been considerable criticism of the long delays in holding a Fatal Accident Inquiry. The First Minister and Scottish Government have recognised that the families of the deceased are a central part of the system of investigation of deaths in Scotland. It is recognised that unnecessary and prolonged delay is intolerable to those families. It is equally obvious that delay affects both the availability and quality of evidence available at a subsequent inquiry. Conversely, the families agree that it is most important that a full and thorough investigation takes place first and that, in complex case, considerable time can pass in undertaking all of the necessary investigations. It is agreed that a compulsory timescale for holding inquiries is not in the public interest.

Much of the criticism for delay however comes not from the need for further investigation but from the apparent lack of transparency in the investigative and decision-making process.

The collision with took the lives of our client’s daughters occurred on 17/12/10. An initial meeting was held with the Procurator Fiscal on 2/2/11. The possibility of an FAI was raised on 6/3/12. On 9 October 2012 the families were advised that there would be no prosecution – a public statement to this effect was not issued until March 2015. On 8 October 2013 the families were advised that a Fatal Accident Inquiry would be held.

The families have held numerous meeting with COPFS since the collision. The families have received no satisfactory explanation for the extensive delay in the investigation and decision making process. The families were advised only that investigations were ongoing. No satisfactory explanation of what investigation were still being undertaken has been provided.
Given the central role that the families of the deceased play in the Scottish system of investigation more must be done to keep the families involved. To reduce delay more must be done to ensure the investigation remains on course.

In the majority of cases it should be clear from an early stage whether the event would meet the criteria for a mandatory FAI or is likely to meet the criteria for a discretionary FAI. In such circumstances consideration should be given to whether COPFS should issue comment on when they expect investigations to be complete.

Such comment would not, of course, be binding. It would however provide the families and the wider public with some comfort that a structure investigation is taking place and some knowledge on when a decision is to be taken. This would assist in managing the expectation of the bereaved families and potential witnesses to any subsequent inquiry. It would also be of assistance to commentator and the public in understanding and following the investigative process. Supportive the objective that justice must also be seen to be done.

**Involvement of bereaved families**

It is essential that bereaved families are keep involved in the investigation. While there are, and must be, limits on what information is disclosed to families, and when, it is important and in the public interest that the families are kept informed about the progress of an investigation.

It is right that bereaved families remain an integral party of the FAI system and have an absolute right to be present or represented at a subsequent Inquiry. At present COPFS have a policy of discussing matters with the families and considering their views. These views are taken into consideration when considering whether to hold an Inquiry but ultimately the decision is taken in the public interest. It is right that the overriding criteria for holding an Inquiry should be the public interest. Given, the stated importance and central role of the families in the investigation of deaths in Scotland it would be appropriate for the families involvement and their right to make comment and observations to COPFS to be placed on a statutory footing. This would ensure the right for the families; ensure it is given due weight and consideration and meet the legitimate public expectation that the bereaved families to indeed play a vital part in the investigation of deaths in Scotland.

**Expenses**

It is proposed that the right of the Courts to make an award of expenses in a fatal accident inquiry be removed. The policy memorandum justifies this on the basis that an Inquiry is not civil proceedings between opposing parties were expenses follow success.

This is an over-simplification of the general rule. A finding of expenses is made, in a civil matter, to reimburse a party for the reasonable costs of that party having to engaged in a process that they ought not to have been required to use. It is not a penalty inflicted on the ‘losing’ side.

The Courts have an inherent jurisdiction at Common Law to regulate their own procedure. This includes the authority to make an award of expenses in certain situations. This applies not only in civil disputes but also in administrative issues.
such as the holding of a public inquiry. The ability to find a party liable in expenses is one of a number of powers available to the Court to prevent an abuse of process.

Participation in an inquiry is voluntary. It is however an expenses proposition, especially in complex cases where the families require legal representation. The existing authority makes it clear that the test which must be met before a Court will make a finding of expenses is very high. The reported cases disclose that this test is rarely met. The remaining powers of the Court can prevent an abuse of process continuing but do not redress the wasted time and expense incurred by such an abuse of process.

The policy memorandum does not set out what benefit, if any, is provided by removing the potential liability in expenses. It does not set out correctly the Courts purpose behind an award of expenses in an administrative process such as an FAI.

In the absence of a potential benefit our client’s question the motivation behind, and the need to remove from the Court a useful power. The authority of the Court to make a finding of expenses, in limited circumstances, should remain.

**Recommendations**

At present the recommendations of a Sheriff are not binding. It is proposed that those people and organisations subject to a recommendation are required to reply stating what steps, if any, they propose to take to address the Sheriff’s recommendations. There is no penalty should they fail to reply or should they do nothing to implement the Sheriff’s determination.

It is suggested that replies are publish by the Courts website so that replies are available should there be any follow up. It is not clear however whether such a follow will or ought to be undertaken.

In our client’s case, it was identified that there were failings in the investigation of a driver’s medical conditions; the training of Doctors in the knowledge of medical conditions which affect driving and how those matters were reported to the DVLA.

On the unique facts of that particular case Sheriff Normand did not consider any recommendations would ‘reasonably’ have prevented the fatal collision. Had such recommendations been made, there is no guarantee anything would have happened and the risk to the public of yet another fatal road collision would not be reduced. This defeats the purpose of the Sheriff making recommendations.

Consideration should be given to whether failing to respond to a Sheriff recommendation should be dealt with by way of contempt of Court. This would ensure that recommendations are actively considered and full and detailed responses are received. To do otherwise would rob the objective or receiving and publishing responses of much of their practical effectiveness.

Should responses be received these should be passed to a committee, such as one of the Scottish Parliament sub-committees, for consideration. This would ensure those will skilled knowledge and interest in an area have matters of concern brought to their attention. Bringing such matters before the Scottish Parliament’s sub-
committees would also improve the likelihood that such issues are given proper consideration for whether further change at a policy or legislative level is required to meet the Sheriff’s recommendations and reduce the risk to the wider public.

Our client’s appreciate your time in considering their comments. Should you require further information or wish to discuss our client’s experience please do not hesitate to contact us to arrange a meeting.

Colin Moffat
Digby Brown LLP
28 April 2015
Justice Committee

Inquiries into Fatal Accidents and Sudden Death etc (Scotland) Bill

Written submission from Autism Rights

Autism Rights receives no funds from the public purse or from commercial enterprises, and so is able to speak freely and honestly. We campaign for the rights of people with Autistic Spectrum Disorders (ASD) and our mental health campaign has been ongoing for some years now. We are responding to this call for evidence as part of this.

I will use the Justice Committee's questions as the framework for our written evidence.

The Committee is particularly interested in hearing views on the following questions:

**Whether the circumstances for mandatory FAIs provided for in the Bill are sufficient**

No, they are not, because they fail to legislate for mandatory FAIs for the deaths of people who are subject to compulsory ‘treatment’ under the Mental Health Act. Although there are mandatory Fatal Accident Inquiries for deaths in custody within the criminal justice system in Scotland, there is no such requirement for deaths of patients within the mental health system, for people who have committed no crime and who, as has been seen in the BBC’s investigation of Winterbourne View hospital, are particularly vulnerable to criminal abuse by those employed to care for them.

On the basis of the views of 2 organisations who might well wish to cover their incompetence – the Mental Welfare Commission and the Royal College of Psychiatry (see Paragraph 78, page 16 of the Policy Memorandum) – the Scottish Government is not going to include mental health patients in its legislation or rules on FAIs, making it fall even further behind the English legal system, which is moving towards fully independent FAIs, from one where these are mandatory, but not fully independent. It also flies in the face of the recommendations in the recent inquiry reports by INQUEST and the EHRC into deaths in mental health detention – and here it should be noted that it was not possible for the EHRC to undertake its inquiry in Scotland, as there was insufficient data to enable this.

The credibility of the Scottish Government is at stake here, as civil servants have claimed in meetings that Autism Rights has had with the former Minister for Public Health – now the Cabinet Secretary for Justice – that the plans for mandatory FAIs for this very group would somehow ensure scrutiny of the deaths of these patients – and yet, they have now reneged on these plans, without any commitment to the collation of data or compilation of statistics that constitute basic measures of human rights compliance within any custodial system. **Autism Rights has stressed that FAIs are useless on their own, without the collation and publication of data and statistics on deaths, suicides, ‘adverse events’, such as assaults and restraints, and drug side effects. Although the English mental health system at**
least collates and publishes statistics on deaths, suicides, assaults and restraints within their mental health system, it has been left to Autism Rights to highlight that there are no statistics available for any of these categories within Scotland. My FOI to the Mental Welfare Commission resulted in the first ever publication of deaths statistics, in the form of a report: http://www.mwcscot.org.uk/publications/visit-monitoring-reports/
- Death in detention monitoring (.pdf, 2KB)
13 March 2014

The MWC have privately admitted to me that this report was commissioned because of my FOI. This report was published within 4 months of my FOI and uses information which was only retrospectively obtained, and so therefore has significant gaps and is otherwise unreliable.

My FOI revealed that there were 78 deaths over the past year in the mental health system. This compares to 97 Deaths over 5 Years in Scottish Prison Custody: https://www.ncjrs.gov/App/publications/abstract.aspx?ID=246263 and to 98 deaths within the English mental health system over that same year: http://www.communitycare.co.uk/2014/06/10/mental-health-deaths-inquiry-launched/#.U5oWnXYSay

My FOI to Police Scotland confirms that they do not hold, nor are they required to hold, any information on deaths or injuries to people who are the subject of police restraint while receiving compulsory treatment under the Mental Health Act: https://www.whatdotheyknow.com/request/police_restraint_of_people_who_a/new
This is spite of the fact that almost half of those who die in police custody in England are being treated in the mental health system.

There is no data on the numbers of suicides within the mental health system. There are overall statistics for Scotland, but these do not give a definite picture of what is happening either in the mental institutions or the wider system. There were, for instance, 3 suicides/ deaths in less than 2 weeks in one hospital - a supposed place of safety. The health board were considering asking the police to assist in the wards in this mental hospital. There are assumptions made about suicides, which are convenient to the mental health system in avoiding liability. There is no mention in any of the official reports, whether from the MWC or ISD, of the known risks of psychotropic drugs – particularly SSRIs – in creating suicidal ideation.

Another activist's FOI discovered that health boards are not required to collate data on restraints of patients within the mental health system. This is in contrast to the Westminster government’s decision to ban face-down restraints, after their statistics revealed that 40,000 of these type of restraint, which are acknowledged to be risky, were carried out in just one year in England's mental institutions.

There is clear evidence of bias in the reporting of deaths, suicides and other ‘adverse events’ within the mental health system, because there is no acknowledgement of the direct or indirect role that psychotropic drugs play in cause of death and suicide. Basic monitoring of health within mental hospitals is haphazard and inadequate – with 25% of long stay patients being found to
have no record of health checks. The MWC and the government think that annual and 15 month health checks are adequate for people who are being forced to take some of the most toxic drugs on the market. Absolutely no account is being taken of individual tolerance of these drugs, in spite of professional guidance recommending psychiatrists seek specialist medical advice where this is needed. Added to which, the situation of people with Autistic Spectrum Disorders, whose behavioural characteristics make them particularly vulnerable to misdiagnosis, is not recorded.

At every single level, the Scottish mental health system fails to put in place the most basic measures of compliance with human rights. Autism Rights is the only organisation that is alerting MSPs and the wider public to this situation. There is no publication of deaths statistics, no separate collation of suicide data for the mental health system, no collation of data on ‘adverse events’, such as assaults and restraints, and no collation of data on drug side effects. Add to this, that the Scottish Government's claim of ‘high ethical and professional standards in the field of medicine’ (see Paragraph 226, page 43 of the Policy Memorandum), which is used to justify ‘procedural aspects’ supporting the Bill's compliance with Article 2 of the ECHR (the right to life), is rather contradicted by their failure to institute a searchable record of commercial payments to healthcare workers. This is needed, because the health boards have failed in their statutory duty to implement a voluntary register of payments and payments in kind (such as training). Given that almost all of the post-qualifying training of psychiatrists is supplied by the pharmaceutical industry, there is a clear conflict of interests between the career aspirations of psychiatrists and the rights of patients to receive appropriate treatments that are not based on psychotropic drugs.

**Whether the circumstances provided for in the Bill in respect of discretionary inquiries are appropriate**

No, they are not – see the whole of this submission

**Whether there are alternative approaches that should be considered**

Yes, there are – see the whole of this submission.

**Whether the provisions in relation to FAIs into deaths abroad are appropriate**

It is notable that there is more of a commitment to justice for those who die outside of Scotland, than there is for those who die whilst receiving compulsory ‘treatment’ with highly toxic drugs for mental illness or Learning Disability or ASD (neither of which disability is supposed to be treatable).

**Whether the provisions in relation to the pre-inquiry procedure are appropriate**

Consideration of these provisions are pretty much redundant for Autism Rights, given that the deaths of people with ASD who die whilst receiving compulsory ‘treatment’ with highly toxic drugs are not considered worthy of mandatory FAIs, nor of any record of their numbers, whether or not they die whilst being physically restrained or
whilst their treatment involves risky drugs or combinations of drugs (polypharmacy).

**What are the practical implications of the provisions of the Bill?**

The practical implications are that the human rights of people with ASD within the mental health system will continue to be ignored.

Fiona Sinclair
On behalf of Autism Rights
28 April 2015

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1 [http://www.scottish.parliament.uk/S4_Bills/Fatal%20Accidents%20%28Scotland%29%20Bill/b63s4-introd-pm.pdf](http://www.scottish.parliament.uk/S4_Bills/Fatal%20Accidents%20%28Scotland%29%20Bill/b63s4-introd-pm.pdf)

Policy Memorandum
6
Independent investigation for the death of a person subject to compulsory detention by a public authority within the meaning of section 6 of the Human Rights Act
Not being taken forward
Lord Cullen recommended that the category of case in which an FAI is mandatory should include the death of any person who is subject at the time of death to compulsory detention by a public authority within the meaning of the Human Rights Act 1998.

2 [http://bja.rcpsych.org/content/176/5/405](http://bja.rcpsych.org/content/176/5/405)
- EDITORIALS
Sudden unexplained death in psychiatric in-patients,
Appleby et al
Psychotropic drugs, cardiac arrhythmia, and sudden death.
Witchel HJ1, Hancox JC, Nutt DJ.

3 The MWC for the first time ever produced an estimate of the numbers of people with ASD within the mental health system in their 2012 Learning Disability Census. This undoubtedly happened only because of pressure from Autism Rights on the MWC and ministers - no other organisation or individual has pressed for statistics on people with ASD. The 2012 Learning Disability Census revealed that 42% of men with a Learning Disability who are receiving compulsory treatment within the mental health system have no additional mental illness. The MWC believes that men with ASD account for the higher proportion of men to women (15%) with Learning Disability but no additional mental illness within the mental health system, but cannot be certain because of the absence of reliable statistics.

4 [http://www.scottish.parliament.uk/GettingInvolved/Petitions/sunshineact](http://www.scottish.parliament.uk/GettingInvolved/Petitions/sunshineact)
Introduction

The Law Society of Scotland aims to lead and support a successful and respected Scottish legal profession. Not only do we act in the interests of our solicitor members, but we also have a clear responsibility to work in the public interest. That is why we actively engage and seek to assist in the legislative and public policy decision making processes.

The Society welcomes the opportunity to respond to the Scottish Parliament’s Justice Committee’s call for evidence upon the general principles of the Inquiries into Fatal Accidents and Sudden Deaths Etc. (Scotland) Bill and has the following comments to make.

General Comments

The Society welcomes the policy objective of the bill which is to reform and modernise the law governing the holding of Fatal Accident Inquiries (FAIs) in Scotland.

The Society has in the past, expressed concern to the number of times an Act of either the United Kingdom Parliament or the Scottish Parliament has been amended by subsequent legislation, the Criminal Procedure (Scotland) Act 1995 being one example where the Act has been amended on numerous occasions. With particular reference to Section 37 of the bill, the Society welcomes the repeal of the Fatal Accidents and Sudden Deaths Inquiry (Scotland) Act 1976 its entirety and replacement with the terms of this bill.

The Society also has the following comments to make.

The Society responded to the Scottish Government Consultation entitled “Proposals to Reform Fatal Accident Inquiries legislation” in September 2014. The Society then made reference to its comments on PE1501 which was firstly considered by the Scottish Parliaments Public Petitions Committee and was then considered by the Justice Committee at its meeting held on 3 February 2015.

In response to the Petition 1501 it was the Society’s belief that the Petition seeks to give family members the right to seek judicial enquiries. In its response, the Society stated that, if only a small number of families are dissatisfied with the decision of the Lord Advocate not to hold an FAI, then the creation of a statutory right to request an FAI may result in only a very small number of additional hearings per annum throughout Scotland. Such a Hearing would provide closure to those families with unanswered questions, should have a minimal economic impact, but reinforce public confidence in Scotland’s system for investigation of apparently self-inflicted deaths.
The Society believes that, ultimately, it would be a matter for the Sheriff at a Preliminary Hearing to decide upon the information placed before him or her by the family of the deceased and by Crown Office as to whether or not to hold an evidential inquiry.

The Society also notes that Lord Cullen’s recommendation that the “test of reasonableness” for relatives of the deceased is not to be implemented in terms of the Bill.

The Society makes particular reference to paragraph 22 of the Policy Memorandum accompanying the Bill and specifically to Lord Cullen’s recommendation number 23.

The Society is concerned that this recommendation is not being taken forward as it believes that, for most relatives of the deceased, the thought of attending Court and cross examining witnesses would at the very least be a daunting task and legal representation should be considered necessary.

On the basis that fatal accident inquiries are fact finding inquiries held in the public interest and are not intended to establish guilt or blame in the criminal or civil sense, we believe that this fact finding exercise can of course be extremely complex and that the civil rules of evidence apply.

With particular reference to paragraphs 53 and 54 of the Policy Memorandum, we remain concerned that the decision not to implement Lord Cullen’s recommendation at number 23 appears to be based against the background of the current financial climate.

We note that the expense of increasing availability of legal representation would be minimal in terms of the entire legal aid bill.

With particular reference to legal aid in respect of relatives under Article 2 of the European Convention on Human Rights, when an inquiry is investigating a potentially unlawful killing by agents of the state or a death in legal custody, we note that Scottish Government accepts that it will be generally appropriate for relatives of the deceased to secure independent legal representation.

We suggest that, where this test is met, there should not be further delay while SLAB carries an inquiry into that person’s means.

We also have the following comments to make.

Section 2 – Mandatory Inquiries

We are generally pleased with the provisions at Section 2 and 3 of the Bill. In particular, that Section 2 of the Bill implements Lord Cullen’s recommendation number 5 to extend legislation to cover death of a person detained by police from “Borstal Institution” to be changed to “secure accommodation” and in this respect notes Section 2(4)(b) of the Bill which covers the death of a person if, at the time of death, the person was a child required to be kept or detained in secure accommodation.
Sections 6 - Inquiries into deaths occurring abroad: general

We agree that the Lord Advocate should, subject to the death of a person within Section 12(2) or (3) of the Coroners and Justice Act 2009 (investigation in Scotland of deaths of service personnel abroad) have the discretion to hold an FAI into the death of a person which occurred outwith the United Kingdom where, at the time of death, the person was ordinarily resident in Scotland and the person’s body has been brought to Scotland. We are pleased to note that Section 6(3) of the Bill sets out the circumstances as to when and in what circumstances such an inquiry should be held and, that the Lord Advocate decides that it is in the public interest for an inquiry to be held into the circumstances of the death.

Section 8 – Reasons for decision not to hold an inquiry

We refer to our general comments and remain of the view that some consideration could be given to a small number of families who are dissatisfied with this decision, then the creation of a statutory right to request an FAI may result in a very small number of additional Hearings per annum throughout Scotland.

Section 12 – Jurisdiction in relation to inquiries

We agree that the Sheriff should be entitled to make an order transferring proceedings to a Sheriff of another Sherifffdom on the basis that the Procurator Fiscal and the participants in the inquiry have had an opportunity to make representations about the proposed transfer and the consent of both the Sheriff Principal of the Sherifffdom of which the Sheriff is a Sheriff and the Sheriff Principal of the Sherifffdom to which the Sheriff proposes to transfer the proceedings has been obtained. This should be done on the basis that the proposed transfer results in the FAI being held in the most suitable Court.

Section 15 – Preliminary hearings

We agree that a focussed preliminary hearing would be of benefit to all parties.

With particular reference to Section 15(4) of the Bill, we believe that Rules for the conduct of preliminary hearings is appropriate.

While these rules will be published on the Scottish Court and Tribunal Service website, we believe that there may be some merit in liaison with the publishers of volumes of Criminal and Civil Court Statutes and Rules to ensure that these Rules are published in both volumes.

It is anticipated that a preliminary hearing as referred to in Section 15, whether that includes meeting experts or otherwise, should help to speed up fatal accident inquiries.
Section 26 – Dissemination of the sheriff’s determination

We consider this a worthwhile proposal on the basis that the Sheriff who has conducted the Hearing is best placed as to who would clearly benefit from his or her findings and in this respect welcome Section 26(1)(b)(iv) of the Bill.

Section 27 – Compliance with sheriff’s recommendations

We note that a person to whom a recommendation is addressed must, if the person was a participant in the inquiry to which the recommendation relates, give the Scottish Courts and Tribunal Service a response in writing.

While we believe that the sheriff’s recommendations should of course be acted upon, we are concerned that there do not appear to be any sanction proposed against parties where they failed to comply or cooperate.

We remain concerned that this process could involve the Scottish Courts and Tribunal Service in protracted correspondence with parties well after the inquiry has been concluded.

Alan McCreadie
29 April 2015
Justice Committee

Inquiries into Fatal Accidents and Sudden Death etc (Scotland) Bill

Written submission from the Centre for Excellence for Looked After Children in Scotland

Introduction

1. CELCIS is the Centre for excellence for looked after children in Scotland. We exist to improve the experiences and life chances of children and young people in Scotland who are ‘looked after’ by local authorities, and those who have left care. We do this by working alongside the professionals who touch their lives, and within the wider systems responsible for their care.

2. We welcome this opportunity to submit written evidence to the Scottish Parliament’s Justice Committee, on the general principles of the ‘Inquiries into Fatal Accidents and Sudden Deaths etc. (Scotland) Bill’, which was introduced into the Scottish Parliament on 19 March 2015 (herein referred to as ‘the Bill’).

3. The Bill is relevant to looked after children and care leavers, as the death rate for these populations is above the average for Scotland’s young people. Local authorities are under a duty to provide support and assistance to these populations of young people, and we believe it is essential that any accidental or sudden death (including suicide) of a looked after child or care leaver is investigated fully and openly. However we do not believe it is necessary to extend the provision for mandatory Fatal Accident Inquiries to all accidental or sudden deaths of looked after children and care leavers at this stage. This is because of concern about the additional burden this would place on the judicial system, without certainty that this would result in clear improvements for looked after children. We would instead recommend that documents accompanying the Bill (including any guidance developed following enactment) clarifies that the sudden or accidental death of a looked after child and care leaver should always be considered by the Lord Advocate in reference to the criteria for a discretionary inquiry. Moreover, in view of local authorities’ legal responsibilities towards these children and young people, we would suggest that it should always be considered in the public interest for a Fatal Accident Inquiry (FAI) to be convened into a suicide of a looked after child or care leaver.

4. Key Statistics

- In 2011, 1.51% of all children who died were looked after at the time of their death\(^1\)
- After life limiting conditions and health issues, suicide and accidental death were the most common causes of death among looked after children in 2011
- The deaths among looked after children, between 2009 and 2011, were highest for those in residential care (12 children). The second highest number of deaths was observed in children who are looked after at home or with

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\(^1\) Care Inspectorate (2013) A report into the deaths of looked after children in Scotland 2009 - 2011
relatives (11 children). One child out the 30 looked after children who died in 2011 was in secure care at the time of death.

- An analysis of the figures relating to deaths of children in care collected by the Social Work Inspection Agency (SWIA)\(^2\) showed that at least two children in care have died from suicide every year since 2000. There is not a legal requirement to report care leaver deaths unless they are in receipt of services from the local authority social work department\(^3\). However, there is evidence that the number of suicides among care leavers is much higher than among those still in care.\(^4\)

5. **Are the circumstances for mandatory FAIs provided for in the Bill are sufficient?**

6. We would agree with the Bill that there should be a mandatory requirement for a FAI for a child kept or detained in secure accommodation.

7. **Are the circumstances provided for in the Bill in respect of discretionary inquiries are appropriate?**

8. In respect to looked after children and care leavers, the state has assumed (differing levels of) responsibility for their welfare and wellbeing, and we would suggest that in many cases it would be in the public interest for the Lord Advocate to convene a FAI into a sudden or accidental death, in order for the full facts to be established. However we have not recommended extending the scope of mandatory FAI's to this group because of concerns about the additional burden this would create (for both the judiciary and other professionals), and in the absence of certainty that this would lead to improvements in services for looked after children and care leavers.

9. We believe the Lord Advocate should continue to determine whether a FAI is appropriate under the discretionary inquiry provisions, but would encourage the Scottish Government to set out clearly what is in the ‘public interest’ (section 4(1)(b) of the Bill). For instance we believe a suicide of a young person in the care of (or in receipt of support from) a local authority should always be followed by a FAI, as all parties need to understand the circumstances which led to the event, to ensure lessons can be learned.

10. **General Comments**

11. Section 12 of the policy memorandum states:

> FAIs are judicial inquiries before sheriffs or sheriff’s principal held in the public interest. The Procurator Fiscal leads evidence with a view to ascertaining the facts relevant to the death and possible recommendations. It is not the purpose

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\(^2\) On 1 April 2011 the work of the Social Work Inspection Agency passed to a new body, Social Care and Social Work Improvement Scotland (SCSWIS)

\(^3\) As of April 1st 2015 there will be a duty to report on deaths of care leavers who are engaged with services

of an FAI to establish blame or guilt in the civil or criminal sense. The purpose is simply to establish the facts surrounding the death, specifically the time, place and cause of death.

12. We welcome the inclusion of this section, stating the purpose of the FAI. It provides clarity and provides an opportunity for learning in terms of the recommendations.

13. Section 13 of the policy memorandum states:

In addition, however, the sheriff may make recommendations as to reasonable precautions, if any, whereby the death and any accident resulting in the death might have been avoided; the defects, if any, in any system of working which contributed to the death or any accident resulting in the death; and any other facts which are relevant to the circumstances of the death. Such recommendations may be intended to prevent deaths in similar circumstances in the future. Sheriffs make such recommendations in around a third of all FAIs.

14. The collation of information regarding the deaths of looked after children and care leavers is essential to developing our collective understanding of how our child welfare system supports (sometimes unsuccessfully) children and young people. Recommendations from FAI are valuable source of this information, and we would encourage sheriffs to provide recommendations wherever possible. This will enable more effective scrutiny of how organisations have changed practice in order to prevent deaths in similar circumstances in the future.

15. Section 41 of the policy memorandum, regarding the issues of compliance with the sheriff’s recommendations, states:

[...] the Scottish Government does not believe that it would be appropriate to make sheriffs’ recommendations legally binding. The Bill does, however, contain proposals which are intended to foster accountability on the part of parties to whom sheriffs’ recommendations are addressed and greater transparency in the process by obliging those parties to respond to recommendations, indicating how they intend to comply.

16. For looked after children and care leavers, where the state is the corporate parent, there needs to be a transparent process for understanding how and in what way recommendations have been enacted. We welcome the proposal, in section 27, of compliance and expected response within a timeframe. However, in order to ensure that any recommendations that may be intended to prevent deaths in similar circumstances in the future are implemented, the recommendations from a FAI should be monitored and reported on. This should include the production of an annual report which includes the recommendations and responses to the recommendations, presented in a format accessible to the public. In this way, beneficial understandings about the implementation of the recommendations could be shared, whilst at the same time enabling a process of monitoring and review.

17. Moreover, a centralised database of FAIs, which could be aligned with Significant Case Reviews, would provide more detailed information from which
services and interventions could be targeted to support primary prevention and early intervention. Fish et al. (2015)\(^5\), at the recent British Association for the Study and Prevention of Child Abuse and Neglect (BASPCAN) congress, described the potential for improvement that serious case reviews (and arguably FAI) bring: ‘serious case reviews and their equivalents are assumed to hold potential to underpin improvement activity and there are efforts to collate findings for greater impact. The equivalent of a national [child protection] observatory is a natural next step’.

18. Under section 8 of the Bill there is a duty to give reasons in writing why a FAI is not held if requested by those matching the descriptions in section 8 (a) (b) (c). We propose that the reasons as to why a decision is made not to hold a FAI in all cases involving a looked after child or care leaver be outlined in writing. These reasons should be reported to the Scottish Minister and Chief Executive of the local authority of the last or most recent place of residence of the child/young person. This information could then be captured and reported in their mandatory ‘Corporate Parenting’ report. This would help Scotland to establish an up-to-date and accurate picture of the deaths of looked after children and care leavers.

Thank you for this opportunity to contribute to this important inquiry. We would welcome any further discussions with Committee.

Dr Andrea Priestley
Policy Implementation Lead
29 April 2015

Justice Committee

Inquiries into Fatal Accidents and Sudden Death etc (Scotland) Bill

Written submission from Sheriff Principal L Murray WS

I am writing on behalf of the Sheriffs Principal in response to your request for comment on Inquiries into Fatal Accidents & Sudden Deaths etc (Scotland) Bill. As you will be aware the Sheriffs Principal responded to the Scottish Government consultation and the committee will have access to the response.

We should reiterate the purpose of a Fatal Accident Inquiry (FAI) which is a fact-finding forum held in the public interest, which does not attempt to apportion blame or guilt in a civil or criminal sense. We support the policy of the bill as narrated in paragraph 102 of the Explanatory Note that a FAI should have two purposes only. First to establish the circumstances of the death which is the subject of the inquiry including the time, place and cause or causes of death or the accident which caused the death and any recommendations on how that specific death might have been avoided and second to consider what further precautions or improvements might have been taken to prevent other deaths in similar circumstances in the future.

We note that the bill provides that a FAI may be held at the discretion of the Lord Advocate into the death of a Scot who happened to die or be killed abroad is restricted to circumstances where the body is repatriated - clause 6(3) (1) (c ). We recognise that such discretionary inquiries may be the exception, but wonder whether the inquiry should only be an option where the body is repatriated, or whether on special cause shown an inquiry could be held in the absence of repatriation of the body.

In relation to the persons who may be participants in the inquiry we welcome the modifications proposed by the bill, likewise we support the proposals in relation to the places at which inquiries may be held. We consider that in most cases a FAI will be held in a court room, with the prospect following discussion of operational requirements for of an alternative venue adapted to best meet the needs of a particular FAI in those cases where that will best serve the interests of justice.

We consider it is important that the period between a death occurring and the issue of the determination to be as short as possible and while we are aware of the need for proper investigation of the circumstances by the Crown we do consider it essential that matters are progressed as efficiently as possible with minimum delay. We support the mandatory requirement for preliminary hearings (clause 15) and would hope that these together with effective use of technology in the courts will assist in the expeditious progress of fatal accident proceedings once they are brought to court by the Procurator Fiscal.

We note the Crown Office & Procurator Fiscal Service have indicated that they are maintaining statistics relating to FAI cases. The Sheriffs Principal welcome this development. We consider it is particularly important that statistics are maintained as to the period between the death and the application for a fatal accident inquiry. We would favour discussion with COPFS with a view to a target being set around the
period between the death and application for an inquiry. We believe that such a
target will enhance the prospects of a reduction in time from the date of death to the
issue of a determination, which we believe to be beneficial and in the wider public
interest.

We should express some reservations about the proposal that rules might provide
for a standard form of determination. We believe that the terms of clause 25(2) of
the bill which substantially follow the provisions of section 6(2) of the Fatal Accident
and Sudden Deaths Inquiries (Scotland) Act 1976 to be satisfactory. This makes
clear the areas which the sheriff should and may address in his/her determination.
The circumstances in which a FAI may be held are many and varied, and we do not
see an additional benefit in being prescriptive in requiring a standard form of
determination as suggested in the policy memorandum at page 6 (28). We do
however see merit in the rules providing for an appendix listing parties to whom any
recommendations are addressed as this would facilitate the monitoring of responses
from these parties, supporting the policy objective of providing greater transparency
in the monitoring of responses.

We do not envisage difficulty with the proposals regarding the publication and
dissemination of the determination (clause 26). We see merit in the view taken by
the Scottish Government that it would not be appropriate to make the sheriffs’
recommendations legally binding. We do still have concerns on the operation of the
proposals intended to foster accountability on the part of parties to whom sheriffs’
recommendations are addressed. Clause 27 deals with compliance with the sheriff’s
recommendations. It is our view that SCTS is not best placed to monitor responses
or to be the repository for responses. We would invite the committee to consider
alternatives to SCTS fulfilling these roles. As we indicated in our response to the
consultation we consider there are both issues of principle and practicality which
make it inappropriate that these responsibilities become judicial duties and we
consider that these same points also have application to SCTS.

We accept that there is merit in clause 28(2) to allow further proceedings where
evidence comes to light which if heard at the FAI and accepted would have likely led
to a different determination. We believe it is important that there is a sufficiently
robust process and test to determine whether “new” evidence warrants further
proceedings which will result in a different determination.

I trust these comments will be of assistance to the committee.

Duncan L. Murray WS
Sheriff Principal of North Strathclyde
29 April 2015
Justice Committee  

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

Healthcare Improvement Scotland response

Introduction

Healthcare Improvement Scotland is the national healthcare improvement organisation for Scotland. We have a vital role in supporting healthcare providers to deliver safer, more effective and more person-centred care and to achieve Scotland’s 2020 vision for health and social care.

Healthcare Improvement Scotland has been given the responsibility of designing a new system to review Medical Certificates of Cause of Death to improve public confidence and simplify and strengthen the governance in this area.

The Certification of Death (Scotland) Act 2011 introduces a number of changes to the current system. In particular, it introduces checks on the accuracy of Medical Certificate of Cause of Death (MCCDs) by setting up a new national review system.

From 13 May 2015 Healthcare Improvement Scotland will implement the Death Certification Review programme and run the service, with the review of MCCDs carried out by experienced and trained doctors.

Comments

General:

1. In general, there may be circumstances where it would be appropriate to instigate some sort of governance review short of a FAI so that lessons may be learned in a less adversarial manner which most observers would say has increasingly been adopted despite the historical aspiration of a FAI being an inquisitorial approach.

The relevant sections of the Bill to our role are sections 6 and 7, relating to Inquiries into deaths occurring abroad and our observations below relate to these:

2. Specifically, sections 6 and 7 are arguably most likely to impact on the MCCD system, under section 6, sub-section 3 (a) (i) and (b) of the Bill, where the Lord Advocate considers the criteria of when an inquiry is to be held.

3. Our service is concerned with ensuring the quality of the MCCD and seeking information in pursuit of the verification of the MCCD. The legislation has a number of catch all sections which mandate LA inquiry: 3(a)(i) ‘unexplained death’, 3(b) ‘circumstances of the death have not been sufficiently established in the course of an investigation’. Paradoxically this seems to promote a higher level of scrutiny and investigation in Scotland in comparison to that required of the Coroner in England and Wales where the statutory requirement is that of ‘the cause of death is unknown’ (Coroners and Justice Act 2009 s1(2)(c).
4. When the Bill comes into force we need to be clear how the Death Certification Reviewer Service (DCRS) fits into the safeguarding work of the legislation. The situation where the documentation is not in order (in the sense that the cause of death is insufficiently established for the purposes of a MCCD – our only metric) seems to present a fairly clear requirement to refer to the Procurator Fiscal (or perhaps request a Post Mortem - but if there is a likelihood that we will refer, a fiscal Post Mortem will likely be preferable). I would however anticipate that this could be quite a frequent occurrence, obviously depending on the jurisdiction of death.

5. It is certainly possible that DCRS will experience an increase in cases we refer to the PF and also, possibly, the number of autopsies we instruct which is currently budgeted for 12 per year.

6. Notwithstanding the proposals, COPFS may be reluctant to actually take on extra-jurisdictional cases because of the difficulties in effectively investigating them, especially in the current financial climate.

Dr C George M Fernie  
Senior Medical Reviewer  
Healthcare Improvement Scotland  
29 April 2015
Justice Committee

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

Written submission from the Scottish Legal Aid Board

1. SLAB has limited its response to the issues that the Committee has stated that it is particularly interested in.

Are the circumstances for mandatory FAIs provided for in the Bill are sufficient?

2. Yes. We noted in our consultation response that extending the scope of mandatory FAIs to cover death beyond those occurring in the course of a person’s employment could put additional pressure on legal aid expenditure. We therefore welcome that the scope of mandatory FAIs has not been extended.

Are the circumstances provided for in the Bill in respect of discretionary inquiries are appropriate?

3. Yes. We do not consider that the discretion afforded to the Lord Advocate to require an inquiry in certain circumstances will have a significant impact on legal aid expenditure.

Are there alternative approaches that should be considered?

4. SLAB does not have any comment to make.

Are the provisions in relation to FAIs into deaths abroad are appropriate?

5. Yes. We noted in the response to the Bill’s consultation that we considered it appropriate for the Lord Advocate to have discretion whether to hold an FAI in these circumstances.

6. As our response to the Finance Committee notes, the average cost to the Legal Aid Fund of an FAI can vary significantly due to a number of factors and therefore it is very difficult to estimate the potential costs of any additional FAIs resulting from the Bill’s provisions. The FM also notes that it is impossible to predict whether those involved in any additional cases as a result of this Bill will require or be eligible for legal aid.

Are the provisions in relation to the pre-inquiry procedure appropriate?

7. Yes. We have previously stated that any provisions put in place to allow for greater focus on the issues to be considered at an FAI, which in turn focusses the work to be undertaken using legal aid funding, are welcomed.
What are the practical implications of the provisions of the Bill?

8. The Bill makes no changes to the availability of legal aid, or requires changes in legal aid processes so there will be no implications for SLAB in the processing of legal aid applications and accounts.

9. If the Bill results in an increased number of FAIs then this has the potential to increase the expenditure on legal aid, but as set out in the Financial Memorandum, this is impossible to accurately predict. The Scottish Government is bound to meet any costs to the Legal Aid Fund under the terms of the Legal Aid (Scotland) Act 1986.

Scottish Legal Aid Board
30 April 2015
Written submission from the Scottish Police Federation

The Scottish Police Federation (SPF) is grateful for the opportunity to comment on the Bill.

The SPF is supportive of the Bill which if passed should make the Fatal Accident Inquiry (FAI) process quicker, more efficient and increase flexibility.

Choosing locations where FAIs are to be held must take cognisance of the location of family members and witnesses as there may be a considerable financial impact on those involved.

Investigation into deaths which occur abroad will undoubtedly have a financial implication for the Police Service of Scotland which is not reflected in the Financial Memorandum accompanying the Bill at a time when there is already significant pressure on the police budget.

Calum Steele
General Secretary
30 April 2015
Justice Committee

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

Written submission from Commander Toby Everitt, Royal Navy (Retired)

I was the President at the Service Inquiry into the accident involving ZD812 and ZD743, the two Royal Air Force Tornados that collided in July 2012 and have been keeping apprised of the events in Scotland pertaining to the accident and any Fatal Accident Inquiry (FAI) that could have been convened regarding the accident. I was informed by Mr Jimmy Jones that he had presented to your committee on the subject of Inquiries into Fatal Accidents and Sudden Deaths etc. (Scotland) Bill, and also that he had spoken with members of the committee regarding aspects of my inquiry that he felt strongly about.

I left the Royal Navy last year to pursue a different career, and have been in sporadic contact with Mr Jones answering his questions when I was able and when appropriate to do so, and have maintained a courteous relationship. I have read his submission to the committee prior to the meeting on 5th May, and was surprised to be quoted directly as he had not informed me that this was his intent, as unfortunately, he has not conveyed my opinion or findings correctly and I would have not allowed the text to be published had he requested it.

Although the references to my Inquiry seem separate from the submission’s main thread of mandated/discretionary Fatal Accident Inquiries, I feel strongly that the record should reflect my personal views on my Inquiry rather than those made on my behalf, and which I presided over agnostic of whether there was to be any additional Inquest. My report was not written for a FAI, it was written for an independent Convening Authority. It could inform and support a subsequent FAI, but as explained at each interview that we conducted, any evidence would need to be re-examined at an Inquiry.

Although several points within the submission misquote me, I do not contest I have been in contact with Mr Jones, and having reviewed correspondence, I feel that he has misunderstood my comments in the statements made within his submission.

Therefore I would like to state:

a. I did not feel bound by the Terms of Reference (TORs), restricting my lines of inquiry. I was given generic themes (which are given to all Inquiries) which could be used as prompts, however the specifics of the inquiry drove the direction of investigation, none of which were restricted by my TORs. I had total freedom to follow lines of inquiry resulting in one of the widest ranging reports that the Military Aviation Authority had seen. This was an internal inquiry which had a remit to highlight any safety concerns and make strong recommendations to ensure, where possible, this could not happen again.

b. I was not prevented from pursuing any lines of inquiry, as I did not have to gain any permissions or authority to investigate themes. I was an independent President who reported to an independent Convening Authority. The
misinterpretation of a Senior Officer attending a court came from a discussion regarding the legal responsibility that a Duty Holder now holds post the Haddon-Cave review. My report does not attribute blame.

c. I stated clearly within my report that I did not feel that the Panel were suitably qualified to fully investigate the Top Level Group of the Ministry of Defence and placed a recommendation on the Secretary of State to investigate further. I do believe, however, that the Panel were suitably qualified to report on the aviation safety aspects of the accident, and I stand by our recommendations.

I hope that I have explained my position regarding my report, the freedoms under which I was allowed to investigate and the expertise of the President and panel under my direction. I apologise for any misunderstanding which has arisen from my correspondence with Mr Jones.

Toby Everitt
15 May 2015
Inquiries into Fatal Accidents and Sudden Deaths etc (Scotland) Bill: Stage 1

10:00

The Convener: Item 2 is our main item of business today and our first evidence session on the Inquiries into Fatal Accidents and Sudden Deaths etc (Scotland) Bill. We will hear from two panels of witnesses.

First, I welcome Lord Cullen of Whitekirk, who conducted a review of fatal accident inquiry legislation in 2008-09. The bill will implement many, but not all, of the recommendations from his review. Lord Cullen, do you wish to make an opening statement, or shall we go straight to questions?

Lord Cullen of Whitekirk: I have a few remarks.

My remit was

"to review the operation of the Fatal Accidents and Sudden Deaths Inquiry (Scotland) Act 1976 ... so as to ensure that Scotland has an effective and practical system of public inquiry into deaths which is fit for the 21st century".

As I started my work, it became clear that I was concerned not merely with legislation in whatever form but with the way in which the legislation is operated by organisations such as the Crown Office and Procurator Fiscal Service. I suppose that the discussion in my report and the recommendations that I made are concerned with three general strands: one is to update the system; the second is to expand the system in certain respects; and the third is to improve the system as far as one could through my report.

As you said, convener, my report was published in October 2009, and since then, the Scottish Government has made a number of responses. I am here to answer your questions and to help you in any way I can.

The Convener: Thank you. I move to questions from members, starting with John Finnie.

John Finnie (Highlands and Islands) (Ind): Your review recommended that the death of any child who is being looked after in a residential establishment should trigger a mandatory fatal accident inquiry. What is the rationale behind that recommendation?

Lord Cullen: When a child is put into the care of others, away from the family, a responsibility of care and protection is owed to that child. I felt that it would be appropriate for such a situation to be considered by a fatal accident inquiry. I appreciate that we are not talking about compulsory measures, because those are accepted by the
Government and now form part of the bill, but the idea is simply that those children are in the protection of others and that, if something happens while they are being protected, it is right and proper that there should be an FAI. I appreciate that, as has been said by the Government, it would open up a wide range of possible situations, but I have said what I can say in my report and I cannot really add to that.

**John Finnie:** Terminology is clearly terribly important, and your recommendation would include boarding schools. Given your original definition relating to children being in the care of others, there is no reason why that would not still apply to boarding schools. Is that correct?

**Lord Cullen:** It certainly would apply. It is perhaps a matter of drafting. If the principle is accepted, appropriate drafting could confine that provision to what are thought to be the areas of concern.

**John Finnie:** My point is that the provision would not necessarily exclude boarding schools.

**Lord Cullen:** Yes, I accept that.

**John Finnie:** To what extent should public interest determine whether the Lord Advocate should hold a fatal accident inquiry?

**Lord Cullen:** From the beginning, the conception has been that a fatal accident inquiry should be held in the public interest, for the information of the public, and for action if necessary. However, that also involves the need to provide for the participation of those who have been directly affected by what happened. The initiative lies with the public authority, namely the Lord Advocate, except in cases in which Parliament decides that there must be a mandatory inquiry—obviously, subject to the proviso about criminal prosecution or an inquiry under the Inquiries Act 2005, which might make that unnecessary. The essential idea, however, is that a fatal accident inquiry is held in the public interest and everything must be responsive to that.

**John Finnie:** Are you relaxed about there being a measure of discretion afforded to the Lord Advocate with that decision making?

**Lord Cullen:** Yes, I am. I think that that discretion has always been exercised responsibly. It is important for the public and the individuals concerned to know why it has been exercised against an inquiry, and that is why I recommended that reasons should be given.

**John Finnie:** Should that power of discretion be open to challenge?

**Lord Cullen:** I suppose that, technically, it could be challenged through judicial review. That is technically possible, but there would have to an underlying legal flaw and, if reasons are given, those reasons might of themselves open up the way to judicial review.

**John Finnie:** That tends to suggest that the system is one of complete disclosure, and that is not always the case with deaths that give rise to public concern.

**Lord Cullen:** I am not sure whether I can agree with your general statement that there is a lack of disclosure. All that I am saying is that, if reasons are given, they might open up the need for judicial review. Of course, it would not lead to a situation in which the court could say that there must be an inquiry. It would simply mean that, if a challenge was successful, the Lord Advocate would have to think again.

**John Finnie:** Thank you very much, Lord Cullen.

**Elaine Murray (Dumfriesshire) (Lab):** There has been some debate around whether there should be a time limit for initiating a fatal accident inquiry. Some of the arguments against have included the idea that any criminal proceedings should take place first. Would it be permissible or acceptable for an FAI to take place before criminal proceedings had taken place or while a criminal investigation or criminal proceedings were under way?

**Lord Cullen:** The general answer to that is that it would not be wise for a fatal accident inquiry to start before the conclusion of criminal proceedings. I appreciate that Ms Ferguson has made proposals for time limits, and that they include the possibility of an FAI opening only to be adjourned. My problem with that idea concerns how much could usefully be achieved during that initial phase, because even an explanation of how the deceased came to die might be relevant to the criminal prosecution. There is always a danger that whatever is said could create a problem for an on-going criminal prosecution, so it is better to have the criminal proceedings finished.

**Elaine Murray:** Could I also ask about sheriffs’ recommendations?

**The Convener:** Before Elaine Murray proceeds, I would like to intervene. Lord Cullen, one of your proposals is to hold an initial court hearing soon after death is reported. What would that be if it were simply to happen and then be adjourned?

**Lord Cullen:** Thank you for raising that point. What I put forward there was a proposal not to embark on the FAI itself, but merely to have a meeting to inform the relatives and interested parties about the progress of the investigation and proceedings, if criminal proceedings are necessary. That is something quite new and the idea is to let relatives and interested parties know
what is going on. I thought that it would be useful to have an independent person in the position of a sheriff who was able to say, “Can you give me an explanation of what is going on here?”

No evidence would be heard and it would not technically be the beginning of the FAI. Perhaps I could describe it as an application for a potential FAI that might not go ahead if there were criminal proceedings and it was found after that that there was no point in having an FAI, so the matter would simply be discontinued. I proposed such a procedure simply to let the families and other persons who are directly involved know what is going on so that they can be satisfied that all proper steps are being taken to progress matters.

The Convener: So, it would be procedural, rather than substantive, and would not therefore prejudice any subsequent criminal proceedings.

Lord Cullen: Yes, but you will appreciate that that particular idea of mine has not found favour with the Scottish Government.

The Convener: That does not always matter to the committee. It is an interesting proposal and I thought that it might help to raise it.

Elaine Murray: There seems to be a difference of opinion between you, the Scottish Government and Ms Ferguson on the issue of sheriffs' recommendations. You recommend that there be an obligation to respond to such recommendations, whereas Patricia Ferguson suggests that complying with them should be a requirement, although there would be an opportunity to explain why they had not been complied with. However, the Government has not taken forward your suggestion that information on recommendations and responses be published in a report to Parliament. What is your view on that?

Lord Cullen: You have covered a number of topics in that question, the first of which is about publication. I was anxious to ensure that everything would be done to bring home sheriffs' recommendations by making them known to the public and those in positions of authority so that they could take whatever action was required—hence my recommendations on the dissemination and publication of the sheriff's determinations and the response. I wondered how I could make sure that those determinations and the responses—or, indeed, the lack of response—to them got as high a profile as possible, and that is why I recommended that they be tendered to the Government. That would ensure that the Scottish and United Kingdom Parliaments would be aware of what was happening and what the responses were so that they could take any appropriate action. However, my proposal about publication and the information being the subject of an annual report did not find favour with the Scottish Government, which has left the matter in the hands of the Scottish Courts and Tribunals Service.

That said, I would still like as high a profile as possible to be given to the recommendations. I do not want it ever to be thought that determinations and recommendations are being overlooked.

Elaine Murray: In their written evidence, some witnesses said that they did not think that the Scottish Courts and Tribunals Service was the appropriate organisation to make such a report.

Lord Cullen: I think that I am correct in saying that when I wrote my report, the website of what is now the Scottish Courts and Tribunals Service set out sheriffs’ determinations and recommendations. At that stage, the responses themselves were not set out anywhere; that was yet to come. The question, then, is: where should the responses go? I thought it better for them to go to the Scottish Government rather than the Scottish Courts and Tribunals Service. Of course, they could go to both, with links between the two of them. However, the issue is all about profile, which is why I thought it best for the recommendations to go to the Scottish Government. I also mentioned the UK Parliament, because some of a sheriff's recommendations could apply to reserved matters, such as health and safety.

You also touched on the question of how the recommendations are dealt with. I have read Ms Ferguson's proposals on what you might call the enforcement of sheriffs' recommendations, and have some thoughts on the matter. At first, I thought that if a party to an FAI thought that it was likely to be the subject of a legal duty to comply with a sheriff's recommendation, it would want, during the inquiry, to have the clearest specification in that respect and an opportunity, if necessary, to contest that with evidence. The position with regard to a non-participant in an inquiry would be even more significant, because they would not hear what the sheriff's order was until after the FAI and, in fairness, they would need to be given the opportunity to contest it, presumably through some form of hearing of evidence after the FAI was over.

10:15

What concerns me about all that is that it runs counter to the idea that an FAI is there for the purpose of inquisition, not for the purpose of establishing rights, duties and obligations. That is actually quite foreign to the FAI process and would, I think, be inappropriate. Apart from anything else, it would involve a considerable increase in the amount of time spent in the sheriff court dealing with matters that really should be followed up by organisations such as the Health
and Safety Executive or one or other of the Parliaments that have an interest in them.

Making the sheriff’s recommendations mandatory places the sheriff in the position of being able to—if you like—enact a legal duty. Apart from the fact that such a move is foreign to the FAI, it places the sheriff in a rather strange position, because the enacting of legal duties is really a matter for the Parliament. If the sheriff were to enact a duty that must be complied with and, if necessary, enforced by some punishment such as a fine, what would you do with that duty if the recommendation itself turned out not to be wise, was superseded or was for some other reason found to be not good? How would you get rid of it? I suppose that you would have to enact some piece of legislation in order to do so, because until that time, the party concerned would have to comply with that legal duty. That point shades into a constitutional question about who is actually in charge, and it seems to me that that is really a matter for Parliament.

My final and purely practical point is that some sheriffs’ recommendations—for example, a recommendation that something be considered or discussed or that there be collaboration—are simply not the sort of thing that you would make the subject of a legal duty. Other recommendations might be misguided, superseded or conflict with what was being done or had been recommended elsewhere in Scotland. It would be far better to leave sorting all that out to potential legislation or the actions of some authority that was actually charged with responsibility for looking after safety.

I am sorry that my answer was so long, but those are three points that came to me when I thought about the matter.

Elaine Murray: Thank you very much.

The Convener: Would European convention on human rights issues not arise if there were such a duty and if, after a recommendation was made, it became binding on a party who had not been party to the proceedings and had not had the right to a fair hearing?

Lord Cullen: Indeed. Of course, that comes back to my earlier point that, if a sheriff were to impose a duty on a person who had not participated in the inquiry, you would have to start all over again by examining the case for and against it.

Margaret Mitchell (Central Scotland) (Con): Good morning. It seems to me that if the bill is to be effective, certain resource implications will have to be taken account of. For example, in your recommendations, you suggest that the reasonableness test for legal representation for relatives be withdrawn. I think that the idea behind that suggestion was that, although the Crown Office and Procurator Fiscal Service could ask some questions on the relatives’ behalf, it represents the public interest. However, the Scottish Government has rejected that suggestion, saying that, given the financial climate, the time is not right. Do access to justice questions not arise in that respect?

Lord Cullen: That is part of the Government’s answer, and I quite appreciate its view. As you will have seen from the report, what led me in this direction was the reflection that the families have a distinct point of view, which means that they have not only the standing to ask questions but reasonable grounds for asking what should or could have been done. I appreciate the comment that the procurator fiscal can take account of what the relatives say, but he is not bound to do so. After all, he is not conducting his part of the inquiry on their behalf. That led me to wonder why the relatives should not be able to access legal aid—subject, of course, to the limits of what is financially available to them. The reasonableness of their participation should not be in question.

Margaret Mitchell: It seems to me that, if we are talking about updating and improving the process, this is a key access to justice question.

Lord Cullen: It could be seen as such, but of course we are not talking about access to justice in the normal sense, which is all about access in a court of law. An inquiry is not a court of law. However, the question is whether there is a public interest, so to speak, in families having that degree of support.

Margaret Mitchell: I also want to ask about the resourcing of the Crown Office and Procurator Fiscal Service. We have seen delays of up to four years before a fatal accident inquiry has even happened is not in accordance with what I suggested. I suggested a team that would be devoted specifically to FAIs, whereas it has turned out to be part of a larger deaths unit. That might be perfectly all right—I do not know. I have heard a lot of reassuring statements by the COPFS, and I trust that it has been working well. When you
hear from it, you will no doubt be able to judge whether that approach has been successful so far.

Margaret Mitchell: There seems to be a bit of a precedent, certainly in criminal matters, as we have the domestic abuse task force within the COPFS to make sure that issues are dealt with as efficiently as possible. It seems to me that there is a relationship between the two.

Lord Cullen: As I said in my opening remarks, the working of the system is dependent on the working together of the legislation on the one hand and the COPFS on the other. The two have to work together well enough to ensure that there are no avoidable delays.

Margaret Mitchell: Returning to Elaine Murray’s question about the early hearing, which would give some information and communication, would the extra resourcing—

Lord Cullen: That is an important connection, because that is the context in which I talked about the delay. If the COPFS has made improvements such that fears about the family not being kept fully in the picture are groundless, that makes an early hearing of the type that I described earlier unnecessary. The two work together.

My idea was to have an early hearing as a spur to effort and disclosure. However, if the COPFS system is working well, it makes the case for that early hearing less good.

Margaret Mitchell: At present, we do not have a commitment in the bill to an early hearing, and it is not clear whether the Crown Office and Procurator Fiscal Service has received the additional funding that would help to improve the system.

Lord Cullen: I appreciate that there is a problem about the early hearing, because when would it be? The Government has said various things at different stages about when it should be. It has tended to say that it should be held only when we know enough to know that the FAI will go ahead. What I had in mind was something rather earlier than that, but getting a time for the early hearing is difficult. What do we relate it to? Given the range of FAs, which cover a diversity of accidents, it is difficult.

Margaret Mitchell: Would it involve just the Crown Office and Procurator Fiscal Service or would it involve Police Scotland as well?

Lord Cullen: I presume that Police Scotland would feature as part of the work that is done for the COPFS. It would not have a separate position but would simply be part of what is done to investigate.

Margaret Mitchell: Thank you.

Roderick Campbell (North East Fife) (SNP): Good morning, Lord Cullen. I want to move on to the question of compulsory detention due to mental health issues. You recommended that a person’s death during such detention would be suitable for a mandatory FAI, but that recommendation has not been taken forward. Indeed, the Government has consulted on alternatives. Despite those alternatives, however, the Equality and Human Rights Commission and the Scottish Human Rights Commission seem to have reservations.

I do not know whether you have had an opportunity to look at what the Government says in its policy memorandum about the position relating to those who are detained for mental health reasons, but it refers to its understanding from the Royal College of Psychiatrists that there is a graduated scale of investigations. In the light of what has happened since you reported, how do you feel about the Government’s proposals?

Lord Cullen: Are you asking how I feel about the fact that it has not incorporated the proposal in the bill?

Roderick Campbell: Yes.

Lord Cullen: At the time, I felt—and, I think, I still feel—that there is a clear read-across between persons who are in a custodial situation through criminal behaviour and those who are in mental health hospitals by way of compulsion. Each of those groups of people is there by compulsion and they are protected, as it were, by the authority into whose care they have been committed. The Human Rights Act 1998 does not draw a distinction between the two. Cases have cropped up in which deaths have occurred in mental hospitals of people who have been held there compulsorily. Such people have been held to be covered by the 1998 act—article 2, I think—in the same way as those who are in prison or another form of custody. That is why I thought that they should be treated in the same way.

I appreciate that it can be said that a person who dies in a mental hospital may die of natural causes, but the same may be said of those who die in prison, so most of the things that apply to one also apply to the other. I feel that there is still something to be said for my recommendation. Nothing that has happened since then has changed my mind. I have read the policy memorandum, of course, and it shows a number of possible avenues, but no mandatory avenue. That is what I had in mind.

Roderick Campbell: So you remain of the view that a mandatory approach is required.

Lord Cullen: I still consider that there is a lot to be said for it.
Roderick Campbell: Notwithstanding the reservations of the Royal College of Psychiatrists and the Mental Welfare Commission for Scotland.

Lord Cullen: Of course, the committee has to balance everything up. Those organisations have a point of view. It is a question of balancing one thing against another.

Roderick Campbell: Okay. You pointed out in your report that, in 1998-99, there were 141 fatal accident inquiries whereas, in 2008-09, at the time of your report, there were 57. I think that in the last financial year there were 59, and in the previous year there were 33. In general terms, do you think that, as a society, we have got it right? Fatal accident inquiries have been quite an expensive procedure. What is your general view on the number of fatal accident inquiries?

Lord Cullen: I have heard nothing at any stage to suggest that we have too few or too many.

Roderick Campbell: Okay. Perhaps I will leave that there.

The Convener: That put your gas at a peep. [Laughter.]

Roderick Campbell: What would you draw from comparing the system that we have in Scotland with the system south of the border?

Lord Cullen: I would hesitate to draw comparisons. I have looked at the system south of the border for certain limited purposes, but not for an overall view.

Roderick Campbell: Thank you, Lord Cullen.

The Convener: I am looking at the distinction that you make between an early hearing before an FAI and a preliminary hearing. Why is the preliminary hearing not good enough? Why do you wish for something else in advance of it?

Lord Cullen: A preliminary hearing takes place in order to organise the management of the FAI. In other words, we have embarked and we want to ensure that the time is properly spent and that we have proper arrangements for what is to come. We are on the way. An early hearing, which I discussed earlier, would be simply and solely for the purpose of information being given—before the sheriff—for the benefit of the families and other interested persons. That is all.

The Convener: Why would it have to be done before the sheriff? Should the Crown Office not be doing that anyway in a more informal fashion? Should it not keep the interested parties—

Lord Cullen: That is the question. I thought that it would be better to have an independent person who could say, “I want to make sure that you tell me in front of everybody what the position is and what is happening.” That is all.

The Convener: Yes. I am quite persuaded by that, because it seems that it would be in the public interest. Quite often, grieving relatives and friends are unaware of or have mixed messages about their role, if any, in an FAI, and it is difficult for them to appreciate their position in that regard. You think that an earlier hearing would be helpful.

10:30

Lord Cullen: I do not want to downplay what the COPFS has been doing and will do, but it would be useful to have the addition of an appearance before the sheriff. If necessary, the hearing could be held in chambers; it would not have to be held in public.

The Convener: I see—so it might not be held in open court.

Lord Cullen: It could be in chambers—I do not see why not.

The Convener: That is interesting.

Christian Allard (North East Scotland) (SNP): Good morning, Lord Cullen. I will press you on one point. A proposed member’s bill wants the categories of death for which a mandatory FAI would be held to include all work-related deaths. Should it be a human right for such deaths to be included?

Lord Cullen: Are you talking about the suggestion in Patricia Ferguson’s proposed member’s bill to cover work-related deaths other than those that are currently covered?

Christian Allard: Yes.

Lord Cullen: There are problems with the proposal. If we take a typical example of industrial disease, long before the death occurs it will perhaps be known what the person concerned is suffering from and what kind of exposure caused that disease. What public interest would be served by holding a public inquiry to establish either the cause of death or the kind of exposure that caused it? If it is a question of where the person acquired the exposure, there will be an employment history. How much can the public interest be served by inquiring into the way in which the particular industry conducted itself? Exposure could have happened years ago—perhaps at a time when there were old-fashioned practices that are no longer being followed.

Would there be a public interest in having a mandatory FAI in all cases into such deaths? I am not suggesting that there should not be an FAI in particular cases, for example if there was a novel form of exposure or if a cluster of things was causing concern. However, would it be in the public interest to have an FAI as a matter of
course when that requires—as was said earlier—the use of public resources?

Christian Allard: Would it be a matter of public resources, or of repetition?

Lord Cullen: Indeed, that could arise. A number of workers could have suffered from exposure to something some years back and, if an FAI were mandatory, an inquiry would have to be held into the death of each worker. I ask myself what each of those inquiries would establish.

Christian Allard: So an FAI would have to be mandatory for one particular type of death, or a new type.

Lord Cullen: An FAI would be required if there was something novel. I am not suggesting for a moment that it would not be useful for the Lord Advocate to be able to do that at his or her discretion, but that is a different matter.

Elaine Murray: The Scottish Trades Union Congress indicated that the ambit of the mandatory FAI should be extended when deaths arise because of new industries such as fracking or nanotechnologies. Would you be sympathetic to that being mandatory or could it be covered by the discretion of the Lord Advocate?

Lord Cullen: I think that there is a difficulty of terminology, so the best course is to leave it to the discretion of the Lord Advocate. It is quite difficult to find a form of words that would bring in what we want to bring in without bringing in things that we do not want to bring in.

Jayne Baxter (Mid Scotland and Fife) (Lab): I return to the convener’s comments about the value of a preliminary hearing and who might convene such a hearing. Should the timescales be monitored? It has already been said that it can take a long time for FAIs to begin or to conclude. Should someone monitor the delays and report back to interested parties on them?

Lord Cullen: Let us not call it a preliminary hearing, because that causes confusion; let us call it an early hearing. The answer to your question on monitoring is that, if an early hearing has taken place and it is inconclusive because things are still in progress, it is up to the sheriff to adjourn it to another date. That is the way in which matters can be kept before the sheriff.

Jayne Baxter: Should that be communicated?

Lord Cullen: The sheriff will communicate it to the parties. He will say, “I appreciate all that has been said today. I hope that it has been useful for the families to hear all this. It is plain that we have to wait for at least a month, so I adjourn this hearing for another six weeks.” That is how it would be done.

The Convener: It is a light-touch way of ensuring that there is not unnecessary delay.

Lord Cullen: Yes. It is a reassurance, if you like.

The Convener: As there are no further questions, does Lord Cullen have anything to add? Is there anything that we have not asked that we ought to have asked? We do not mind being insulted.

Lord Cullen: I do not think so. You have covered all the things that I thought you would ask about, and any of the things that were not taken up from my report have come up anyway. Thank you very much.

The Convener: Thank you very much. I suspend the meeting for a couple of minutes to allow a changeover of witnesses.

10:35

Meeting suspended.

10:37

On resuming—

The Convener: We move to our second panel of witnesses. I note that you were all present to hear the evidence in the previous session, which I hope you found useful.

I welcome Julie Love, chairperson of the group Death Abroad—You’re Not Alone. Members will be aware that she lodged petition PE1280, on fatal accidents abroad, which the committee is considering alongside the bill. I also welcome Louise Taggart, founder member of families against corporate killers, and Flt Lt James Jones, a retired member of the Royal Air Force who has advised on several inquiries into fatal accidents involving military aircraft.

Before we start, I have some brief information for the witnesses. When questions are addressed to you directly, your microphone light will come on. Otherwise, you may indicate if you want to comment, then I will call you and your light will come on. The microphones come on automatically.

You may wish to make brief opening statements. I emphasise that they should be brief, as we have your submissions, but I am sure that the committee would be happy to hear from you. Does any of you wish to do that? As no one does, we move straight to questions from members.

Margaret Mitchell: I think that most of the witnesses were in the room when Lord Cullen gave evidence in response to questions on legal representation and his proposal to drop the reasonableness test. Do you have any experience
of relatives finding it difficult to get legal aid for legal representation?

**Julie Love (Death Abroad—You’re Not Alone):** When a death occurs abroad, the difficulty is that legal aid is not available, because the case is in another country. Most families I know of have definitely not had legal aid or aid for travelling outwith the country to attend court or whatever. They have had no assistance whatsoever.

**Margaret Mitchell:** What is the position more generally?

**Louise Taggart (Families Against Corporate Killers):** I have no specific examples but, in a work-related death, it is often the main breadwinner who has been killed, so there are significant financial issues for the families who are left behind. If legal aid were to be more readily available, that would certainly be a positive move.

**Flt Lt James Jones:** My only experience has been in dealing with the families who were affected by the Nimrod accident in Afghanistan, when the bodies were repatriated to the coroner’s court in Oxford in England. There were no real problems with that.

**Margaret Mitchell:** Have you experienced delays in the holding of fatal accident inquiries? Will the proposals in the bill help to speed up the process? Do you have any suggestions for measures that are not included in the bill?

**Louise Taggart:** I know that Lord Cullen said that it is not necessarily helpful to draw comparisons with what happens in England and Wales but, from our perspective, it is useful to look at what used to be done there. An inquest used to be held before the criminal prosecution took place. That was the case when the Crown Prosecution Service had decided that there was not to be a gross negligence manslaughter case or a corporate manslaughter case but that the Health and Safety Executive would take forward charges under the Health and Safety at Work etc Act 1974. If a manslaughter case was to proceed, an inquest would be held off and the manslaughter case would go ahead in the Crown court. An inquest might be held subsequently.

If only offences under the 1974 act were being considered, the inquest would be held first. The HSE would often say that it saw the inquest as forming part of its investigative process and that things could come out of the inquest that it found helpful for its prosecution. That meant that families got answers earlier, because the inquest took place first. That was not considered to have a negative impact on the subsequent criminal prosecution. Therefore, I think that consideration should be given to holding the FAI before the criminal prosecution.

**Margaret Mitchell:** Lord Cullen suggested that an initial or early hearing, if not a full FAI, would give the families more information. It would do what you just described without jeopardising anything else, which is the reason that is given for delaying the holding of an FAI. It would involve informing relatives of what had been discovered up to that point. That initial or early hearing would be held in chambers, a maximum of three months after the death.

**Louise Taggart:** An early hearing would probably not give families as much information as they would need at that stage. I am not sure how much progress it would be possible to report on at that stage but, if that served as a bit of a kick up the backside for the Crown Office and Procurator Fiscal Service—as a way of saying, “This hasn’t been progressed and it needs to be progressed, so what are you doing about it?”—it would be a positive step.

However, that in itself would not be enough for a family. As someone said earlier, we can wait for up to four years for an FAI to kick off. As I said in our submission, some families have had to wait seven years to find out that an FAI is not to take place. Delays of six or seven years are wholly unacceptable. Families need more answers, and they need them more quickly. They need more than just an update on progress—they need answers on how and why their relative died.

**Margaret Mitchell:** I think that the idea of the initial or early hearing was purely to focus the mind—

**Louise Taggart:** That is a better way of putting it.

**Margaret Mitchell:** —and to try to prevent such long delays. As I understand it, it would not be a hearing to establish the facts, but it would put the case on the radar and would allow progress to be kept track of.

**Flt Lt Jones:** I do not want to keep talking about what happened south of the border but, if we go back to the Nimrod inquiry, the families certainly had meetings with the potential coroner long before the inquest. They talked issues through, which I think they found beneficial. They got things off their chests and they knew that they could raise questions with him that they felt would be brought up at the inquest. Talk of criminal proceedings came up during the inquest, and there was talk of corporate manslaughter as a verdict that could be returned. That went ahead before there was any talk of criminal proceedings.

10:45

**The Convener:** Do you accept that there could be an issue? Ms Taggart mentioned questions as
to how and why people’s loved ones died. If we proceeded with an FAI and family members and relatives wished—rightly—to know those things, might that prejudice a trial, because the party who might thereafter be accused would not have had the protection of the presumption of innocence or even representation? Heaven forfend that I should interpret Lord Cullen, but that is the kernel of what he was saying—a trial might be prejudiced, and we would get into a grey area.

Louise Taggart: It is a grey area, but there are some protections. A witness could not be compelled to answer a question that they thought might incriminate them, and the sheriff’s determination could not be referred to in future criminal proceedings. Those protections are built in.

The Convener: Does anybody else wish to comment on that? Are there sufficient protections? I have grave concerns, as you can hear from my questions. It is not that I am not sympathetic to your proposal, but I think that the proposal that my colleague Margaret Mitchell mentioned—an early hearing in procedural terms—is as close as we could get without prejudicing a trial in circumstances when criminal proceedings might be in the air. If somebody was taken to trial afterwards, we would not want the trial to be unable to proceed because issues had been in the public domain in advance.

Louise Taggart: My only point is that the inquest procedure in England and Wales has operated for a number of years and it has not prejudiced criminal proceedings. In some instances, the coroner has stopped the inquest at a point when he has thought, “Hold on a minute—we need to refer this back to the CPS.”

The Convener: I think that that has happened in Scotland, too, if something has not been foreseen.

Louise Taggart: That is another protection. If the sheriff thought that something had gone too far, they could stop proceedings and refer the case back for further consideration.

John Finnie: Good morning, panel. My question is for Ms Taggart. You did not make an opening statement, but the opening paragraph of your submission talks about the background of your organisation and states that it is

“a national campaigning network which aims to stop workers and others being killed in preventable incidents”.

There is clearly a role for the Health and Safety Executive in that. Further on, you say:

“Often, where a ‘mandatory’ FAI does not take place, it is because it is said that the full facts and circumstances have been explored in criminal proceedings.”

You express frustration about that. Will you share your views with the committee?

Louise Taggart: It is fairly rare for a case to go to a full trial when there is a work-related death. My brother was killed at work, which is why I am involved with families against corporate killers. He was killed in 2005 and a criminal prosecution went ahead in 2008. It was a full trial that was three and a half weeks long, but such trials tend not to happen. Four or five years down the line, the Crown Office and Procurator Fiscal Service tends to come to a plea arrangement with the employer.

In court, people go in and hear the plea arrangement that has been made. They do not get to hear from witnesses or to see all the documentation, such as photographic evidence or whatever else there may be. In that sense, it bursts people’s bubble. They have waited that long and they think that the case is going ahead and that they will find out all the facts and circumstances, but they do not. They are told, “We’re not going to hold an FAI because we think all the facts and circumstances have come out.” How can they possibly have come out if people have not heard from anybody?

John Finnie: Of course, the purpose of putting out the full facts and circumstances is for others to learn from them or for the HSE, for instance, to initiate further proceedings.

Louise Taggart: In my brother’s case, when we got to the end of the three-and-a-half-week trial, we were asked whether we wanted an FAI. You would have thought that, with my campaigning background, I would have said, “Yes—of course we do,” but by the end of the trial we were so exhausted that we could not—[Interruption.]

The Convener: I suspend the meeting.

10:50

Meeting suspended.

10:51

On resuming—

The Convener: We are back in business with a question from John Finnie.

John Finnie: I will follow up my previous question with a question for the whole panel—Ms Taggart, too, can pick it up if she wants—about the proposal to make sheriffs’ recommendations more effective.

Louise Taggart: I will pick that up—

The Convener: I think that the committee is fairly sympathetic to giving more power to sheriffs’ recommendations in order to ensure that organisations, businesses or companies cannot
simply walk away. We would be happy to hear from anyone on the panel on that point.

**Julie Love:** When my son died, there was no fatal accident inquiry. There was no inquiry whatever. However, what pushed me to submit my petition to Parliament was that there was no one to speak on my behalf or on behalf of any family, when a death occurs abroad. I had to write to President Chavez, who was the Venezuelan President at the time, and I was just a wee Glasgow mum. I felt that if there had been a recommendation from my elected MSP, the Scottish Government or the UK Government, something else might have been done. My question was why there were no lifeguards or warning signs on that particular beach. Colin had researched his holiday thoroughly and knew about everywhere he was going. He would say, “This is great. This is where I’m going, and this is what I’ll be doing.” The same thing could happen to anyone who goes to the same area; in fact, it has happened again and is still happening today.

The most important thing when someone dies abroad is that our Government can make specific recommendations. I know that the recommendations will not always be carried out, but at least the process would be in place.

**The Convener:** Will the provision in section 6, on “Inquiries into deaths occurring abroad”, be helpful? It says:

“An inquiry is to be held into a death to which this subsection applies if the Lord Advocate ... considers that the death ... was sudden, suspicious or unexplained, or ... occurred in circumstances giving rise to serious public concern”.

**Julie Love:** I think that the provision will be helpful. There has to be a broader discussion about the issue, but that provision will definitely make a difference.

**Flt Lt Jones:** With regard to repatriation of Scottish military personnel who die overseas, I think that having FAIs here in Scotland rather than coroner’s inquests in England would be a commendable move. Having spent three weeks with the families on the Nimrod inquest, I know how gruelling and demanding it is to go south of the border for that.

I would say—I hope that I get the chance to explain this later—that it is also important that we in Scotland know how we should deal with the deaths of servicepeople, because the issue is not just about repatriating people who have died abroad. If we bring them back, we have to bring them back to a system that is the same for all.

**The Convener:** I do not know whether Mr Finnie is ready to develop that line.

**John Finnie:** My question was about how robust sheriffs’ recommendations can be. Does the panel have any suggestions on how to enhance the standing of those recommendations?

**Flt Lt Jones:** I would just say—

**The Convener:** We will come back to military personnel, Flt Lt Jones. We have a specific question for you on that.

**Louise Taggart:** We decided not to go ahead with an FAI at the end of the trial partly because we wondered what use would come of it at the end. If a recommendation was made but nothing could be done if it was not followed, what valuable outcome was likely, given what we would have needed to put ourselves through again? If recommendations were binding, and if FAIs took place earlier, families would be more likely to go ahead with FAIs. Families absolutely want lessons to be learned from the deaths of their loved ones.

Towards the end of my submission is an example about Barry Martin and Michael Adamson, who was my brother. We had to listen to evidence at the trial that seven electricians had died across the UK between 2004 and 2006 because of the exact same failure to ensure that safe isolation equipment was provided to electricians. If an FAI had been held earlier, families would be more likely to go ahead with FAIs. Families absolutely want lessons to be learned from the deaths of their loved ones.

**The Convener:** Your submission makes a point about what happens when there is a criminal process first and there is a guilty plea and plea bargaining, so the family do not hear anything. Is it your proposal that, when a guilty plea is made pre-trial and when the family has not been privy to any evidence, we should have an FAI of some kind—perhaps it could be restricted—to establish the facts and circumstances?

**Louise Taggart:** Yes. Such an inquiry should consider the facts and circumstances and go on to determine lessons to be learned. There would be even more impetus to make recommendations binding if there were a move to take FAIs out of sheriff courts. Although that would be a good move for families, who would feel a bit more relaxed, it would perhaps take away from the gravitas of what sheriffs recommend at the end.

**The Convener:** I have always found sheriffs to be scary.

**Louise Taggart:** Me too.

**The Convener:** I have appeared in front of them in a professional capacity, and they usually have gravitas.

**Louise Taggart:** I mean that somebody who has not been a party to an inquiry might see the
recommendations and ask whether they must really do what is recommended.

They are termed “recommendations”, but I would go further. There has been a move in England for coroners’ reports to be termed “reports to prevent future deaths”. Something similar would be helpful; a report would have more impact than recommendations. People might wonder whether they have to follow a recommendation.

**Elaine Murray:** I return to military deaths. I was surprised—to say the least—to read in Flt Lt Jones’s written submission that

“The interpretation of the current Act, by the Crown Office, discriminates against members of the Armed Forces in that ... They are not regarded as ‘employees’

Will you expand on that and its effect on military personnel?

**Flt Lt Jones:** I am not sure that I am the person who should expand on that: the Crown Office needs to do that.

**Elaine Murray:** What is the effect of that on military personnel?

**Flt Lt Jones:** As far as the Crown Office is concerned, the 1976 act talks about employees and employers and, for some reason, because servicepeople do not have an official signed contract—they are Crown appointees—they are not considered to be employed. That came as a big surprise to me and to a lot of my colleagues, who must obviously have been unemployed for many years. The Crown Office’s interpretation is that servicepeople are not employees. Therefore, when we have what I would term “a work-related death” and a call for a mandated FAI, servicepeople are not being fitted into the category of employees, which is wrong. That interpretation seems to go against what I believe is the intention of the 1976 act.

**11:00**

When the 1976 act was written I am sure that people did not sit down and say, “Let’s put in the words ‘employee’ and ‘employer’ so that we can exclude military personnel.” It was just a way of saying that the death was work related. I think that Lord Cullen said that we should have mandated FAIs for work-related deaths.

To take just one example—there are others—for me, the deaths of the three crew members who died in the Tornado collision were work-related deaths. I cannot get my head round any other explanation. The Lord Advocate has the power to decide not to go ahead with an FAI for a work-related death as long as there has been a public inquiry or a criminal investigation, but those have not taken place, either. The military aviation authority has carried out an investigation and produced a report. The authority would say that it is independent, but it is part of the Ministry of Defence. In carrying out that investigation, no independent judge was present and there was no cross-examination. It was, by the authority’s own definition, an in-house internal investigation. Families were not involved and no one was allowed to put any questions. That is what has been presented to the Crown Office and Procurator Fiscal Service, which said that that would do instead of an FAI. I do not think that it will. I cite that example in my submission.

To go back to the accident on the Mull of Kintyre about 20 years ago, Lord Philip carried out a review in 2011. He said that the inquiry “was an internal process ... The Board of Inquiry was not a substitute for a legal inquiry into the cause and circumstances of a death”.

That point was in his report. Interestingly, he went on to say that

“the Lord Advocate concluded that a Fatal Accident Inquiry was necessary because some of those on board at the time of the crash were engaged in the course of their employment”.

That point comes up in the email that I got from the procurator fiscal. The report continues:

“while not mandatory in respect of all of the deaths, the inquiry should relate to all onboard.”

That shows that even 20 years ago, the line was being drawn between civilian deaths and service deaths. The Mull of Kintyre FAI took place only because there were civilians on board.

**Elaine Murray:** Did you make those recommendations to the Government at the time of the consultation? Do you feel that your concerns were taken in properly?

**Flt Lt Jones:** I am sorry. Do you mean the consultation document from last year?

**Elaine Murray:** Yes.

**Flt Lt Jones:** No—I did not make those recommendations. I was, however, involved in the case that I am describing.

I must say that no one pointed out that a consultation document was coming forward. It is just fortuitous that a few weeks ago, when we were all bitterly disappointed about the Crown Office’s decision not to hold an FAI for the Tornado crash, I stumbled through the website, found out about the bill and thought that perhaps there was a chance to come forward. Unless we acknowledge what has gone wrong in the past, it will be wrong in the future.

**Elaine Murray:** It is a pity that we did not get the opportunity to ask Lord Cullen about this. I
presume that it was not within the remit of his review.

The Convener: What is bewildering me is that the explanatory notes say that section 2(3) “replicates the effect of” a “section of the 1976 Act”, and section 2(3)(b) says that an FAI is mandatory “while the person was acting in the course of the person’s employment or occupation.” It is not just “employment”; it is “employment or occupation”. Therefore, even if there is an argument—which I do not necessarily agree with—that a person is not employed by the services because of the system under which people join the armed forces, it is still their “occupation”. I thought that that provision was new, and therefore would cure the problem, but it seems to be in the 1976 act anyway, so I am not quite sure why the Crown Office considered that people in the armed forces are not engaged in their “occupation”. I am just putting that in the air, because I do not understand.

Flt Lt Jones: This is the first time that it has been challenged. I refer you to the statement about the Mull of Kintyre helicopter crash. At some time, someone decided to play around with the words “employee” and “employer” and to take service personnel out. That was wrong.

The Convener: I am keeping away from the words “employee” and “employer”. The bill says “or occupation”, so even if you fail on the employment criterion—which I do not think you necessarily do—“occupation” seems to me to cover the situation. That is not even new; it is under the 1976 act.

Flt Lt Jones: That is absolutely correct.

The Convener: Perhaps servicepeople are covered anyway. We can ask the Crown Office.

Flt Lt Jones: As I said, the Crown Office’s interpretation is not in line with the intention of the 1976 act. After the Mull of Kintyre accident, what was even crazier was that a Tornado took off from RAF Marham in England, flew over the border and crashed in Glen Ogle in Scotland, but there was no fatal accident inquiry because those guys were not in their “employment or occupation”, and because they had left English air space there was no coroner’s inquest.

The Convener: They were in the course of their “occupation”.

Flt Lt Jones: Yes, I know, madam—which is why I am asking the Crown Office why it is coming up with such decisions. It does not make sense to me, to Angus Robertson, to the families’ lawyer or to the families.

Roderick Campbell: We obviously need to look back at the background, for what it is worth, to the passage of the 1976 act. What I have to say is not really a question; it is more of a comment. The royal prerogative and the comments in the “Stair Memorial Encyclopaedia” are not new.

The Convener: You had better tell us what they are.

Roderick Campbell: Flt Lt Jones refers to them in his written submission.

Flt Lt Jones: What I quoted is the answer that I got from the Crown Office and Procurator Fiscal Service. I also said that, in 2012, when he was dealing with the Snatch Land Rover accident, Lord Neuberger made it clear that the people who died were employees and that the MOD was their employer. For me, that makes the situation even clearer.

The Convener: There are two lines of argument—about employment and occupation.

Christian Allard: On what you said earlier about the MOD investigating itself, are you recommending that such inquiries should be civil inquiries?

Flt Lt Jones: I am saying that it is okay for the MOD or the Military Aviation Authority to do their own inquiries, and that it is important for them to do that because any immediate problems can be put right, but such inquiries do not replace proper inquiries in the public domain. There is no input to a military inquiry. It is like asking a person who runs a factory in which someone has died because a machine was operated unsafely to carry out their own investigation and to make recommendations, and then taking the factory owner’s report and saying, “Thank you very much—that’s fine.” You would not do that. As Lord Cullen said, FAIs are carried out in the public interest, which has not been satisfied in this case.

Christian Allard: As a representative of North East Scotland, I am used to public inquiries into such accidents, but will you elaborate a little on the difference between what the MOD has done and what happens with accidents in the North Sea, such as the one involving the Super Puma? Is there a huge difference between the two kinds of inquiries?

Flt Lt Jones: The air accidents investigation branch carried out a detailed investigation into the Super Puma accident, which took about 30 months. It was then decided that, as an inquiry would be in the public interest and the incident needed to be discussed, there should be an FAI.
The Ministry of Defence now has the Military Aviation Authority, which carries out investigations. It has strict terms of reference. The procurator fiscal can take such a report and say, "Okay—that is a piece of evidence. Let us now have a fatal accident inquiry."

You will see from my submission that the president of the service inquiry into the Tornado crash, with whom I have been in touch, said that he was prevented from going down certain lines of interrogation and that he thought that his report was incomplete. Since the FAI was rejected, he has written to me and said that that makes a nonsense of one of his conclusions, which was that the panel did not have enough skills to go the full way and that he expected another inquiry to take place.

Christian Allard: I have a question for not only Mr Jones but Ms Love, on the recovery of bodies. Can a full air accident inquiry be held when fatalities happen abroad and the bodies cannot be recovered? Do you have views on that?

Flt Lt Jones: Do I have any personal views on that?

Christian Allard: Yes.

The Convener: I think that the question was for Ms Love.

Christian Allard: It is for Ms Love as well.

Flt Lt Jones: I was around when we brought the bodies back from Afghanistan. They came back by Brize Norton and went to a coroner’s inquest there. Until we know how servicepeople will be dealt with or what the interpretation is when servicepeople come to Scotland, I would bring back through Brize Norton people who had died abroad, because that would guarantee them an inquest. Here in Scotland, a dead person is not guaranteed an FAI.

Christian Allard: My point is that, if the body cannot be recovered, there cannot be an inquiry in England or Scotland.

Flt Lt Jones: In the Nimrod case, recovering the bodies was difficult. It was a token recovery—let us put it that way. The families should have input and should be asked whether they want the body to be repatriated to England or Scotland. Right now, I would go for England. I would like to go for Scotland, having lived here for so long, but I know that my interests would be best served if I was repatriated to England.

Julie Love: I know of few incidents involving Scots in which their bodies have not been recovered. There was a Scot in Thailand during the tsunami who has still not been registered as dead; they are still a missing person. We have dealt only with cases in which the body has been repatriated to Scotland and there has been no inquiry whatsoever.

Christian Allard: So the members of your organisation are not concerned about what I described.

Julie Love: There are no major concerns about that issue. We deal with missing persons organisations throughout the world, but there have been no major cases in which the body has not been recovered.

The Convener: Are you content with the section in the bill that says that the decision to hold an inquiry into a death abroad is discretionary when it is considered that the death “was sudden, suspicious or unexplained, or ... occurred in circumstances giving rise to serious public concern”?

We know what happened in the tsunami, so surely you would not want an inquiry to be mandatory in all circumstances.

Julie Love: Definitely not. Investigations will be carried out in other countries and we do not want to mimic them in this country. However, there definitely are circumstances in which families believe that the investigation has not been thorough enough.

The Convener: The Lord Advocate gave Mr Jones an explanation of why there was no FAI in one case. When an FAI is not carried out, should there always be at least a fairly full written explanation from the Lord Advocate of why there has not been one?

Julie Love: I think so. Even the talk about the preliminary hearing or inquiry—

The Convener: It is an early hearing—we must not get our words muddled up.

Julie Love: Yes. An early hearing would be beneficial for families as well, because they could express their thoughts at that stage.

11:15

The Convener: My colleague Christian Allard asked about the recovery of bodies, which might be an issue in some circumstances. He might want to pick up on the point, given the North Sea experience.

Christian Allard: Yes—I want to speak about that with Mr Jones. After some air accidents, it could be impossible to recover any bodies, which would be a barrier to having a fatal accident inquiry.

Flt Lt Jones: Yes. The air accidents investigation branch’s inquiry into the Super Puma accident focused on what went wrong with the
helicopter. That is a piece of useful evidence that a sheriff could consult or refer to during an inquiry.

The Convener: With regard to someone dying abroad, my colleagues are concerned about the criterion in section 6(1)(c) of the bill that
"the person’s body has been brought to Scotland."

Notwithstanding what Ms Love said about bodies generally being recovered, we are concerned that there might be a circumstance in which it is not possible to recover a body, but an FAI might be the appropriate way forward. I think—I am looking round my colleagues—that we might look fairly sympathetically at it not necessarily having to be the case that a body was returned to Scotland if there was sufficient evidence to go for an FAI. Do you have concerns about the criterion that a body must be returned to Scotland?

Flt Lt Jones: If it is clear from what happened—for example, someone falling overboard—that there is no question of finding a body, that should not rule out having an FAI. Sometimes there are aircraft accidents when there is nothing left, to put it bluntly. That should not stop an FAI taking place.

The Convener: That is our point.

Julie Love: In some instances, but more so in the past, the Foreign and Commonwealth Office has recommended to UK and Scottish citizens that, for financial reasons and so on, a body should be cremated in the country where the person died. We have come across families who had a cremation in that situation but then found out suspicious things. They did not have a body at that point, so they could not have a post mortem to investigate the death further.

The Convener: That perhaps supports the point that it should not be necessary to have a body for an FAI, although that is mandatory in the bill at the moment.

Julie Love: Yes.

Christian Allard: I have a question for Ms Love on the submission that we had from Police Scotland. If the bill was implemented, do you think that Police Scotland might not have the resources or expertise to respond to families’ need for investigations abroad?

Julie Love: I read the submission, but I have not had much time to speak to our trustees about it. However, I believe that the resources are there for Police Scotland to support families now. We do not have a process in Scotland whereby Police Scotland delivers the death message when someone dies abroad, but a system is in place that could be used for that. We do not have a process whereby the family of someone who dies abroad is allocated a—

Louise Taggart: Police liaison officer.

Julie Love: A police liaison officer—thanks very much—or a family liaison officer. We do not have a process for that, but a system is in place that could be used for that. There are systems in place, which means that there would be no financial impact from using them for families of people who die abroad.

I suppose that there would be a financial impact if an investigation had to take place in another country. We do not have the statistics—or they are scarce—on how many Scots have died abroad and had their bodies repatriated to the UK. We would need to consider how many investigations we were looking at. I would say that it would be a maximum of three a year. In the past three years, there has maybe been one a year, if we go by the statistics that we have gathered.

Flt Lt Jones: Earlier, the convener talked about the Lord Advocate giving the answers about why we did not hold an FAI—

The Convener: We cannot go into a specific case, but we can deal with the generality.

Flt Lt Jones: Okay. Someone said that the Lord Advocate had given an answer, but he did not. The final answer that was given was that the report that the MOD prepared was sufficient. I am saying that that does not meet the criteria that are laid out in the bill.

The Convener: We can talk about the generality of whether—

Flt Lt Jones: I am saying that that report did not satisfy those criteria so, in my humble opinion, the view that was expressed by the Lord Advocate or his department was wrong.

Louise Taggart: Could I make a couple of final points?

The Convener: Of course.

Louise Taggart: As the bill is drafted, a family have to request the written reasons why a decision has been taken not to hold an inquiry. A family should automatically get written reasons why an FAI—

The Convener: I think that that is a requirement in the bill—I will check.

Louise Taggart: I think that there is a requirement to give reasons, but only if the family ask for them. A family should not have to ask for the written reasons.

The Convener: I appreciate your point; I am just checking for the provision in the bill. Has anyone found it? [Interruption.] It is in section 8. You are right—it says that the Lord Advocate must give reasons in writing
"if requested to do so"
**Louise Taggart:** The reasons should be given to a family automatically. Further, as Julie Love said, the reasons should not turn up out of the blue. Families should have some sort of warning that they are on their way. However, families should get a full explanation of why an FAI is not going ahead, if that is what has been decided.

**The Convener:** Should we retain the categories of people who can receive the information—the people in paragraphs (a) to (c) of section 8?

**Louise Taggart:** Yes—that would be sensible.

There was discussion earlier about whether FAIs should be mandatory in cases involving people with mental health issues. The sister of a school friend of mine committed suicide in a mental health hospital. Two months later, I read about two suicides in a Glasgow mental health hospital and noted that the circumstances were similar. FAIs should be mandatory in cases involving people with mental health issues, particularly in cases of suicide. Those people are some of the most vulnerable people in our society and are under the hospital’s care.

**The Convener:** We will certainly put those points to the Crown, and to the cabinet secretary when he comes to the committee.

Thank you for giving us your evidence. It is hard to do, but you did it well.

11:23

*Meeting suspended.*
On resuming—

Inquiries into Fatal Accidents and Sudden Deaths etc (Scotland) Bill: Stage 1

The Convener: Item 3 is a continuation of our inquiries into the Fatal Accidents and Sudden Deaths etc (Scotland) Bill. We have an evidence session with three panels of witnesses today looking at the bill and the themes emerging from last week’s evidence session.

I welcome to the meeting the members of the first panel: Jake Molloy, regional organiser, National Union of Rail, Maritime and Transport Workers, and Ian Tasker, assistant secretary, Scottish Trades Union Congress. Thank you for your written submissions—we will go straight to questions from members.

Gil Paterson (Clydebank and Milngavie) (SNP): Why do you think that it is necessary to hold a fatal accident inquiry into every death caused by an industrial disease and what benefit might we get from that?

The Convener: I should have said that the microphones will come on automatically. If one of you particularly wants to answer, just indicate that to me and I will call you.

Ian Tasker (Scottish Trades Union Congress): The STUC’s view is quite clear that it would be impractical to have fatal accident inquiries into every death caused by an industrial disease. The reason why we have a serious problem with asbestos-related diseases is that, although the problem was known about for most of the last century and even before, proper inquiries were never carried out.

Our intention in seeking mandatory inquiries in relation to industrial disease is to future proof against new technologies—such as fracking, and nano-technology and the materials that are used in that process—and the ways in which they may cause problems for individuals. Our intention is not to place a burden on the fatal accident inquiry process by covering old ground; it is to investigate new ground.

Gil Paterson: I am particularly interested in what you said about asbestos, because we know a lot about it. One of the problems that we have right now is seeking proper compensation. There are processes involved and tribunals and court cases. Are you relaxed about that? It is not the area that you want to be engaged in.

Ian Tasker: There might be some circumstances in which we would engage. We have not come across any in Scotland but in England and Wales there are cases in which very young people have developed asbestos-related diseases. If there is no indication where the exposure had taken place, we would suggest a mandatory or discretionary inquiry to establish how that death had occurred.

Gil Paterson: In those circumstances, would it work for you if the Lord Advocate had discretion?

Ian Tasker: Perhaps it would work for diseases that relate to known exposure to asbestos. In cases in which something does not fit in relation to a person’s past, a discretionary inquiry might be appropriate. However, we believe that new diseases or exposure to new industrial processes should be subject to mandatory inquiry.

Gil Paterson: I am fairly au fait with a lot of new products that come on to the market, particularly in the automotive industry, so I can understand your concerns in that regard. Does more work need to be done in relation to the new processes that are appearing?

Ian Tasker: In the absence of the precautionary principle, which would set strict standards for new processes, we need to ensure that, where issues occur, there is a proper and full inquiry into the death at the time. That is how lessons can be learned, so that we do not revisit the old problems that we had with asbestos, when a lot of people, including workers, buried their heads in the sand about the damage that asbestos could cause.

Jake Molloy (National Union of Rail, Maritime and Transport Workers): I concur with Mr Tasker, especially in relation to new technologies such as fracking, coal gasification and other, as yet unknown, areas. We need to ensure that, in the event of an accident, we learn everything that we can in order to prevent recurrence.

The Convener: That is in relation to industrial diseases, not accidents at work, which of course would mean a mandatory inquiry.

Jake Molloy: Yes.

Margaret Mitchell: Good morning, gentlemen. Do you still consider that there is a problem with delays in holding FAIs? If so, will you comment on Lord Cullen’s recommendation for early hearings, which was not taken up in the bill?

Ian Tasker: We fully support the suggestion in Patricia Ferguson MSP’s proposed bill that there should be a timescale set so that the Lord Advocate has to take a decision on holding an inquiry. That would kick-start the process at an early stage. I looked at the fatal accident inquiry into the death of a Brazilian national who fell in a...
wind turbine. It took seven years to get to an inquiry hearing, but we believe that things could have been addressed at an early stage. Although the individual was not wearing a hard hat, he was wearing a harness. Information about that death could have been released to the family that, in our opinion, would not have prejudiced any criminal inquiry but might have put the family’s minds at rest at an early stage.

Another example is the death in custody of James Bell in 2011. The inquiry was held in 2014. Three years is perhaps quite a long time to wait for a death in custody inquiry. When the fiscal was asked why the delay had occurred, they could not answer the question. The sheriffs know that there are unacceptable delays in the system but, for some reason, the fiscals cannot say why those delays are occurring.

Margaret Mitchell: The question was specifically about early hearings. It was proposed that there would be a hearing a maximum of three months from the time of death in order to inform the families of where things were at. It would mean that the Crown Office and Procurator Fiscal Service would have to say why they were not ready to proceed and give an estimate of when they thought that they would be ready to proceed. It would not just end there, though. Another time would be set to review the process. It would almost be a time limit. However, it is a proposal for an early hearing as opposed to a preliminary hearing, which is in the bill and which is all to do with getting ready for trial.

Jake Molloy: We agree with the principle, but there are still delays. An example is the death of a lad on the Brent Charlie platform in 2011. The prosecution was only done this year and no information about the incident has been disseminated. That is put into context when we consider the fact that, since that event, there have been two further fatal accidents involving people falling into the sea. That generates speculation, anxiety and concern among the wider workforce.

That is why we propose that there should be an early hearing to deal with the facts and to dispel perceptions, fears and concerns, address the family’s issues and share as early as possible the specific facts of the accident to prevent recurrence.

Margaret Mitchell: I think that the early hearing will be just to see where the case is and how imminent the FAI is or whether it is going to go in another direction.

Let me move on a little bit and—

The Convener: Before you move on, do any other members want to come in? This is an important issue. I think that we all accept that there are delays and that that needs to be cured. Margaret Mitchell’s point about the early hearing is that it is about the process but it would be almost impossible to go into substantive matters within a mandatory timescale. It would have to apply to all and it would be difficult in certain circumstances. It might prejudice an FAI or criminal proceedings. Perhaps a mandatory timescale is too blunt an instrument, if I can put it like that. We all want to see FAIs accelerated, but I have concerns. A mandatory timescale would not be suitable in all circumstances. It might be prejudicial to what relatives and friends want. Lord Cullen suggested that an early hearing would not just be the Lord Advocate telling relatives how he is proceeding; it would be a mandatory hearing to keep the Crown Office on its toes. Do you see the difficulty that we might have to face if there were to be a mandatory timescale for announcing that there will be an FAI?

Jake Molloy: We accept the difficulties that are associated with a mandatory timescale, but we are still greatly frustrated with the time that is being taken to get to FAIs.

The Convener: Absolutely, and we are looking at the cure.

Jake Molloy: Liaison and co-operation between the police, the procurators fiscal and the Health and Safety Executive seem to have delivered nothing in the way of reducing that timescale. In some cases, timescales are becoming ever greater. That is a concern for us and for workers generally.

The Convener: Is Lord Cullen’s suggestion of an early hearing gaining any ground with you, especially given his concerns about going in another direction?

Jake Molloy: We have requested that the regulators look at the air accidents investigation branch model of producing a statement of fact at a very early stage to diffuse some of the concerns that linger around some of these events.

Margaret Mitchell: The main point about an early hearing is that it would concentrate the Crown Office and Procurator Fiscal Service’s minds. It would still be in charge of the evidence and the presentation of facts. There would be nothing to jeopardise the case, for example by hearing the facts too early, but it would concentrate the mind of the COPFS and give it a date by which it has to report and say why there has been a delay.

Another way of addressing what might be seen as causing a lot of the delays is by ensuring that the COPFS is properly resourced. The Cullen report recommended that there should be a special unit to deal with FAIs and to make sure that the COPFS is properly resourced so that it can deliver as quickly as possible. What are your comments on that?
Ian Tasker: We welcomed the setting up of the FAI unit but, having studied the findings that are listed on the Scottish Courts and Tribunals Service website, we have some concerns about whether it will speed up the process. It certainly was not designed with the speeding up of the process as the sole priority; it was to make the procedure more effective, and we might well have a more effective procedure.

You mentioned resources. As far as we are concerned, the proposed mandatory timescales would be workable under a properly resourced regulatory system. That would mean proper resources not just for the Crown Office and Procurator Fiscal Service but for the HSE as the regulator.

We have spoken to a number of families. The only way they will be comfortable and be sure that matters will proceed is if there is a mandatory timescale.

Margaret Mitchell: Have the families had the chance to look at the early hearing proposal, along with the resourcing issue? There is a subtle difference between forcing through something mandatorily when people are not properly prepared with all the evidence at their fingertips that is needed to go forward and keeping track of a case to ensure that it is presented at the right time, while knowing that it cannot disappear into the ether because there will be another hearing and the parties will need to be accountable for any delays. Have the families had the opportunity to look at the two different approaches and the distinction between them?

Ian Tasker: The families that we are in touch with are very switched on to where the failures in the system are. They have studied these proposals and they have studied Patricia Ferguson’s proposals. We are talking about only two or three families who have been part of the process and who feel let down. In their experience, setting mandatory timescales to get matters in motion would address some of the issues that they have faced.

Jake Molloy: I concur. The families who were involved in the 2009 helicopter crash were repeatedly told that a prosecution was coming and that they should refrain from talking to the press, the trade unions and the public in any way and work with the Crown Office and Procurator Fiscal Service to get the right result. They then subsequently heard on the television that a fatal accident inquiry was to be held and that there would be no prosecution. It is quite clear that there are problems in the COPFS’s dealings with the families.

The Convener: I think that we agree with that. The concern is about whether there should be time limits in all circumstances. Would it not be a good idea to have a mandatory time limit when there is a death abroad, which is in the bill? I will leave that issue for now, because I have a queue of members wanting to ask questions. Christian Allard, is your question about delays?

Christian Allard (North East Scotland) (SNP): Yes, but I want to talk about deaths abroad. Perhaps I could do that later on.

The Convener: Leave that topic until later and just cover delays.

Christian Allard: Jake Molloy gave an example and talked about the air accidents investigation branch. I want to be clear that a mandatory timescale would cause problems with complicated cases, because there must be a proper investigation.

I like your idea that we need a statement of fact to start with. In the example that you gave, was the problem the statement of fact or was it the fact that, as with Piper Alpha, the procedure made it slow at the start? Where did the delay come from in that example?

Jake Molloy: We have had five helicopter incidents, and the AAIB has issued a statement of fact within 48 hours of each of them. The most recent case was the incident at Sumburgh. We got a statement of fact from the regulator to say that there was no mechanical issue whatsoever and that the investigations would go on about why the event occurred. That allowed the industry to consider putting helicopters back in the air again—they had been voluntarily grounded because we did not have that knowledge.

If I was to replay what happened in the case of the Brent Charlie death, for example, the facts were quickly known about how the individual’s ropes were cut through and how he came to be in the sea. In that incident, a statement of fact would have said that the ropes were cut through as a consequence of an unseen piece of steel and that investigations on how the steel came to be there and so on would be on-going.

10:30

I do not see how a statement of fact would jeopardise prosecutions. I feel that we have become such a litigious society that lawyers are advising companies now not to talk about events and not to provide facts; similarly, the lawyers are telling the HSE that it cannot comment. We therefore now have a situation in which the families and the greater workforce around any incident start to make up stories for themselves. That cannot be good for society as a whole or the Crown Office, or for how we deal with death at work. That is why I think that there should be an
early statement of fact, and then a timeframe based on that should be introduced for projections of when an inquiry will be held and whether it is likely that prosecutions will occur.

**Christian Allard:** You would not want to set a timeframe for the statement of fact to come out because, of course, investigations can take some time to find the facts. You would want a timetable after the statement of fact had been produced.

**Jake Molloy:** As the convener said, that then puts the impetus and accountability on the regulator, the police and the industry to conduct the investigation in good time to try and meet those timeframes.

**Christian Allard:** I am not sure whether you have—

**The Convener:** Are you able to summarise something for me, please, before I go to Patricia Ferguson? Are you saying that there should be no timescale for a statement of fact?

**Jake Molloy:** I would say that a statement of fact could be done within a matter of days after an event.

**The Convener:** In every case? You see, this is the problem.

**Christian Allard:** Yes, that is the problem.

**The Convener:** You have quoted very good examples, Mr Molloy, but if we are changing the law, we change it for every case and every foreseeable circumstance so that there are no unintended consequences from it.

**Jake Molloy:** I know that when the HSE is investigating an incident, it already produces an early-day incident report, which is essentially a statement of fact for the minister as to what it has found in its initial investigations. The report is little more than that; it does not prevent an investigation from going on but is simply a statement of fact as to what occurred in the incident.

**The Convener:** Just for clarification, are you talking about having a statement of fact within a certain timescale in all circumstances?

**Jake Molloy:** Yes.

**The Convener:** Which is?

**Jake Molloy:** That would be determined by the event. If we are talking about multiple deaths, then it is obviously going to take a bit longer. I do not know that we can have a mandatory timeframe—sorry.

**The Convener:** Right. So we should not have that, but once we have the statement of fact, we should then have a time limit for the announcement of whether there will be an FAI.

**Jake Molloy:** Yes.

**The Convener:** And that would be a period of three months.

**Jake Molloy:** Yes.

**The Convener:** Thank you. I just wanted to clarify that, Christian.

**Christian Allard:** Yes. I am happy with that if Mr Tasker is happy with it.

**Ian Tasker:** Yes. A good example of where it worked well was not for a fatal accident inquiry but for a public inquiry: the Stockline inquiry, which was a very complex investigation. Again, it could be argued that the families were not communicated with properly, but it was clearly established in the early days what caused the Stockline explosion. There was a lot of—this was mentioned earlier—rumour about what other things might have caused that tragedy, which does not help the families. There should be more openness and transparency about what has been found at an earlier stage, although I accept that there cannot be a mandatory timeframe for that. However, as soon as any regulator is in a position to issue a statement of fact, that should be communicated to the families.

**Patricia Ferguson (Glasgow Maryhill and Springburn) (Lab):** Good morning, gentlemen. I think that I am right in saying from my consideration of the Government’s bill that it mentions no timescales. Is that a disappointment?

**Ian Tasker:** Certainly for the STUC, that is a disappointment. We appreciate that the Government has taken on points from your earlier proposals. Our biggest disappointment is that the Government has not taken on board the timescales that we believe would push the process forward and encourage the Lord Advocate to take decisions. If there were mandatory timescales, they would become part of a process in which the decisions would—we hope—be taken well within those timeframes.

**Patricia Ferguson:** If the Lord Advocate had a timeframe of six months in which to say whether he would apply for a fatal accident inquiry, would that period be long enough, provided that a mechanism allowed the Lord Advocate to say that, if a matter was for example particularly complex, he would take seven months or nine months or a year? Would that be reasonable?

**Ian Tasker:** I think so, provided that the reasons for the decision were properly communicated to families and their legal representatives or trade unions. We have worked with families to make sure that their expectations of when things will happen are realistic. We would do that in such cases. If the Lord Advocate felt that there was a genuine need to extend any timescale, it would be
irresponsible of the trade union movement not to support that decision.

Roderick Campbell: Do you agree that it is in the public interest—as distinguished from the families’ interests—that criminal investigations should take precedence over fatal accident inquiries, that anything that might prejudice an investigation should be discouraged and that that concern should be foremost in the Lord Advocate’s mind?

Ian Tasker: That is very much the case, but more could be done—that relates particularly to the example of reports by the air accidents investigation branch, as Jake Molloy said. The Maritime and Coastguard Agency issues reports very quickly in relation to deaths at sea and it has what is basically a disclaimer that the reports will not prejudice any future criminal investigations.

We think that more could be done. It is clear that the public interest has to come first, but more could be done to publish reports on fatal accidents at work—we are talking mainly about such accidents—that would help us to improve safety standards at an earlier stage than we do now.

Roderick Campbell: I am trying to pull this together. Does the more that you think could be done go back to the idea of a statement of fact?

Ian Tasker: Yes.

The Convener: Could a statement of fact—not the ones that you have cited about mechanical failure, although they might have an effect, too—sometimes prejudice criminal investigations because it is put forward and not challenged? I have absolute concerns about delays and the families’ position, and I fully appreciate that FAIs are in the public interest and that we have to cure a lack of safety measures in workplaces as swiftly as possible. However, my concern is that taking the steps that you suggest would prejudice criminal proceedings.

We might prejudice criminal proceedings by having time limits. We might prejudice the position when, for example, a decision is taken within the time limit not to hold an FAI and then other evidence comes to light. Do we then hold an FAI? That is the problem.

We want to cure something, but I do not know whether your remedies would provide a cure in the way that you wish over all FAIs. What would happen if there was a time limit and the Crown said, “We are not holding an FAI; we have done a statement of fact and decided, within your time limits, not to hold one,” but a year later we thought that we should have held an FAI?

Ian Tasker: We are not aware of any circumstances when that has been—

The Convener: No, because we do not have time limits now. If we had them, what would they do?

Ian Tasker: The decision on whether to hold a fatal accident inquiry is being taken far too late. It is not being communicated to families—

The Convener: I agree with all that. However, if you set a time limit of six months and the Lord Advocate said that he was not holding an FAI, but a year later evidence came to light to show that there should have been an FAI, what would we do? What would happen?

Ian Tasker: If a full investigation had been carried out into the circumstances relating to a death and a decision had been taken on whether to pursue a criminal prosecution, we would question whether new evidence would come to light. If new evidence came to light, given that the double jeopardy rule has been abolished for criminal prosecutions, why could a process not be introduced in law to allow the situation to be revisited?

The Convener: The double jeopardy rule has been eliminated for very serious offences. I just wanted to put that difficulty to you as a possible unintended consequence of your worthy proposals for the FAI process to be speeded up and for families to be kept informed.

This is an important issue. Does anyone else want to ask about it before we move on?

Christian Allard: In response to me, you said that you did not want mandatory timescales, but you said in response to Patricia Ferguson that you were disappointed that the Scottish Government did not introduce mandatory timescales, so I am confused. Do you want mandatory timescales or do you realise that we cannot have them? I do not think that you have been clear.

Ian Tasker: Our preference is for mandatory timescales, but Patricia Ferguson raised an important point about situations in which the Lord Advocate might feel that mandatory timescales could not be adhered to, for whatever reason.

Christian Allard: Do you agree with the Lord Advocate?

Ian Tasker: He should have discretion to extend the mandatory timescales if he can provide an adequate explanation to the families of why he needs more time.

Christian Allard: Do you want there to be mandatory timescales to start with—yes or no?

Ian Tasker: Yes.

Patricia Ferguson: Mention has been made of criminal prosecutions against companies, firms and individuals who might be involved in such
unfortunate and tragic incidents. I presume that, if there were to be a criminal investigation, you would not expect the timescales to kick in until any prosecutions had been concluded.

Ian Tasker: That is correct. I already stated that we believe that criminal prosecution in the public interest must take priority. However, when a fatal accident inquiry is announced following the conclusion of criminal proceedings—particularly when a guilty plea has been made and, in the family’s view, there has not been a full examination and full disclosure of the circumstances relating to the death—we believe that mandatory timescales are vital.

Patricia Ferguson: I am interested in the point about the public interest perhaps being different from or superior to the interests of families. You made an interesting point about criminal proceedings. I think that I am right in saying that you have had some involvement in criminal proceedings in which a guilty plea was made, which meant that the facts were not explored in public, and no rationale was given to anyone who was involved in the tragedy in question.

Ian Tasker: I have been involved in a number of cases. I already mentioned the Stockline case. A few years ago, there were four fatalities in opencast mining, on which the companies pled guilty. The families were extremely angry that they went to court yet they did not hear the full facts of the circumstances in which their loved ones lost their lives. We supported some of those families in raising their concerns with the then Lord Advocate. We believe that that led to changes such as the setting up of the health and safety division.

The Convener: We are sympathetic towards your position. I am looking for a solution in situations in which someone pleads guilty and we do not get full exposure of the events that took place. Roddy, do you have a solution to that?

10:45

Roderick Campbell: No.

The Convener: Unfortunately.

Roderick Campbell: I think that you suggested that, if the Lord Advocate sought to extend the mandatory timetable, he would need to get the agreement of the victims’ families. How would that work?

Ian Tasker: I am sorry—I might have used the word “agreement”, but we would say that he could do so provided that the reason why he required that time was communicated to the families.

Roderick Campbell: So the Lord Advocate would still have to provide a reason. What would be the sanction if the victims’ families did not agree with him?

Ian Tasker: In my view, the Lord Advocate is in a position to take the decision and communicate it to the families. The families could then take whatever view they wanted on the decision. As I said, provided that the reasons were set out, perhaps with legal advisers engaging with families and saying, “Here are the reasons why the extension is required,” we would support that.

Some families might be very much displeased about the proposal to extend the time limit, but that happens at present. We see participants in fatal accident inquiries trying to introduce elements that are not part of the investigation into the circumstances leading to the death.

Roderick Campbell: Would there be a danger of creating something that was different from what a fatal accident inquiry is supposed to be, which is an inquiry, rather than a process that creates legal rights, duties and obligations? You are talking about lawyers being involved in advising families.

Ian Tasker: Lawyers advise families in fatal accident inquiries at present; families need that support because they have not been part of a legal process before. We have trade unions that support members at fatal accident inquiries. That does not take away from the fact that an FAI is an inquiry, but that support is there for people who are taking part in a process that is totally alien to them.

Jake Molloy: I will supplement that answer by using the example of the Brent Bravo tragedy in 2003 that we included in our submission. In that case, the families and the workforce at large felt that the scope of the proceedings did not enable learning points for the industry to be drawn out as they could have been, because plea bargaining occurred and the COPFS took the view that, as there was a guilty plea, there was no need for an inquiry.

We did some lobbying and got the inquiry, but the sheriff took a narrow remit to look at specifics without the input of the families, the trade unions, safety representatives or the workforce at large. Had that input occurred, the timeframe adopted by the Lord Advocate for holding the inquiry could reasonably have been expected to be extended because of what we saw as the complexities of the corporate structures of the company involved.

Mr Tasker is saying that we could, and I think that families would, reasonably accept an extension of any mandatory timeframe—whatever it might be—if the families were consulted on the justification for the extension and given the reasons and the detail on why the investigation needed to be broadened to look at other aspects of the deaths.
**John Finnie:** You have had some robust questioning. Some people might assume that the present situation is perfect, but it is far from perfect, which is precisely why we are sitting here.

I wonder whether you would care to comment on the points that have been raised regarding reinvestigation. I have the policy memorandum in front of me. There are six bullet points on the bill’s policy objectives, and the fifth is to “permit FAIs to be re-opened if new evidence arises or, if the evidence is so substantial, to permit a completely new inquiry to be held”.

It is clear that you do not want to come to that position, but you would support it if the need arose.

**Ian Tasker:** Yes—the STUC would support that. We agree with your statement that we would not particularly want to get to that position but, if we are to have an effective fatal accident inquiry system, that kind of strong test at the end would be welcome.

**John Finnie:** The RMT and the STUC are making representations for greater involvement of trade unions in FAIs, which I support. What role would the trade unions play, and what barriers—or perceived barriers—are there to the active participation of workers’ representation?

**Ian Tasker:** I go back to the Stockline public inquiry. In the very early days, the general council of the STUC took the position that, regardless of whether the workplace was trade unionised, we would support the families and the injured workers as long as they required support. That included helping them to learn how to campaign to get their public inquiry. Throughout the process, it was very clear that the trade union representation was not welcomed by the inquiry team, and it was not welcomed when we supported the families at the court hearing, at which they were deeply disappointed.

We should be seen as very much a part of the process where we have trade union members. The Stockline explosion was a terrible tragedy, and it is probably not something that we could deal with day in, day out. However, families need such support throughout the process, whether it comes from trade unions or from some other body, and I do not think that they get it.

**John Finnie:** We are told that their interests are represented by the procurator fiscal—is that not the case?

**Jake Molloy:** No—it is not the case. I have been involved with four fatal accident inquiries and two public inquiries—

**The Convener:** Can I stop you there? I do not mean to correct John Finnie, but the committee is well aware that the Crown Office and Procurator Fiscal Service represents the public interest. That has been a matter of confusion for families over the years and I am glad that progress has been made on bringing them more into the process. It is confusing when someone has died who you are very close to. We are well aware that a distinction is made and that families are often bystanders in the process. We are hoping that the situation will improve and change as the bill progresses.

**John Finnie:** Maybe I should rephrase what I said.

**The Convener:** Yes.

**John Finnie:** There is a perception that is widely held by families. I have been involved with a fatal accident inquiry into a death in custody, for example, and the family have said, “Who’s representing our interests?” The fiscal represents a range of interests. Whatever people may think, the status quo is not desirable.

**Jake Molloy:** During the entire period for which I have been involved in FAIs, I have never been asked by the prosector’s fiscal’s office, and the union has not been approached by the fiscal’s office or by the Lord Advocate’s office, to offer evidence. The only time that we endeavoured to submit evidence, we were told that the evidence that we offered was the rantings of a disgruntled ex-employee. That disgruntled ex-employee was the primary auditor of the global corporation and had produced data that demonstrated that the corporation had failed fundamentally in its duty of care. However, that evidence was dismissed as the rantings of a disgruntled ex-employee.

That is why we feel that there is a need to engage with all stakeholders prior to determining the scale and timing of an inquiry, and so on. That would also allow the families to hear directly from workforce representatives, the trade unions and fellow workers—safety representatives and the like. Many of those people could have made significant contributions to many fatal accident inquiries—certainly, the four that I have been involved with.

On the flipside, in the public inquiries, at which we got that input, the outcomes were significantly different. They were far more encompassing and resulted in far greater recommendations. They made a difference, whereas most of the fatal accident inquiries that I have been involved with—apart from one—have made little or no difference to operations or the prevention of accidents.

**John Finnie:** Although it has been suggested that the outcomes be binding, Lord Cullen told us last week that such a move would be challenging; in fact, it would almost pre-empt legislative presumptions and give those who make the recommendations authority that they do not
currently have. How should any findings be put in place? The families against corporate killers network, for example, expressed real frustration that although one death was being addressed, another six had happened in the interim because action had not been taken.

**Jake Molloy:** I will use another example from the most recent fatal accident inquiry, which was on the 2009 tragedy. I note that during the course of the investigation and the decision not to prosecute and then to hold an FAI, we were privy to evidence from a trade union official who said that four of the five incidents with helicopters would never have occurred with the company that he worked for; he was quite adamant that that was the case in his evidence to the minister at that meeting. He said that the 2009 accident would never have happened, because the helicopter would never have left the hangar. Although such evidence is fundamental to the investigation and inquiry process, it was excluded.

**The Convener:** What do you mean by “excluded”?

**Jake Molloy:** I am sorry—I should perhaps say instead that the evidence was not considered, because there was no mechanism to allow trade union or workforce input to that investigation. The families met the Crown Office and Procurator Fiscal Service, but there was no invitation to any trade union to be involved in the process.

**The Convener:** We can certainly put those points to the Solicitor General when she appears before the committee.

**Ian Tasker:** I recall a fatal accident inquiry into the deaths of a mother and her two children in a road traffic accident just north of Montrose. Although the accident happened in January 2008, the inquiry did not take place until four years later, which I call an unreasonable delay. However, in his judgment, the sheriff expressed disbelief at the fact that mobile cranes are not subject to MOT tests. Moreover, evidence was put forward that the United Kingdom Government was in contravention of the European directive on the matter, so the sheriff recommended that the UK Government take that on board and introduce legislation, as a matter of urgency. However, that has not happened. I realise that there is a difficulty with regard to devolved and reserved responsibilities, and that road traffic regulations are reserved, but we think that a sheriff should be able to make legally binding recommendations on matters relating to the Scottish Parliament’s devolved powers.

**John Finnie:** Should that power be fettered in any way, or should a sheriff be able to make a judgment in the knowledge that it will be enforced?

**Jake Molloy:** On enforcement, ensuring that the recommendations of a judge or sheriff are in the public domain, and requiring that those against whom recommendations are made put their responses in the public domain, would lead to a lot of emphasis being put on those companies responding positively. It would act as a great deterrent to bad practice and would promote good practice, as long as the process was open and transparent. The idea that those against whom recommendations are made simply respond through correspondence to the Lord Advocate or whoever is not healthy, open or transparent and is not conducive to what we are trying to achieve, which is to learn from such examples and make significant improvements.

**John Finnie:** Can we learn anything from the air accidents investigation branch, which you mentioned? I presume that its findings are not simply noted, but are acted on.

**Jake Molloy:** In most cases, yes—although it took the deaths of 10 drilling workers and two fatal accident inquiries for the drilling industry to change. As a consequence of Sheriff McLernan’s recommendations, we got that change eventually and—touch wood—we have not killed a drilling worker since that hearing in 2003. We have come close, but we have not had a fatal accident in the drilling sector since then, because the significant recommendations that were made were acted on by the employers and were enforced by the regulator to a great extent. It is important that the regulator is seen to be acting on the regulations, just as happens in the aviation industry.

11:00

**John Finnie:** Could you expand on your comments on improvements to access to legal aid?

**Ian Tasker:** We are concerned about access to legal aid. I came across one inquiry in which an individual had represented himself because funding was not available and he could not afford legal representation, and because the family thought that the procurator fiscal was not the best person to represent their interests. The case was heard in a sheriff court in the north-east, and the person who was representing himself, following the death of his son, was taken to pieces by the sheriff because he could not present his case as the sheriff expected. One case in which that happens is one case to many. We believe that individuals should have access to legal aid if they want to be represented at a fatal accident inquiry.

**Jake Molloy:** I agree with that. As time goes on, confidence in the Crown Office and Procurator Fiscal Service wanes. By the time an inquiry comes around, the families of people who have
died have little confidence in the service, so they come to organisations such as ours for support to get legal representation.

**The Convener:** Section 10(1)(e) says that “any other person who the sheriff is satisfied has an interest in the inquiry” may participate in inquiry proceedings in relation to the death of a person. Would not that cover trade union representation, if that was appropriate?

**Jake Molloy:** I stand to be corrected, but in our experience the sheriff is not involved until the inquiry has been staged. Rather, it is the fiscal’s office.

**The Convener:** I might be misreading the bill, but it says that “The following persons may participate in inquiry proceedings in relation to the death of a person”, and lists people whom one would expect to be listed, including the spouse, the civil partner and the employer. Section 10(1)(e) mentions “any other person who the sheriff is satisfied has an interest in the inquiry”.

Does not a sheriff have power, then, as master of the proceedings, to say that they would like to hear from the trade union?

**Jake Molloy:** That is what the bill says, and I hope that that would be the case.

**Christian Allard:** Mr Tasker said that there would be a difference in relation to reserved and devolved matters, and that in respect of devolved matters, a sheriff’s recommendation should be acted on immediately. What kind of mechanism do you envisage, in that regard?

**Ian Tasker:** It has come to my mind in the past couple of days that there is a question around the power that a sheriff in our legal jurisdiction would have to instruct the UK Government to introduce legislation to ensure that mobile cranes were subject to MOTs. I do not know the answer. That might be an issue for the constitutional experts.

**The Convener:** I think that there might be a tactful way of doing it, perhaps involving the words, “respectfully suggests”.

**Ian Tasker:** There is an opportunity for sheriffs to raise those issues in an appropriate manner.

**The Convener:** I am getting a frown from our practising member.

**Roderick Campbell:** I refer to my entry in the register of members’ interests; I am a member of the Faculty of Advocates.

I am not persuaded that there is any constitutional distinction between devolved matters and reserved matters in terms of the sheriff’s role.

**Christian Allard:** That was my point.

**The Convener:** There we are. It is good to have an expert.

**Ian Tasker:** Yes.

**Christian Allard:** Do you agree that it does not matter whether recommendations are for the UK Government or the Scottish Government? Recommendations are, of course, important, but I do not see how we can make them stronger than their being merely recommendations. Is there any way to do that?

**Ian Tasker:** The sheriff’s recommendation in relation to mobile cranes—which was made many years ago now—has not been taken forward because it is purely a recommendation; basically, it carries no legal power. In that case, a mother and her two daughters were killed: that left behind a father whose family was wiped out. However, the sheriff’s recommendation—which was justifiable, in our view—has been totally ignored by the UK Government because it is merely a sheriff’s recommendation. It is not a legally binding instruction.

**Christian Allard:** You are saying that the two Governments—the devolved and reserved Administrations—are not responding in the same way. Is that why you think that recommendations should be stronger?

**Ian Tasker:** I was perhaps just complicating matters for myself in relation to devolved and reserved matters, so I am glad that we have had clarification.

**The Convener:** Let us keep to the principle of recommendations being enforceable. There could be issues with that, as we heard from Lord Cullen.

I want to move on to something that we have not explored yet, because I am conscious of the time.

**Elaine Murray:** At section 6, the bill states that in cases where “the death occurred outwith the United Kingdom, ... the person was ordinarily resident in Scotland, and ... the person’s body has been brought” back to Scotland, the provisions of the bill would apply. In some industries—the fishing industry, for example—it might not be possible to retrieve the body of a person who has died. The oil and gas industry is possibly covered by section 5 of the Petroleum Act 1998, although I am not familiar with its provisions. However, there are instances of people who were employed by British companies, who were ordinarily resident in Scotland dying overseas and whose body was not
retrievable. Should such cases be included in the legislation?

Jake Molloy: Yes. The current consultation on the European Union offshore directive talks about extending best practice globally to corporations. If a fatal accident inquiry were to be held and the recommendations shared, that could have the impetus to improve health and safety understandings and operations. Sharing such learning could prevent recurrence globally.

Elaine Murray: One of the counterarguments is that it would be very difficult to enforce recommendations in other jurisdictions.

Ian Tasker: We certainly support the idea that a fatal accident inquiry should be carried out when a worker is killed abroad. It has to be said that the UK has some of the best-developed health and safety legislation and regulation; many other countries do not have such sophisticated regulation and enforcement. However, that does not mean that UK or Scottish companies that operate abroad cannot learn from a fatal accident inquiry when a worker is killed abroad. They could then make changes within their organisations to ensure that the risk of workers being killed abroad is reduced. We think that positive things could come out of that, but we appreciate that in some countries even carrying out that level of investigation could prove to be difficult because of the circumstances in those countries.

Elaine Murray: Police Scotland was quite concerned about the implications for the police—for example, about whether the police would be expected to do investigations elsewhere, if there were to be criminal investigations and so on.

Ian Tasker: In our view—the Health and Safety Executive is probably not going to like this—if there is a death at work, the UK regulator should investigate that death. However, that would clearly have resource implications for the Health and Safety Executive in relation to its capacity to carry out that additional task.

Christian Allard: The RMT submission refers to the problem of boats under flags of convenience. I have great difficulties understanding what you are saying about that, because I cannot see how the bill can allow us to override other jurisdictions’ approach in relation to investigations.

Jake Molloy: I do not think that we are arguing that we should override other jurisdictions. We certainly argue that all marine accidents in UK waters should be subjected to the same level of inquiry. Irrespective of flags of convenience, if something has occurred in the UK state, there has to be learning that will ensure that vessels that enter UK waters are fit for purpose and that they act in accordance with the jurisdictions of this country. Again because of resources, the Maritime and Coastguard Agency simply cannot police and inspect all such vessels. If we do not examine such issues through inquiries, we have no means of preventing recurrence of accidents.

Christian Allard: I understand the point about UK waters, but I have difficulties when you talk about other jurisdictions’ waters.

The Convener: Is that not covered by the provisions on deaths abroad, which includes non-UK territorial waters?

Jake Molloy: Yes.

The Convener: It is covered, Christian. We are talking about practicalities.

Christian Allard: So the witnesses are not asking to duplicate what happens abroad if the level of stringency is as good as that in the UK.

Jake Molloy: That is what we are trying to achieve.

The Convener: I am moving on. Does Rod Campbell have a question?

Roderick Campbell: I will leave it there.

The Convener: Excellent. I was giving you one of my crushing looks, I hope.

That brings this evidence session to an end. Thank you very much for your evidence, gentlemen. I hope that you accept that we were testing you because that is what we are required to do to ensure that we get the law operating properly in the interests of everyone.

I suspend the meeting for five minutes to allow a change of witnesses.

11:12

Meeting suspended.

11:18

On resuming—

The Convener: I welcome our second panel of witnesses. We have Alistair McNab, head of operations in Scotland at the Health and Safety Executive; Dr Gary Morrison, executive director (medical) with the Mental Welfare Commission for Scotland; and Cathy Asante, legal officer, human rights-based approach, with the Scottish Human Rights Commission. I thank you all for your written submissions. We will go straight to questions from members.

Elaine Murray: Lord Cullen’s recommendations have not been totally taken up in relation to deaths of people who are detained not in legal custody but for reasons of mental health. Should Lord Cullen’s recommendations be implemented in full in that regard, or are there problems with that?
Cathy Asante (Scottish Human Rights Commission): Our view is that there is a gap in relation to the protection of the right to life for those who die in mental health detention. Under article 2 of the European convention on human rights, which is the right to life, there is a duty to investigate deaths, particularly of those who are in custody of the state, in recognition of the fact that they are in a very vulnerable position. The European Court of Human Rights recognises that people who are in mental health detention are in a particularly vulnerable situation. In looking at article 2, the court has set down certain requirements for investigations of that nature. The essential elements are that inquiries must be independent, they must be effective, they must have promptness and reasonable expedition, there must be an element of public scrutiny, the next of kin must be involved and inquiries must be initiated by the state.

We know that there is a system for investigating deaths that happen in hospitals, including in mental health detention, but the system is variable and is spread across a number of agencies. We think that there are gaps. In essence, no independent formal inquiry takes place as a matter of course for deaths of that nature. For that reason, we think that deaths of people who are in detention under mental health legislation should be brought within the category of mandatory FAIs, as Lord Cullen suggested.

However, having taken into account some of the discussion that has arisen since Lord Cullen’s report, we think that there is merit in considering a two-tier system whereby an initial investigation is carried out to rule out deaths from natural causes or those in which there is no further cause for concern, and that mandatory FAIs should apply in all other cases. The Mental Welfare Commission for Scotland has put forward a proposal for a two-tier system of that nature, and we think that it merits further consideration.

Dr Gary Morrison (Mental Welfare Commission for Scotland): Simply put, our position is that we do not agree that there should be mandatory FAIs for all people who die while detained under mental health legislation, but nor do we think that the current system is adequate. Broadly speaking, that is for the reason that Cathy Asante outlined, which is that the current system does not comply with the requirements of article 2, and particularly that of independence. Also, we do not think that the current system provides adequate public reassurance.

In our written submission, we gave the committee information about a bit of work that we did on deaths of people who were detained in a year. I will go over the figures quickly, to aid the committee. In one year, there were 78 deaths. We have reviewed the case notes of 73 of those. Of those 73 people, 39 died of expected natural causes. For example, they included a 67-year-old man with alcohol-related brain damage who had cancer and who died in a hospice. A further 14 deaths were unexpected but natural. That included people who died suddenly of a heart attack or stroke. We argue that having a mandatory fatal accident inquiry for 53 deaths out of 73 would not be an efficient use of resources. Importantly, it would be distressing for the families of people who died of natural causes while detained.

Therefore, as Cathy Asante mentioned, we suggest that there should be changes to the current system to introduce more independent oversight and more public reassurance, but we should not automatically have a fatal accident inquiry in all cases.

Elaine Murray: Any death in legal custody will be subject to an FAI, even if it is a death by natural causes. Why should that be different from those who are subject to compulsory treatment, for example?

Dr Morrison: I appreciate that point and I note that it was one of the arguments that Lord Cullen made when he appeared before the committee. I suppose that what is done with legal custody is up to the Government but, from looking at the information that we have, it just does not seem proportionate, effective or reasonable to carry out FAIs for 53 people who quite obviously died of expected or unexpected but natural causes. As you heard in the earlier evidence session, FAIs do not happen quickly, and families get very anxious and distressed by them. One of the bigger or more significant arguments about FAIs is the distress that could be caused to families.

Alistair McNab (Health and Safety Executive): From an HSE perspective, the issue is really the investigation phase. I agree that, in many cases, we would not investigate all of those deaths; in fact, most of them would not be mandatorily reportable to the HSE in any case. We would learn about them through selected cases being put to the HSE by the Crown Office and Procurator Fiscal Service specialist health and safety division or the Scottish fatalities investigation unit. If they thought that there might be a work-related element, they would contact the HSE. The HSE does initial inquiries to establish the circumstances and decide whether further investigation would be required, and I think that that works fine at the moment.

It is true that we have not been involved in many FAIs. To give members some context, the HSE investigates between 25 and 35 work-related deaths a year, sadly, and we give evidence in approximately 10 to 15 FAIs a year. Some of those cases are pretty complex and require us to
have legal representation to explore the policy and sectoral issues behind them. However, the vast majority are relatively straightforward and simple and involve quick investigation.

I heard earlier evidence that suggested that everything takes too long. However, very many investigations are complete within three months, although there are complex investigations that certainly go beyond a year.

We would not have a difficulty with the investigation phase. We are happy that the COPFS refers the right cases to us; we can then take a view and report to the Crown Office on whether we think that there has been any potential breach of health and safety law. We have working arrangements with the Police Investigations and Review Commissioner to investigate relevant police-related cases, as well.

The Convener: So we would be looking at an addition to one of the sections or a separate section for deaths that occurred when people were detained under mental health legislation. Is that what you are saying? It would be a matter of taking your two-tier tests.

Cathy Asante: Yes. I think that we would be looking at section 6. We suggested that that section could include in the mandatory category deaths in mental health detention, but it could also have an exclusion in the way that some of the other categories do

“where the Lord Advocate is satisfied that the circumstances of the death have been sufficiently established during the course of an inquiry by the”

Mental Welfare Commission for Scotland, in this instance.

The Convener: So that would be mandatory; it would not be a presumption of an FAI. I was thinking that it might be argued that there could be a presumption of an FAI subject to other tests, as presented by the Mental Welfare Commission for Scotland.

Cathy Asante: I think that that would have broadly the same effect. However it was drafted, it would amount to a presumption that an FAI would take place unless it was ruled out by the Mental Welfare Commission for Scotland.

Roderick Campbell: I direct your attention to the policy memorandum, which says:

“The Scottish Government understands from the Royal College of Psychiatrists that there is a graduated scale of investigations which are carried out into mental health deaths—

- adverse incidents ...
- critical incident reviews (these involve a consultant from another Health Board area);

- significant adverse incident reviews (involving another Health Board);
- independent investigations by the Mental Welfare Commission Scotland;
- independent investigation by the procurator fiscal and possibly a discretionary FAI.”

The Scottish Government talks about possibly formalising and rationalising that system, “though not necessarily in legislation.”

In light of the powers of the Mental Welfare Commission for Scotland in particular, would it not be more appropriate for that to be in mental health legislation rather than the bill? I would like comments on that bit of the policy memorandum.

The Convener: What page is that on?

Roderick Campbell: It is on page 22. Notwithstanding Lord Cullen and recognising that there is certainly a case for minimising the number of fatal accident inquiries, particularly in cases involving people who have died of natural causes, would that not be one way forward?

11:30

Dr Morrison: It is certainly an option and something that we have had discussions with the Royal College of Psychiatrists about. That may well be what the policy memorandum is referring to because, at the moment, there is substantial variability in the system, particularly in the degree of independence. In a substantial number of critical incident reviews, or even significant adverse incident reviews, there will be nobody from outwith the local service, and that runs the risk of falling foul of the requirement for independence under article 2 of the ECHR. Were our suggestion to be taken forward, we would seek either more powers or agreements with local services to oversee and to direct their local incident reviews, to ensure that they take those reviews sufficiently seriously and that any conclusions are robust.

Whether that happens under the bill that the committee is considering or under mental health legislation is possibly more of a discussion for lawyers and draftsmen. I know that the closing date for lodging stage 2 amendments to the Mental Health (Scotland) Bill is this week, so the suggestion that we change something at this stage might not be welcome.

Cathy Asante: I support what Dr Morrison says about the article 2 requirements that are missing from that graduated scale of investigations. That is where our concern arises, particularly as regards independence but also as regards public scrutiny and whether the next of kin is involved, which varies in the current system.
Lord Cullen, he said that substantive issues would matter about progress being made. When I asked have had, it seems that it would be a procedural any further action that might be taken. whether an early hearing prejudices in any way earlier evidence and I think that the main issue is inquiry, the interval between the death and the involved that have proceeded to a fatal accident speaking. In the few cases in which I have been problem in mental health, I must have been mis - hearing recommendation in particular? sometimes there can be. I may have picked you up wrongly, but could you comment on the early question about delays and the recommendation to hold an early hearing. I note what Dr Morrison said about there not being a huge problem with delays in mental health cases, by and large, but that perhaps, if they had legal representation and legal aid to facilitate that, it might help. Cathy Asante: We did not comment on that in our response. In terms of human rights implications, there is no explicit provision for the right to legal aid in cases of that nature in the European convention rights, but there is an issue about equality of arms and allowing people to participate on an equal basis with other parties that have legal representation, so there could be a case to be made for ensuring that people are provided with legal representation in such cases.

Margaret Mitchell: I was picking up on what you had just said about the extent to which the families were involved, making the link that perhaps, if they had legal representation and legal aid to facilitate that, it might help.

Cathy Asante: That would certainly facilitate the involvement of the next of kin. It would be a strong measure for ensuring that that happens as a matter of course in FAIs.

Margaret Mitchell: I have a more general question about delays and the recommendation to hold an early hearing. I note what Dr Morrison said about there not being a huge problem with delays in mental health cases, by and large, but that sometimes there can be. I may have picked you up wrongly, but could you comment on the early hearing recommendation in particular?

Dr Morrison: If I said that delays were not a problem in mental health, I must have been mis-speaking. In the few cases in which I have been involved that have proceeded to a fatal accident inquiry, the interval between the death and the inquiry seemed to be substantial. I listened to the earlier evidence and I think that the main issue is whether an early hearing prejudices in any way any further action that might be taken.

The Convener: From the evidence that we have had, it seems that it would be a procedural matter about progress being made. When I asked Lord Cullen, he said that substantive issues would not be raised, so it would not be prejudicial to criminal proceedings.

Margaret Mitchell: I think that there is some confusion with preliminary hearings.

The Convener: Yes.

Margaret Mitchell: An early hearing is just a matter of process. The question is: are we ready to go ahead? If there is a delay, what is causing it? We should pin that down with the Crown Office and Procurator Fiscal Service and we should make it accountable. It should not just be a matter of having an early hearing; it should be a matter of setting another date if it has not been possible to establish the reason for a delay. That way, things are always kept in view.

Dr Morrison: I would have thought that it would be helpful for families to know that something is happening and for them to have a rough idea of the timescale for that something. It would also be helpful for families if the agencies involved were prompted to take action.

Alistair McNab: There is a stage before—the investigation stage—at which the HSE, the police and the Procurator Fiscal Service talk to the families. We explain what our role is. We have to control expectations, because we cannot say at an early stage whether or not there may be proceedings, which is not our decision. However, we can explain the investigative process and what the HSE does. That is what we try to do.

There could be improvement to that phase. I know that that is not the prime purpose of the examination of the bill, but the HSE views the investigation phase very much as leading into any FAI or decision on proceedings. There is no doubt that there could be improvements in the liaison with the families and in explaining how the process works. When we do that, we get praise for supporting families, who understand what is happening. We can also give them an indication of how complex the investigation is, emphasising that it will take time.

Margaret Mitchell: In a way, the early hearing might facilitate that. To specify in the bill that it must be held within three months might be helpful.

Alistair McNab: Yes. The statement of fact issue does not help.

Margaret Mitchell: Absolutely.

Alistair McNab: From an HSE evidential position and with regard to the criminal law, we are not investigating for fatal accident purposes.

Margaret Mitchell: Absolutely. I take that point.

Alistair McNab: We are investigating for potential breaches of criminal law. There are
safety alerts and other steps involving enforcement notices to prevent recurrence.

Our main aim in life is to prevent incidents from happening again by enforcing things by enforcement notice, if necessary, and by issuing safety alerts where that can be done. Safety alerts can be issued in agreement with the Procurator Fiscal Service so as to avoid prejudice. It is possible, by careful wording, to put out a safety alert, and we can therefore influence the wider community. That was done with the legionnaire’s disease outbreak in Edinburgh, for example. We put out a safety alert about our research on what causes outbreaks of legionnaire’s. That was agreed with the Procurator Fiscal Service so as to avoid prejudice to potential proceedings in the future.

We see the whole process through, starting from the investigation phase. Good communication at the start of the investigation phase would help families.

Margaret Mitchell: Does anyone else wish to contribute?

The Convener: Nobody else is indicating that they wish to speak.

Cathy Asante: I do not have anything to add.

The Convener: I cannot poke the witnesses with a stick from here to make them answer.

Do you have a supplementary question, Mr Campbell?

Roderick Campbell: It is on a different issue.

The Convener: You are on my list. John Finnie has a supplementary.

John Finnie: Mr McNab, it was interesting to hear about the range of powers that you have at the moment. Perhaps it was just me who did not pick this up, but could you expand on the issuing of a safety notice without prejudice? Perhaps it is more compelling than simply a warning, but how can you do that without prejudice?

Alistair McNab: That is what I am saying. It depends on the stage of the investigation, but if we believe that we are going to be reporting to the procurator fiscal and we think that the matter is important enough to need to issue a safety alert—for example, if—

The Convener: Yes, if you could give a nice example, please.

Alistair McNab: If a child is killed in electric gates in Birmingham or somewhere in the midlands, the HSE in England and Wales would put out a safety alert. We would want to do the same for a Scottish investigation, but we would talk to the Procurator Fiscal Service as early as possible, saying, “We think an alert is necessary.”

In my experience of discussions with the Procurator Fiscal Service, it would not wish to constrain a safety alert that the HSE believed to be important. We would seek to negotiate a form of words that avoided prejudice against a particular duty holder or employer, but which made a generality that was open to the public.

Such things are done reasonably regularly. We do not have to issue safety alerts for every workplace death investigation. We do so only when new information comes out—on a new topic perhaps—and we want to get the word out as quickly as possible. That can be done.

The same applies to the enforcement notices that we issue. Once the 21-day appeal period is up, the notice goes on to the HSE public database.

These things can be done without prejudice to future court proceedings and we are well versed in how to do them. It is all about clear dialogue with the COPFS and the police. We have tripartite investigations for work-related deaths. There is a work-related deaths protocol for Scotland, as there is for England and Wales, which is all about tripartite strategic decision making, with the police looking at potential breaches of the Corporate Manslaughter and Corporate Homicide Act 2007 alongside the HSE looking at potential breaches of the Health and Safety at Work etc Act 1974.

The investigation phase can go in a number of different directions, but we are very conscious of avoiding potential prejudice to proceedings.

John Finnie: The nature of your organisation is that you seek prevention rather than cure. Political philosophy suggests that we should be "slaying the health and safety monster"—you will know that that has been said. Do you have sufficient resources to be proactive, even in the event of a death? What liaison do you have with trade unions and staff associations, which have a statutory duty to inspect workplaces and which, I presume, have records that in many instances would facilitate your investigations?

Alistair McNab: It is difficult to answer your question on resources. How much is enough for any organisation? We have sufficient resources for the number of workplace deaths that I have talked about. A top reactive priority for us is to do thorough investigations, and that priority will always be resourced.

We still manage to run a proactive inspection process: Scottish workplaces get proactive inspections to try to prevent incidents from happening and, based on statistical evidence and
local knowledge, we target which sectors and places would be best to look at, such as the waste or construction sectors.

**John Finnie:** I stress that I am not being critical of your work; I am being supportive of it. I would like to facilitate your having more resources.

**Alistair McNab:** That is very helpful; thank you.

**The Convener:** Except that we are not allowed to have pins on our poppies anymore, because of health and safety. That seems a bit bizarre.

**Alistair McNab:** That is one of those myths that we try not to pin on the HSE. [Laughter.]

**John Finnie:** It is not helpful.

**The Convener:** Do you carry out investigations into all workplace fatalities?

**Alistair McNab:** For natural cause fatalities we do initial inquiries only. Quite often we get an out-of-hours call about a death when it is not certain whether it was as a result of natural causes or a work-related death. Initial inquiries with the police would establish that. Any reportable deaths at work would come to the HSE or the local authority. As you know, local authorities are co-regulators for warehousing and leisure type activities, whereas we cover the factory end of the market.

The answer to your question is yes, but it goes beyond what you might think of as factory-type accidents into issues of mental health, suicides in prison and healthcare. The Health and Safety at Work etc Act 1974 is very broad, as you know, so the Procurator Fiscal Service brings us in for many incidents that are not reportable directly to us.

Our role in road-related deaths has been of interest—there have been some submissions on that. The HSE’s main role in road-related deaths is police led, under the road traffic legislation. The police involve us from time to time, in circumstances that might involve management systems behind hours of work or allegations about driver and employer practices. The HSE can be, and has been, brought in in such circumstances. The phrase “cause and permit” usually allows the police to look at management systems and employer duties under road traffic legislation, but there are occasions when it would be more appropriate for the HSE to look at things under the Health and Safety at Work etc Act 1974. We have discussions with the police and the Procurator Fiscal Service about when they should let us know.

We are involved in a wide range of issues. With many fatalities, the Crown Office alerts the HSE to see whether we have an interest. That is the kind of relationship that we have; it is very proactive.

**The Convener:** It is very helpful to see how broad the range is.

11:45

**John Finnie:** You say in your submission that “the question of delay in investigation is real and this should be minimised, wherever possible. However, HSE believes that it is possible to achieve this without resorting to the inflexibility of a fixed timetable.”

How can the situation be improved without a fixed timetable?

**Alistair McNab:** I mentioned the work-related deaths protocol for Scotland. We were working with the police and the Procurator Fiscal Service well before the COPFS health and safety division was set up, but since that came into being, we have all made a concerted effort to try to speed up the investigation process. I am not going to claim that there are not some investigations that drag on too long, but as far as the vast majority is concerned, it is a priority for the HSE to carry out investigations as quickly and as thoroughly as possible. In such situations, we recognise the needs of the families and, indeed, of the employers, as well as the need to tell the wider world about the lessons that must be learned.

That said, after five years of tripartite working involving the police, the HSE and the COPFS, we are looking at what we have learned in that time and how we can improve the speed of investigations. We have already agreed with Police Scotland and the COPFS how that can be done, but the complexity arises in the interaction between corporate manslaughter and corporate homicide legislation and health and safety legislation. An examination of a larger corporation with a complex structure to find out whether corporate homicide is a possibility requires a certain degree of thoroughness and will not be a short investigation. It will be police led—“police primacy” is the term that we would use—but we work in partnership with the police and the procurators fiscal. It is all about strategic decision making; if that is done properly on day 1, week 1 and month 1, and if the investigation’s direction of travel is known by all the parties, we can talk about the resourcing that is needed to ensure that the investigation keeps up a reasonable pace. We have therefore taken steps to improve the investigation phase where possible.

I should also point out that HSE sets itself in-house expectations with regard to speed. Indeed, our track record in Scotland has always been good, because of the need to submit reports to the procurator fiscal and tell him the direction in which we think an investigation is going. We are therefore quite comfortable with having some expectation of a timetable on us. Part of my job as head of operations is to ensure that I have enough inspector resource, and we might double or treble up or put extra specialist resource into certain investigations to try to keep things moving.
Nevertheless, I accept that occasionally some investigations run far too long, and we are trying to look at what is causing the delays. I realise that Police Scotland will be giving evidence later on, but I think that there are resourcing issues for Police Scotland and the HSE. That said, Police Scotland, like us, puts a lot of resource into work-related death investigations—and rightly so.

**John Finnie:** Would the HSE make a recommendation to the COPFS that a corporation be the subject of a prosecution?

**Alistair McNab:** Yes. In fact, that regularly happens. Where there is evidential sufficiency and where we think that it is in the public interest, our practice is to report on that basis to the COPFS. That happens in quite a number of cases every year.

**John Finnie:** Would that require two separate reports to the COPFS?

**Alistair McNab:** No. We have meetings with the COPFS and the police and give verbal intimation of what we think is the direction of travel. Sometimes it is very obvious to us that there has been an alleged breach of law.

**John Finnie:** Is that information shared with the family?

**Alistair McNab:** No, because that is just our opinion. Like the police, we would report objectively to the COPFS, and on that basis, the Crown Office would report to Crown counsel, who would decide whether the matter had moved into prosecution territory or whether it should be the subject of an FAI.

**John Finnie:** Thank you very much.

**Alison McInnes (North East Scotland) (LD):** I want to return to a related issue that arose during our discussion about deaths that happen during mental health detentions. Are there also human rights considerations in the investigation of the deaths of those who are subject to compulsory treatment orders in the community, whose liberty might be quite significantly curtailed, or of those who are under welfare guardianship?

**Cathy Asante:** It is quite difficult to get the right balance. The coverage of the requirements of article 2 of the European convention on human rights is essentially strongest in relation to people who are in the custody of the state. Some people who are on community orders might simply be required to take medication; if they were living in their own home, they probably would not be considered to be in the custody of the state.

Other people who are on a community order or have a welfare guardianship might be required to live somewhere against their will—essentially, they are detained in a place where they do not wish to be. In some of those circumstances, those people might be considered to be in the custody of the state.

It is difficult to strike the right balance. This probably would not apply to everyone who is subject to an order of that nature, but some of those people may require the same protections as people who are detained in hospital.

**The Convener:** Do you want to comment from the Mental Welfare Commission’s point of view, Dr Morrison?

**Dr Morrison:** Of the 78 people I mentioned who died while being detained, more than 30 were in the community. The issue is clearly significant in relation to the number of people who are detained each year. I echo what Cathy Asante said: there will be some people on a community-based compulsory treatment order who are essentially living a normal life, except that they have to go once a month to receive medication. It would be very hard to say that their liberty is being restricted or that they are being deprived of their liberty by the state. However, there will be other people on community orders who have to stay in a certain place—possibly supported accommodation—and who cannot go out freely without staff with them. They are nearer to being in a position that could be described as the state depriving them of their liberty.

The issue that you raised about welfare guardianships is the one that is potentially the scariest—if that is a technical word that I can use in front of such a committee. There are close to 10,000 people under welfare guardianships in Scotland at the moment. About 40 per cent of them are older people with dementia. Their liberty is being restricted—most of them are in care homes where they cannot freely go out. Because of their age and their frailty, they are highly likely to die over any given period.

If that large number of people also required fatal accident inquiries, we would be introducing into the system something that was probably entirely unworkable. In addition, we would be distressing lots of families—for example, where a grandmother with dementia had simply caught pneumonia and died, as older people do.

**Alison McInnes:** Do you think that a subset of that group might need some further analysis? Many families have concerns about the overuse of medication in care homes, for example. Are there any circumstances in which you think that we should be looking for FAIs?

**Dr Morrison:** Off the top of my head, no, because I think it would be hard to silt out from that population which issues were of most concern. Over the past few years, the Scottish Government has been doing really good
preventative work as part of the dementia strategy, helping people with dementia whose behaviours show stress and distress without resorting to medication. I hope that that would prevent that kind of situation.

I suppose that we would rely on the discretionary role of the procurator fiscal and the Lord Advocate, if somebody felt that circumstances were out of the ordinary.

**The Convener:** There is probably also a role for the Care Commission, which would be alerted if something seemed to be happening in a particular care home. [Interuption.] Sorry— it is the Care Inspectorate now. It is not the Care Commission— that is old hat. Put it correctly in the *Official Report,* please.

**Roderick Campbell:** Mr McNab, what are your views on the status of sheriff’s recommendations at the end of a fatal accident inquiry?

**Alistair McNab:** We would not support mandatory directions because in our experience, important as they are, inquiries do not always cover all the issues, nor do they always call the right witnesses. The sheriff could be left in a position where they are putting mandatory decisions on regulators, such as the HSE, when there may be more risks that have not emerged or been debated at the FAI.

If the HSE were giving evidence, we would put forward our view in order to prevent such a situation from arising, but ultimately it can happen. I know that it is dangerous to use one example and suggest that it proves the case, but the best example that I have relates to the Rosepark care home fire. I submitted pages of written evidence to the inquiry, but for various reasons the HSE was not called to give oral evidence. That meant that our evidence was never tested in the public domain.

We see the sheriff’s determination as important and we always try to act on it; we do our utmost to comply and promulgate information to other Government departments as relevant. In the Rosepark case, the sheriff put a recommendation on not just ourselves but the Scottish Fire and Rescue Service and the Scottish Government. We had meetings with all those parties to try to do what the sheriff wanted, but we could not do exactly what the sheriff recommended.

That issue was never explored at the FAI and it gave the HSE quite a few problems, because the assumption was that in the future the HSE would inspect the electrics in cupboards in care homes. However, that is not a priority area for us to inspect. Statistically, one major incident, terrible as it is, does not necessarily mean that we need to inspect the cupboards in every single care home. The idea was never explored. The issue for me is a pragmatic one, and that is why we would prefer to be left with a strong steer rather than a mandatory direction.

In the example that was raised about the family that was killed by a crane, the HSE was involved and had legal representation at the FAI. That was because there was a complex interaction between road traffic legislation and the Health and Safety at Work etc Act 1974. The HSE took forward the sheriff’s recommendations, even though we were not the main authority—that was the Department for Transport, which did not give evidence. We took forward the sheriff’s view that such cranes should have MOTs. We took it on ourselves to go beyond what was said in the FAI and what the sheriff recommended: we approached the DFT and the relevant mobile crane association directly. We did everything that we possibly could, but it was not within our gift to make it happen.

I understand that MOTs for road-going cranes are being considered in the UK, but there is a cost to creating facilities that can test them. There are many issues in the crane incident that were not explored at the FAI and which would have made it impossible to meet a mandatory direction. However, it is very possible for the HSE to do something under the current arrangements or under the proposal to give a strong steer and to ask bodies such as the HSE to report back to the court on what they have done. If we could not do something, we would be more than happy to give an explanation as to why there were constraints on what we could achieve.

**The Convener:** That is interesting. Are you saying that, if the recommendation was not mandatory, there could be a further hearing with the sheriff?

**Alistair McNab:** What is proposed would mean that a sheriff could make a recommendation and the relevant party, such as the HSE, would do its utmost to comply and then report back to the sheriff on what it was doing and why. If we could not quite agree and considered that other risks might be created, we would point those risks out.

There might be a reason why the HSE would not be the relevant authority. For example, we might not have the vires to take all of the recommendation forward. That would be part of our response. There would be a public explanation of what we had done and, if we could not do everything in the recommendation, there would be an explanation why. We would be very comfortable with that approach; it is what we do anyway, but it is not fully in the public domain.

**The Convener:** It is not part of the process.

**Patricia Ferguson:** I take your point, Mr McNab, but I presume that the sheriff would make recommendations to whomsoever he thought it
appropriate to make recommendations, which would not necessarily be the HSE. The sheriff would make a judgment as to who the appropriate authority was.

**Alistair McNab:** Yes, I accept that.

**Patricia Ferguson:** I am thinking of the example of the Rosepark fire that you gave, and I understand the difficulties that may have occurred in that case. However, I am also thinking about the crane incident that you and Mr Tasker mentioned. Mr Tasker said that the sheriff had written to the UK Government to try to ensure that MOTs for such vehicles became the norm or a requirement, and you have told us that that is going to happen. That suggests that the recommendation made by that sheriff, although not binding, was a good one to make.

**Alistair McNab:** Yes, I accept that, but in that case it would have been better if the DFT had been at the FAI to lead evidence. The point is that the HSE is not the relevant regulatory authority for road-going cranes and the safety of road-going equipment. We have a responsibility for crane-lifting equipment rather than the crane itself. The relevant people who have the expertise should be giving evidence to the FAI for the right decision to be made in the sheriff’s determination.

**Patricia Ferguson:** That is not necessarily an argument against the sheriff having the option of making a recommendation where they think fit. You raised the example of Rosepark and perhaps using one example is not always helpful. Let us look at the Bellgrove and Newton train crashes. After Bellgrove, recommendations were made by a sheriff that could have prevented another such accident happening, but a couple of years later the exact same issue arose again, because the sheriff’s recommendations had not been taken into account by those responsible. Those are the kinds of recommendations that the committee is trying to consider whether it is appropriate for a sheriff to make in such cases.

**Alistair McNab:** Yes, I can see the argument, but the HSE’s position is that we can achieve the same outcome. We have always tried to promulgate professionally those issues that fall to us as a regulator—we do not ignore determinations. I am talking about complex overlaps of legislation that do not always lend themselves to being fully explored at an FAI. That is just a fact.

**Patricia Ferguson:** Convener, I was just trying to establish that we are not necessarily talking about the HSE; we are talking about the sheriff making recommendations to whichever body is appropriate.

**The Convener:** I appreciate that. I think that the issue is whether it is practicable, enforceable and appropriate if those recommendations are mandatory.

**Patricia Ferguson:** Indeed.

**The Convener:** Section 10(1)(e) allows the sheriff to call "any other person who the sheriff is satisfied has an interest in the inquiry."

Does that happen just now? Can a sheriff say that they should have HSE, the trade union or whoever in front of them?

**Alistair McNab:** It is slightly different for the HSE. The bill repeats the power for the HSE to be a witness—we have always had that. We would automatically be a witness in a case involving a work-related death that falls within the HSE’s jurisdiction.

**The Convener:** In the case that you gave as an example, the HSE was not a witness, and neither was the Department for Transport.

**Alistair McNab:** That was an unusual case, which is why I said that I did not want to use one example to prove everything else. We gave written evidence, as I said, but we did not give oral evidence. In most cases, specialist HSE inspectors give evidence to work-related death FAIs. We are represented.

Part of my job is to look at the wider tactics, which is why I mentioned that in certain cases we have legal representation because we think that we need to explore some policy areas to help the inquiry. In such cases, that works pretty well and the determinations tend to explore the territory that we think will be beneficial and in the public interest.

**The Convener:** Thank you all for your evidence. It has been a very interesting area for us to explore. I suspend the meeting to allow for a changeover of witnesses.

**Meeting suspended.**

**The Convener:** I welcome the third and final panel today: Iain Miller is executive legal manager, litigation and licensing, corporate services, at Glasgow City Council; and Detective Chief Superintendent Robbie Allan is from Police Scotland. Thank you for your written submissions. Again, we will go straight to questions from members.
I am looking to my left first, to let those members come in earlier, if they want. Elaine Murray and Margaret Mitchell are the faithful two.

Elaine Murray: On deaths during detention under mental health legislation, and deaths of children who are compulsorily living away from home and for whom local authorities are responsible, will you outline the current arrangements in that regard and say whether you think that they are sufficiently independent?

Iain Miller (Glasgow City Council): Glasgow City Council supports the proposal in the bill to have a mandatory inquiry on the death of any child who is in secure accommodation. A local authority may well be involved with such a child in respect of their being “looked-after”, under the relevant legislation.

There are other regulations; namely, the Looked After Children (Scotland) Regulations 2009, in which there is a compulsory measure whereby the local authority must notify the Scottish ministers and the Care Inspectorate of the death of any child who is looked after by the local authority—not just those who are in secure accommodation. That must happen within one day of the death, and a further fuller report to the Care Inspectorate must be submitted within 28 days. In the local authority setting, irrespective of the regulations, there would certainly be a significant case review that would examine all the circumstances. Very early on, the local authority would be aware of the very real possibility of a fatal accident inquiry—that is one of the circumstances in which there could be a discretionary FAI.

Overall, however, the council’s response is that the current measures are sufficient.

Elaine Murray: Is there no argument for doing what Lord Cullen has recommended, which is to make a fatal accident inquiry mandatory in all such circumstances?

Iain Miller: I hesitate to refer to resources, but one wonders in how many circumstances there would be mandatory fatal accident inquiries, and what they would achieve.

I argue that under the Looked After Children (Scotland) Regulations 2009 reporting mechanisms—the early reports and internal investigations—there is early investigation of all the facts. There could well be, at the insistence of the Lord Advocate, further scrutiny in the form of a discretionary fatal accident inquiry. Based on our experience, and having canvassed widely within the authority—principally people in our social work department and others who are involved in social care—we do not see that there is a requirement for mandatory fatal accident inquiries in all cases.

The Convener: Are in-house inquiries sufficiently independent? I do not mean to be scathing

Iain Miller: There would not only be the internal inquiry. The 2009 regulations require that within one day notification be given to the Scottish Ministers and the Care Inspectorate, and that within 28 days a much fuller report be submitted to the Care Inspectorate. The Care Inspectorate would review the matter by seeking medical information and looking at it from the point of view of education. We would also separately liaise with the Crown Office and Procurator Fiscal Service. From that point of view, I think that there certainly are safeguards. We are not talking about just an internal inquiry.

The Convener: Alison, do you want to ask more about that?

Alison McInnes: No.

The Convener: Are you sure? I trampled on you earlier by mistake.

Alison McInnes: Perhaps I will come in later on.

Margaret Mitchell: Good afternoon, gentlemen. On delays, the Cullen review recommended—Police Scotland will obviously be involved in initial consideration of this—the establishment of a specialist unit within the COPFS, and that such a unit and the COPFS be properly resourced, thereby ensuring that there would not be delays because of lack of resources. Would you comment on that specifically, DCS Allan?

Detective Chief Superintendent Robbie Allan (Police Scotland): I am quite comfortable with the current arrangements in relation to the deaths units that exist within the COPFS. We investigate the full variety of deaths—from criminal, corporate and accidental causes—and we engage with HSE as well. There are within the Crown Office specific units already established that we go to in relation to each of those types of death. I do not think that the lack of another specialist unit is causing delays; I believe that what is currently in place is sufficient.

Margaret Mitchell: There is the resourcing question. Police Scotland expressed concerns that in relation to deaths abroad there would be investigations that would have resource implications.

Detective Chief Superintendent Allan: Yes. We wrestled with what the exercise in relation to deaths abroad would look like, as it would apply to the COPFS and Police Scotland. Would it be very much a paper exercise in which we would take information from abroad and review it, or would we need to be more proactive? What level of intrusion would be required? That is not something that we
do at the moment, so additional resources would obviously be required to undertake that role, and it would depend on what level of scrutiny was to be applied.

Margaret Mitchell: I will leave the resource issue now and move on to early—as opposed to preliminary—hearings. An early hearing would be procedural, held within three months and would, I suppose, just be an assessment of where we are. If there were to be delays, they would explained at it, it would be a way of keeping the family informed, and it would keep the Crown Office and Procurator Fiscal Service—and, by extension, the police and anyone else who is involved—very much on their toes.

12:15

Detective Chief Superintendent Allan: Having been the senior investigating officer in a number of such inquiries, I fully support that move. Obviously, we undertake a considerable amount of inquiry in those three months—there is no doubt that a great deal of the work is done then. It is only right that that initial work should give us a clear idea of the direction of travel—whether corporate issues must be dealt with or the matter is to remain with the HSE. The three-month timeline is a good idea, and I think that a significant amount of information can be handed over in that time without our having to go into the specifics of the case, the evidence and so on. Moreover, such an approach would provide to families and interested parties a great deal of transparency about the timescale that we are working to.

That said, every inquiry is different—some will be much further ahead than others at the three-month stage. In some inquiries we have had to stop to wait for other people, but that sort of thing can be made obvious when it happens. I am currently involved in quite a high-profile case in which I can do no more until I receive a report from an outside agency. If it was out in the public domain that that was what had stopped the police inquiry, that would be very helpful to everyone concerned.

The Convener: Do you wish to comment, Mr Miller?

Iain Miller: I have no particular comments to make about the early hearing.

Roderick Campbell: Can DCS Allan share with the committee any information on current practice with regard to the triangle of the police, the Crown Office and victims’ families who might be seeking a fatal accident inquiry? How does that communication work?

Detective Chief Superintendent Allan: The police will deploy to every death, and in cases involving unexplained or suspicious deaths, we also deploy family liaison officers. That initial engagement with the family happens, and we keep them updated during the initial stage of the police inquiry. They will know what we are doing, particularly with regard to how we are managing the initial investigative strategy, the scene and so on.

I think that where we need to tighten things up a fair bit is what happens when we complete the initial investigation and report the circumstances to the COPFS. It is not that we back away from the matter, but that we have done the work that is expected of us and have made our report to the Crown. There is then an onus on the Crown to maintain that engagement with the family, because the matter is now subject to the judicial process. Things need to be tightened up during that longer period when the case is going through due process.

Roderick Campbell: Would you like the bill to contain something that would improve matters in that respect?

Detective Chief Superintendent Allan: That goes back to the earlier question about additional resources. There are mechanisms in place by which the Crown and the police engage with families, but such engagement is difficult simply because of the resources and time that are required. Our having sufficient resources to do that work is paramount.

Christian Allard: Sections 6 and 7 do not appear to contain any details about what you are expected to do in relation to deaths that occur abroad. Would you like the bill to be more precise about the engagement that you should have with other jurisdictions and about how you are expected to deal with, for example, travel, language issues and so on? Should the bill make it clear that you should not duplicate work that has already been done abroad?

Detective Chief Superintendent Allan: That needs to be made clear—it was certainly not clear from my initial reading of the bill. Indeed, my first question was whether the bill would require us to deploy Police Scotland officers in foreign countries. If that is not the bill’s intention and if the idea is that we engage through the Foreign and Commonwealth Office, get information from the country in question, review and assess that information and then ascertain what we will actually do, that is fine. However, if the idea is that we must start deploying officers abroad, that will give rise to huge logistical problems. As a result, we are looking for clarity about what is intended and what exactly we are expected to do.

Jayne Baxter (Mid Scotland and Fife) (Lab): When matters have come to a conclusion and an
investigation into a death ends, what systems are in place to communicate, liaise or have discussions with families—especially those who are not happy about the outcome? Would that engagement include giving them information or letting them see evidence? How do you draw matters to a close?

Detective Chief Superintendent Allan: Again, that is down to the COPFS, to which we ultimately report on all deaths. That said, no matter the circumstances of the death that we deploy to, Police Scotland officers work on the assumption that those circumstances will at some stage be tested in some form of judicial process, whether it be an FAI or a court case. We undertake investigation to that level, and we report every death to the COPFS. If there is absolutely nothing suspicious about a death—if it is a result of natural causes—that will be communicated to the family. If there is something more complicated about the matter and if the family requires more explanation, that is very much a matter for the COPFS, which will decide how to move forward from the police investigation.

Jayne Baxter: Thank you.

The Convener: Thank you for the witnesses, that was a brief evidence session, even though you had to wait a while for it. Thank you very much for your evidence.

I suspend for a minute to allow the witnesses to gather their papers.

12:21

Meeting suspended.
Scottish Parliament

Justice Committee

Tuesday 19 May 2015

Inquiries into Fatal Accidents and Sudden Deaths etc (Scotland) Bill: Stage 1

10:01

The Convener: Agenda item 3 is our third evidence session on the Inquiries into Fatal Accidents and Sudden Deaths etc (Scotland) Bill at stage 1. We will hear from three panels of witnesses today.

I suspend the meeting briefly to allow the members of the first panel to take their places.

10:01

Meeting suspended.

10:01

On resuming—

The Convener: Before I welcome the panel, I ask Roderick Campbell to declare an interest.

Roderick Campbell (North East Fife) (SNP):

Thank you, convener. I refer to my interest as a member of the Faculty of Advocates.

The Convener: I welcome to the meeting James Wolffe QC, dean of the Faculty of Advocates, and Tom Marshall, president of the Society of Solicitor Advocates. Thank you both for your written submissions. We will go straight to questions from committee members.

Margaret Mitchell:

Good morning, gentlemen. I would like to look at the issue of delays. You will be aware that, to tackle the issue, Lord Cullen recommended that an early hearing be held within three months. The hearing would set out where the Crown Office and Procurator Fiscal Service were and how imminently a fatal accident inquiry would be heard. Do you have any views on the matter?

James Wolffe QC (Faculty of Advocates):

I begin by saying that we very much welcome the bill, which modernises the system for inquiries into fatal accidents and sudden deaths.

By way of a preliminary comment, it is worth observing that FAIs vary enormously in their nature and complexity. At one end of the range are mandatory inquiries into situations such as deaths in custody, where there is no real complexity. The inquiry will convene and deal with the evidence very quickly, and the sheriff will be able to make a determination on an entirely uncontroversial basis—the matter may be dealt with within part of a day.
At the other end of the range are extremely complex inquiries, such as two that I have conducted. One was the Rosepark inquiry, which I conducted for the Crown. I was led to believe that it was the longest FAI that had been held—I hope that it was not cause and effect—but it was a very long, complex and difficult inquiry for a variety of reasons. The other was the Declan Hainey inquiry, which followed on from a prosecution.

There is such a range and diversity of circumstances and such complexity in the subject matter and nature of an inquiry that it is very difficult to be prescriptive about timescales for starting an inquiry. There is also the need, where a criminal prosecution is in prospect or under consideration, to allow the criminal process to be dealt with by way of priority. While we all favour expedition in inquiries, I suggest that being overly prescriptive is not necessary or helpful.

**Margaret Mitchell:** The idea of an early hearing is not to say that the fatal accident inquiry should be held within a certain timescale, although other witnesses may recommend that; the idea is that it is merely to inform the relatives, within three months, of the state of play. It is to concentrate the minds of the Crown Office and Procurator Fiscal Service, to ask what point the investigation has reached, and to make sure that the investigation does not disappear or get put on to the back burner and that there are no unnecessary delays.

As I understand it, the hearing does not have to be a very formal occasion—it can be in chambers—but it keeps the relatives involved. Are you in favour of an early hearing on those terms?

**James Wolffe:** I can see that there could be merit in a process in which the Crown is required to keep people informed. The question in my mind is whether the Crown is doing that anyway. There would be concern if the Crown were not keeping those most intimately concerned apprised of where it was and, if there was to be a significant delay to the start of an inquiry, why that was the case.

**Tom Marshall (Society of Solicitor Advocates):** I agree in principle with the idea of an early hearing. I read Lord Cullen's evidence to the committee with great interest. It seems to me that having an early hearing does not leave the matter entirely within the hands of the Crown Office and Procurator Fiscal Service. It brings the court into play at an early stage and, therefore, it gives the court an element of control of the pace at which matters happen in future. That must be important.

Parliament has recently legislated on court reform, and one of the principles that lay behind Lord Gill’s recommendations was that litigants should not be allowed to litigate at their own pace. It seems to me that that principle could equally apply to fatal accident inquiries. Giving the court the power at the start to keep an eye on things and make sure that matters are moving forward is extremely important.

**Margaret Mitchell:** I would add to that another suggestion from Lord Cullen: that the Crown Office and Procurator Fiscal Service should be properly resourced—that in effect a fatal accident inquiry unit should be created. He then said, however, that such a unit, to be located in the deaths unit, was almost there already. The key point was that it should be properly resourced to ensure that resourcing was not a factor in any unnecessary delays.

**Tom Marshall:** There is almost a conflict of interest for the procurator fiscal, because the public interest in having a prosecution is not the same as the public interest in having an inquiry that is there so that lessons can be learned for the future. Those two things are entirely distinct, and therefore, if the Crown is to remain in charge of both aspects, separating the responsibilities within the Crown Office and Procurator Fiscal Service would be a good thing.

**Margaret Mitchell:** That is helpful. We have not heard that aspect before, which is interesting.

**The Convener:** Do you wish to comment on that, Mr Wolffe?

**James Wolffe:** It is plainly essential that the COPFS is appropriately resourced to be able to handle its responsibilities.

**Margaret Mitchell:** An issue that follows on from what you have just said, Mr Marshall, is whether the reasonableness test should still apply to fatal accident inquiries. Giving the court the power at the start to keep an eye on things and make sure that matters are moving forward is extremely important.

**Tom Marshall:** In my opinion, it is important that families are represented. In some workplace accident cases, there may be support from a trade union, but in other circumstances financial backing may not be available. My own experience of last year’s Super Puma helicopter inquiry was that the families wanted to bring forward a number of different issues that did not seem to be on the procurator fiscal’s agenda. Without the support of the trade union movement, those issues might not have been aired at all—that is an important point. With reference to what Lord Cullen said to the committee a fortnight ago, it seems to me that he has hit exactly the right note.

**The Convener:** I will let other members in on that point. Does Rod Campbell have a supplementary question?
Roderick Campbell: It is on a different point.

The Convener: I will just put you on my list. I call Elaine Murray.

Elaine Murray (Dumfriesshire) (Lab): The bill puts into practice many, but not all, of Lord Cullen’s recommendations. I particularly want to ask for the witnesses’ views on his recommendation that there should be mandatory FAIs for people who die while in the care of the state, such as children in care or people detained under mental health legislation. I also ask for views on whether the bill meets our human rights obligations.

James Wolffe: We have expressed the view that the scope of the mandatory inquiry requirement should be expanded to cover the category of children who are not in secure accommodation but who are in residential establishments listed in the Children (Scotland) Act 1995 and the Social Work (Scotland) Act 1968. I read with some interest the submission from the Equality and Human Rights Commission, and it strikes me that the issue is one that the Government should think about again.

There are two elements to consider, one of which is the requirement on the state. Whether it is a death in custody or a death of someone who is in the care of the state, there is at least the potential for human rights obligations to kick in through a series of procedural requirements, including a requirement for public scrutiny. Without wanting to commit myself to the stark proposition that the bill does not comply with our human rights obligations, I would say that there is a need for the Government to look carefully at categories of cases and to consider whether the mandatory provision is drawn broadly enough.

Lest there be concern that to expand the scope of the mandatory inquiry is to put pressure on the inquiries system, I reiterate my earlier point that, in an inquiry where the facts are straightforward and uncontroversial, what one is securing by having an inquiry is an element of public scrutiny, through the sheriff, of what the COPFS has done by way of its own inquiries, but that such an inquiry need not take up large amounts of court time.

The Convener: Perhaps it would just establish that it was not controversial, but that is also important.

James Wolffe: Indeed. That in itself may be important.

Tom Marshall: I have nothing to add to that. I agree.

Elaine Murray: My colleague, Patricia Ferguson, has proposed her own member’s bill—

The Convener: Is this still on the same point?

Elaine Murray: Yes, it is on mandatory FAIs.

The Convener: Okay. Other members have supplementary questions, but we will come to them later. Please carry on.

Elaine Murray: Patricia Ferguson proposes to extend mandatory FAIs to deaths caused by industrial diseases or exposure to hazardous substances. Have you a view on that?

10:15

Tom Marshall: As someone who practises daily in the area of industrial disease, my personal view is that there would be value in having inquiries in certain circumstances. Although, particularly in the case of asbestos, the events that gave rise to the illness and death will have happened many years ago, a considerable number of cases are still coming forward that involve organisations that are still in existence, such as public bodies or former nationalised industries.

The working practices that gave rise to the recent development of an asbestos-related disease may still be going on. They may not be still affecting the individual who has developed the disease, but they may affect others who currently work in the same environment. There may be some value in holding an inquiry from time to time, perhaps in slightly unusual circumstances, where the mere fact of having an inquiry would promote better working practices among those who are dealing with dangerous substances.

James Wolffe: I wonder whether the matter is adequately dealt with by the provision for discretionary inquiries. It is implicit in what Mr Marshall said that, from time to time, an inquiry may be justified in the case of death through industrial disease. I do not for a moment dissent, but I suggest that such cases be dealt with through the opportunity to hold discretionary inquiries, which, under the bill, is fortified by the requirement for the Lord Advocate, on request, to give reasons if he chooses not to have an inquiry in a particular case.

I would be concerned about putting all deaths through industrial disease into the mandatory inquiry category, partly because of the potential for a death to take place long after exposure to a substance and also because, if one is dealing with a case in which there are multiple exposures, and consequences, a series of deaths may effectively raise the same issue. That may be a good reason for having a discretionary inquiry in those circumstances, but to have to have a mandatory inquiry in each case might be thought not to be necessary.

The Convener: Section 8 is on “Reasons for decision not to hold an inquiry”. Obviously,
someone has to request that the reasons be provided in writing. Should the bill perhaps make provision for someone to challenge the reasons why the Crown is not to hold an inquiry once those reasons have been provided in writing? I do not think that there is any such provision in the bill.

**Tom Marshall:** There is precedent for that without the need for any provision. A judicial review—

**The Convener:** But that is a cumbersome procedure, is it not?

**Tom Marshall:** Essentially, that would be the means by which—

**The Convener:** Should there be something in the bill that might be more potent and efficacious?

**James Wolfe:** I will pick up on Tom Marshall’s point about the current position, which is that if the Crown refuses to have an FAI, a judicial review can be brought. The requirement to give reasons will enable the justification given by the Crown to be scrutinised by the court in a judicial review. The grounds of review are limited: one would have to be able to show that the Crown had gone wrong in its understanding of the law, or that some other aspect of the decision made it unreasonable in a technical sense.

The cases that have been brought have tended to focus on whether the Crown has adequately reflected article 2 of the European convention on human rights in the decision not to hold an FAI. One can scrutinise the circumstances and, if the Crown has decided not to hold an FAI when article 2 requires it to do so, the court can intervene.

Ultimately, whether one wants more intrusive scrutiny of the reasoning given by the Crown is a matter of policy. The parameters of a judicial review depend on showing that the Crown has acted unlawfully or, in the technical sense, unreasonably. The question is whether there ought to be some sort of appeal process in which somebody independent reviews the Crown’s decision. I do not have a view one way or the other on that. I am inclined to think that it would add a potential layer of complexity, but I do not have a particular view to advance.

**Tom Marshall:** I wonder whether this could fit in with the early-hearing proposal. If the court was seized of matters at an earlier stage, and subsequently a decision was taken by the Lord Advocate that the inquiry should not proceed further, the court would already have the matter in front of it and would be in a position to oversee the decision not to hold an inquiry in those circumstances. Do you follow me?

**The Convener:** I follow you; I am just thinking about the word “oversee”. Where does that take us? Would the court be in a position to overrule the decision? That would be different, would it not?

**Tom Marshall:** That would be the direction.

**The Convener:** It is worth exploring, anyway, rather than staying with the status quo. That was what I was wondering about: I understand the word “oversee”, but it is possible to oversee and then not do anything, although you meant that the court would oversee and then do something.

I want to stay with mandatory FAIs and the issue of what should be mandatory for this spell of questioning.

**Jayne Baxter (Mid Scotland and Fife) (Lab):** Good morning. We heard evidence on 5 May 2015 about people who were subject to mental health detention and who committed suicide. If an FAI is to be a means by which lessons are learned in order to prevent or minimise the risk of recurrence, do you think that FAIs should be mandatory when people who are subject to mental health detention commit suicide?

**Tom Marshall:** Would the point not be that it should be mandatory for there to be an inquiry into the death of anyone who is in mental health detention? My view is that the law should err in favour of having mandatory inquiries, with the option to opt out at the discretion of the Lord Advocate, rather than having discretionary inquiries that have to be opted into. The mental health situation is one such where, in my opinion, that is the way the law should go.

**Jayne Baxter:** I would agree.

**The Convener:** That is nice to know. [Laughter.] Mr Wolfe, do you wish to comment?

**James Wolfe:** As I said earlier, having read the evidence of the Equality and Human Rights Commission I think that there is an issue in precisely the kind of situation that you are describing, and that needs to be looked at again by the Government.

**The Convener:** Is your question on mandatory FAIs, Mr Campbell?

**Roderick Campbell:** It follows on from Jayne Baxter’s point. At paragraphs 116 and 117 of the policy memorandum, the Government refers to the graduated scale of investigations into mental health deaths from the Royal College of Psychiatrists. The witnesses may have seen that in the policy memorandum and I also raised the matter last week. Do you have any general comments about that as an alternative?

**Tom Marshall:** I read that note in the policy memorandum and I also read the evidence that was given by the mental health witnesses last week. However, for the reasons already given, I
still favour the view that it is better to have an opt-out than an opt-in.

The Convener: Ms Baxter agrees, so you are all right there. [Laughter.] Do you wish to comment on that, Mr Wolfe?

James Wolfe: My only point is that if the facts are uncontroversial, the inquiry process will be relatively short and formal but it will fulfill an important public function—public exposure of what has happened.

The Convener: It seems to continue the thread of the principle that for the death of anyone who is in the mandatory custody of the state, whether it is by statute or by order of the court—in prison or residential care, or under some kind of mental welfare legislation—there should be at least an opt-out of an FAI, rather than an opt-in. Is that where we are going?

James Wolfe: Yes.

Tom Marshall: Yes.

Gil Paterson (Clydebank and Milngavie) (SNP): My question relates to industrial disease. If it were compulsory to hold an FAI in cases of industrial disease, how many would there be? If it were discretionary to have an FAI in such cases, how many FAs would there be likely to be? What sort of cost are we talking about?

One of the forever-running campaigns relates to compensation for sufferers and victims of asbestos-related disease. If we went down the line of having an automatic FAI, would that impact on them or is it a separate issue?

Tom Marshall: First, the inquiry procedure does not have anything to do with compensation, other than that it may allow evidence to be brought out that could be useful for other purposes, such as a claim for compensation or a prosecution. The number of mesothelioma deaths in Scotland is now more than 200 a year. There are also cases of lung cancer, which may or may not be related to asbestos exposure. There are potentially many hundreds of those cases. However, even if there were a mandatory requirement to hold an inquiry, there is still the option to opt out.

It may be that, for the reasons that have already been explored this morning and in previous evidence sessions, it is unrealistic to have a mandatory inquiry in every case of industrial disease, and that the better course for such cases would be to take the opt-in approach, picking those cases where there is some new issue that it would be worth exploring for wider reasons of health and safety, which would have lessons that would resonate in industry today, rather than just establishing the facts of what happened in the past.

Gil Paterson: I was aware that an inquiry would not lead to compensation, but I am thinking of the system itself. If more inquiries were held automatically when there may not be a need—as we already know what the cause is and it is probably on the person’s medical record—it would add cost to the system. There are finite amounts of money and pressure might be felt further down the line. Some people believe that compensation should bear the costs. We know what the cause is and we know that people are carrying it, but in some people’s minds that is the pinchpoint.

Tom Marshall: I know that members have been looking at recovering the cost of healthcare for industrial disease sufferers, which is a potentially controversial area. I am not sure that I can add a great deal more.

There is no doubt that there is cost in holding an inquiry, and the question must be whether that expenditure is worth while in looking forward as much as looking back. An inquiry is about looking forward in order to prevent the same circumstances from happening again as far as possible, allowing people to learn lessons and adopt different practices. If it can be seen that an inquiry into events that are long in the past would still have lessons for us today and for the future, that would be money well spent.

Christian Allard (North East Scotland) (SNP): I have a couple of points on deaths abroad. Section 6 says that an inquiry could be held when “the person’s body has been brought to Scotland.”

There could be exceptional circumstances around a death abroad that mean that it is not possible, for one reason or another, to have the body recovered and sent back to Scotland. Should the bill reflect that?

10:30

James Wolfe: I confess that that is not an issue that I have thought about. I do not have an immediate view to express.

Tom Marshall: I am not sure that I have got anything very useful to add on that subject either.

The Convener: I think that the committee wonders why it is necessary to bring back a body. There will be circumstances in which it is impossible to do that but there might still be an FAI. Rather than asking you to chew the matter over now, we ask you to write to us once you have reflected on it.

Christian Allard: It would be good if you could.

My other point is on what the Faculty of Advocates wrote in its submission about the location of an inquiry. You have expressed the view that it maybe should be stated in the bill that...
the inquiry should take place locally. However, paragraph 43 of the explanatory notes, on section 12, says:

“indeed it is expected that the majority of FAIs will be held in the same sheriffdom as the place of death.”

I do not understand. What kind of amendment would you like to see to the bill? Is there really a need for the amendment that you suggest? Is it more the spirit of such an amendment?

James Wolfe: Yes. The particular point that has been raised is that one of the reasons why it is a good idea for inquiries to be held locally is the accessibility of the inquiry to those who are most intimately affected, particularly the family of the deceased but also witnesses who may have to travel to give evidence to the inquiry. There are of course circumstances in which the death occurs at a location that is not where the deceased lived and not where the family is, so the first of those is not always a compelling factor. We recognise that it is a good thing to put flexibility into the system to allow inquiries to be held at the appropriate place, which may not always be the local sheriffdom. Our particular concern is that the decision-making process should take into account the interests and views of the family in particular. It may be that that could be built in by way of an amendment.

I notice, for example, that, under section 12, where the sheriff makes an order transferring the proceedings to a sheriff of another sheriffdom, he has to give

“participants in the inquiry an opportunity to make representations”.

The family will not always be participants in the inquiry, and one could add in a requirement that the family be given the opportunity to make representations. Equally, where the Lord Advocate, under section 12(2), is choosing the sheriffdom in which proceedings are to be held, there could be a requirement on him to take into account the wishes and interests of the family. I am not suggesting that those can always be determinative, because there may be a range of factors, but at least an obligation to take those interests into account could be added to the bill.

Christian Allard: That answers the question regarding the families but it does not address another issue. Should the sheriff principal have a greater role in the decision about the location? Should the sheriff principal defend their own location?

James Wolfe: As I read the provisions in section 12, the Lord Advocate chooses the sheriffdom, but the sheriff may also make an order transferring proceedings. Sorry, I may have said “sheriff principal” in error, but I see that it says the sheriff. That is my mistake.

Christian Allard: I am just thinking that the sheriff principal might be seen as being excluded from the process.

Tom Marshall: One way of dealing with that would simply be to say in the interpretation section, section 38, that “sheriff” includes “sheriff principal”. In practical terms, the sheriff principal would be involved, because he is managing the business in the sheriffdom.

Christian Allard: In other words, it might not need to be added. I take the point that was made with regard to sections 12 and 6.

The Convener: The issue of the early hearing was raised by Margaret Mitchell might sit alongside the issue of families and relatives being consulted. It might be appropriate for the matter to be heard in a different sheriffdom, but families should know why.

Roderick Campbell: When Lord Cullen gave evidence on 5 May, he said:

“an FAI is there for the purpose of inquisition, not for the purpose of establishing rights, duties and obligations.” — [Official Report, Justice Committee, 5 May 2015: c 6.]

In that context, would you have concerns about sheriffs’ recommendations being binding? How should we approach sheriffs’ recommendations?

James Wolfe: Our view is that sheriffs’ recommendations should not be binding. We take that view for a number of reasons. The first is that, ultimately, if there is a recommendation to change a public authority’s system or a particular policy or approach of a private employer, the authority for making policies to ensure that the authority or the employer has an appropriate system of work falls on the public authority or the employer. Although one would expect any responsible public authority or private body to take seriously recommendations from a sheriff following a fatal accident inquiry, there might be considerations that, quite properly, had not been brought within the ambit of the particular circumstances of the death, but which are taken into account when deciding what is the right thing to do. For that reason, which is one of principle, it would be wrong to make the recommendations binding.

Making the recommendations binding would also have a material impact on the nature of the inquiry process, because the stakes will be all the higher for those who might be affected by recommendations and who might not, indeed, be participants of the inquiry, as other bodies might be involved. That could lead to the inquiry process becoming more difficult, protracted and adversarial, because if the recommendation is going to be binding, it matters to those who will be affected by it that all the issues within the confines of the inquiry are dealt with.
Tom Marshall: The issue is a conundrum, and one that is difficult to answer. On the one hand, you have a public judicial inquiry—witnesses may be compelled to attend; they give evidence under oath; submissions are made on behalf of interested parties; and the sheriff makes a detailed and reasoned determination. Should that disappear in a puff of smoke at the end of that process? Clearly, that is a major concern. On the other hand, however, I have some sympathy with what James Wolfe has said. It is difficult to say that making recommendations binding will not alter the nature of the inquiry process. One of the values of the inquiry process is that it ought to be an open process in which people should not be taking sides, because the object is to get the facts into the open and to bring as much information to light as possible, so that lessons can be learned. However, the question is how you ensure that the lessons that have been learned are acted on.

Roderick Campbell: That brings me to my next question. If we accept your point for the moment, how do we improve the response to such recommendations and ensure that proper regard is had to them? Has the bill got it right?

Tom Marshall: I agree that people to whom recommendations are directed should respond and that those responses should be publicised. In fact, that is the very least that should happen. If the response is put on record, people will be able to see whether it is likely that the recommendations will be acted on. There might be an impact for victims of a subsequent event if recommendations have been made, responses of one sort or another to those recommendations have been given and there is a repeat of the same event in future, but I think that the difficulty lies in formally binding people to do certain things.

James Wolfe: Another way in which making the recommendations binding would affect the process is that sheriffs might become much more cautious about the recommendations that they make. What might seem sensible in the light of the tragic circumstances of an individual case might not be appropriate to implement for very proper reasons when things are looked at in a broader context.

For that reason, it seems to me that the bill has struck the appropriate balance because, as I understand it, those to whom recommendations are directed will be expected to respond to them. I expect that, if someone decides not to implement a recommendation, they will wish to explain why, and the requirement in and of itself to consider a response ought to have an impact on those to whom recommendations are directed. There is perhaps a question whether the procedure for publication through the Scottish Courts and Tribunals Service is exactly the right way to go about that, but the broad thrust of the policy in the bill seems to strike the right balance.

Roderick Campbell: Is there an alternative to using the Scottish Courts and Tribunals Service?

James Wolfe: I suspect that that might be the problem. I suppose that it could be done through the Scottish Government itself. I do not have a particular answer to your question, but I recognise that an issue has been raised about giving that body the responsibility for publishing these matters.

Tom Marshall: It does have the advantage that those who are looking for information about fatal accident inquiries will probably go first to the Scottish Courts and Tribunals Service website. If they have to go somewhere else to find out information about recommendations that have been made and responses that have been given, the prospect is that they are not going to find it—or, at least, the Scottish Courts and Tribunals Service website is going to have to include a link, which means that it is going to have to do some work somewhere.

The Convener: Accepting your point that making recommendations enforceable would completely or significantly change the nature of an FAI, I nevertheless find it somewhat unsatisfactory that when such recommendations are made, someone has to reply in writing or tell the Scottish Courts and Tribunals Service why they are not fully complying with them—and that is it. Could the bill contain a provision under which if the process as set out had been gone through and the Scottish Courts and Tribunals Service was not satisfied with the response from the party or parties involved, it could make something enforceable or undertake a further process?

I understand that there could be further criminal or civil proceedings, and there would be pressure to have those, but simply to publicise the recommendation is not enough. I understand that a recommendation from an FAI could not be made enforceable in all cases, for the various reasons that we have heard. Is there not some way, however, in which to ensure that there is more push for compliance, even in part, within section 27, when the Scottish Courts and Tribunals Service is not happy about things?

10:45

James Wolfe: The problem would then be who would do that in the Scottish Courts and Tribunals Service. Is it envisaged that it would go back before a sheriff who would have some monitoring role over the way in which a recommendation is implemented or not implemented? If it is to be a sheriff who has that role, what sanction is to be applied other than the sanction of public opinion or
the pressure that comes from being forced at least to confront the recommendation and make a response to it?

One should not lose sight of the fact that what a judicial inquiry is very good at is making determinations about what has happened—what caused the death, what failings there have been in systems of work and the like. The question of what needs to be done in order to put things right is much broader. It is not a simple question of working out what the facts are and applying the law to the facts. It is an exercise of deciding what a policy response should be, if we are talking about a public authority, or how a private enterprise ought to change its systems. That is almost a quasi-legislative role, particularly if we are talking about public authorities.

Sheriffs in our current system are free to, and do, make recommendations about changes that they think emerge from the facts of the case. At the end of the day, however, it has to be for the body concerned to consider the issue at large and to decide for itself what its responsibilities are.

**Tom Marshall:** Could I suggest that one option would be to require a response to the recommendation to go back to the sheriff rather than to the Scottish Courts and Tribunals Service, and for the inquiry proceedings themselves not to close until a response to the recommendation had been received?

**The Convener:** That is helpful. At the moment, people must wonder, when a recommendation is made, whether that is it. I understand the reasons that you have given, but families and the public do not understand why a recommendation cannot be tougher.

**Patricia Ferguson (Glasgow Maryhill and Springburn) (Lab):** Good morning, gentlemen. On that point, at the moment sheriffs can clearly make recommendations and there have been occasions when sheriffs have made recommendations that, if they had been followed, would have prevented future incidents. By “incidents”, we are necessarily talking here about the loss of life. In the circumstance in which a sheriff chooses to make a recommendation, and feels strongly enough that that recommendation would in all probability prevent future fatalities or casualties, should there not be a mechanism whereby that sheriff can say so and have a sanction that they can apply if that recommendation is not carried out?

**Tom Marshall:** As you were talking, I was thinking of the case of Louise Taggart’s brother, which she movingly discussed at the meeting on 5 May. One can see that, if some step that could have been taken to protect electricians in the work that they were doing had been publicised, further lives would not have been lost. I do not know enough about the details, but I suspect that the electricians who lost their lives after Louise Taggart’s brother lost his were not all employed by the same people and therefore the recommendation, had there been one at an earlier fatal accident inquiry, would have had to be acted upon not only by Mr Adamson’s employers, but by the employers of the other men who subsequently lost their lives. Had those men still lost their lives, notwithstanding a recommendation, then the sanction would surely be for the Crown to prosecute those who had failed to take the appropriate measures to protect those other men, rather than for there to be some follow-up from the fatal accident inquiry that had been held into the death of Mr Adamson. One would be introducing a new breed of sanction almost, the limits of which would be ill-defined.

As I indicated, it is a conundrum, but that imperfect situation may be the best that can be achieved.

**Patricia Ferguson:** I understand that the reason for an FAI, or the circumstances of the case that leads to an FAI, may vary; however, that was just one example. Another example to which I can refer you is the case of the Newton and Bellgrove train crashes, both of which were caused by drivers passing signals that told them not to pass. At the first of those fatal accident inquiries, the sheriff clearly said that if there were to be a system of double blocking—in other words, if two signals would have to be passed before such a danger would be encountered—that would be a good thing to come out of that inquiry. That recommendation was ignored, and a few years later the same thing happened again.

It seems to me that there is not much point in a fatal accident inquiry being held if all that it does is find out what happened and no lessons are learned from it. I suggest that a sheriff being able to make a recommendation when he or she feels that that is appropriate should be considered at this stage.

**Tom Marshall:** I agree entirely that finding the correct solution—one that works in law—is the difficulty.

**James Wolff:** I agree entirely that one of the purposes of an inquiry is to learn lessons. If there is a failure to follow a recommendation by the person to whom that recommendation is directed, and further lives are lost, as Tom Marshall said earlier, that may be relevant in the context of subsequent decisions on whether to prosecute or in questions of civil liability. It may not be entirely without sanction.

**Patricia Ferguson:** I accept that that is the case in law, but in practical terms, should we not
be trying to prevent further loss of life, rather than prosecuting people when it happens?

**Tom Marshall:** Absolutely.

**James Wolfe:** Yes.

**The Convener:** Even in law, is it not possible that, as Ms Ferguson posits, a sheriff could make a recommendation not just in relation to an employer but at large, as in the circumstances described? If the practice is prevalent throughout, that recommendation, because of its very nature, should be enforceable.

**Patricia Ferguson:** That was my point.

**The Convener:** Yes, you made a very important point. Such a recommendation should be made in law, not just because it was morally correct.

**James Wolfe:** In a way, that points up the conundrum that we all probably grapple with, which is that if the sheriff makes a recommendation that will have a binding effect on people at large, or on a group of people who are not represented before the inquiry, there is a real problem about how the interests of those people, or any views that they might wish to express, are taken into account before the recommendation is made.

Sometimes one sees recommendations along the lines of, “Consideration should be given to” the issuing of guidance, or a change of policy or whatever. Sheriffs may well frame their recommendation in such a way deliberately, recognising that it may be for a trade body to issue guidance to its members or for the Government to take forward in certain ways and that it would be wrong for the sheriff to be unduly prescriptive about the outcome of that because there are other parties whose interests need to be taken into account.

**The Convener:** I am not convinced—although I praised Mr Wolfe once before for being convincing versus the Lord Advocate.

Surely, if it were the case that, as Ms Ferguson says, the recommendation would have wider application and the sheriff could see that coming, would it not be possible in an FAI for the sheriff to continue the proceedings to allow representations to be made, as he or she pondered the recommendation until any such representations were made before issuing an enforceable recommendation? If the problem is that some of the people affected are not party to the FAI, but there are special cases that it can perfectly well be seen require a recommendation with general application, would it not be possible to do that, so that an enforceable recommendation could be issued after other parties have had the opportunity to make representations? Would that just be a mess?

**Tom Marshall:** The answer ought to be some method of translating the recommendation into a new law.

**The Convener:** That takes time.

**Tom Marshall:** However, it is much tidier.

**The Convener:** It is tidier, but we would be in the same position that Ms Ferguson explained. People die.

**Tom Marshall:** Yes.

**The Convener:** We do not want more time for letting people die.

**Tom Marshall:** No.

**The Convener:** I will leave it to the faculty to think of a solution. I think that we would like a solution that comes from greater brains than ours.

**Alison McInnes (North East Scotland) (LD):** Lord Cullen’s original proposal envisaged the Scottish Government being much more involved and overseeing the implementation of responses. It seems to me that, if responses are not implemented, it is likely to be because there are a lot of knock-on effects that have not yet been worked through and the issues are quite complex. That policy making should be made either at local government level by elected members or in this Parliament.

Could we not work out a role for the Scottish Government that would require it to conduct an annual review of the recommendations that were not taken up, to see whether there are patterns? Should we be imposing something on the Government to do at the end of the process? You can imagine, convener, that what you suggest would go on forever if people started to feed back in that they would be affected by a recommendation but they have not been considered. It would not be a tidy system at all.

**James Wolfe:** I think that the general thrust of the approach that we agree with is that the right balance is a process that involves reporting. If the reporting process can be made more robust and effective through a requirement for Government or others to collate information and make it available, that would go with the grain of the approach that we are advocating. I have not thought specifically about the solution, but I could see that, if the basic principle is that reporting is the right way to go, mechanisms that make the reporting process transparent and robust would be entirely consistent with that.

**John Finnie (Highlands and Islands) (Ind):** I want to talk briefly about participants, who are listed in section 10. Section 10(1)(d) is very specific about deaths that occur “within section 2(3),” which relates to acting in the course of the individual’s employment or occupation, and lists...
two participants: the employer and an inspector appointed under the Health and Safety at Work etc Act 1974. Should it also list a trade union or staff association representative?

**Tom Marshall:** Yes

**John Finnie:** That is my kind of answer. Thank you very much indeed. [Laughter.]

**The Convener:** You waited a long time for that.

**John Finnie:** I have a follow-on question, if I may. It concerns information that we have received that suggests that section 10 is open to “abuse if not properly regulated.” Indeed, the suggestion is that a subsection should be drafted

“to allow the sheriff to limit, in advance, the issues in an FAI upon which any participant should be entitled to adduce evidence and the issues that such a participant should address in making submissions.”

There is a further suggestion that any participant should “provide written notice of the topics upon which he wishes to examine or cross-examine any witness.”

Do you have a view on that?

11:00

**James Wolffe:** The general thrust of civil justice reform is in the direction of sheriffs and judges taking a much more active role in managing the cases that are before them.

I do not have any difficulty with the notion that the sheriff manages an inquiry by asking the participants to identify the issues that they particularly want to raise, or with the sheriff being in a position to determine the issues that ought to be inquired into. I think that there is a balance to be struck about how far that goes and how far, in an individual case, the sheriff will consider it right to confine parties in the way they wish to approach their involvement as participants. The principle of sheriffial management of the process seems to me to be a sound one.

**Tom Marshall:** In my view, the answer is in the preliminary hearing—as opposed to the early hearings that we discussed before. If the preliminary hearing system works well, by the time the inquiry starts everybody should know what issues are to be explored.

Everyone will be able to give you war stories and horror stories about inquiries that have run out of control like a runaway train—for example, topics emerged as the inquiry went along, new parties appeared and other people wanted to ask questions and the whole thing grew arms and legs, to mix many metaphors. If the scope of the inquiry is mapped out before it begins, that is the stage at which people can make representations about the issues that they want to explore. Those matters can then be the subject of agreement and it will be known in advance what the inquiry will cover.

**John Finnie:** Who should determine the scope of the inquiry?

**Tom Marshall:** The sheriff, after submissions from the interested participants.

**John Finnie:** What would be the avenue of redress for someone who was not happy with the terms of reference?

**Tom Marshall:** Currently, there would have to be a judicial review of the sheriff’s decision.

**John Finnie:** Thank you very much.

**Roderick Campbell:** This is a question for Mr Marshall, on the use of summary sheriffs. The bill provides for them potentially to be involved in fatal accident inquiries. Do you have a view on that?

**Tom Marshall:** I do not see any particular difficulty with a sheriff of any description hearing an inquiry. The important factor must be whether the person is sufficiently experienced and capable of dealing with a matter of this sort.

I am sure that members of the committee are well aware that the qualifications that are required to become a summary sheriff are exactly the same as those that are required to become a sheriff; in effect, they are the same as those that are required to become a senator of the College of Justice. It is difficult to imagine that people who apply to be, and will be appointed as, summary sheriffs will be anything other than experienced solicitors or advocates. It is also difficult to imagine that the sheriff principal would appoint someone who was not competent, whether they be a summary sheriff or a sheriff, to hear an inquiry. I do not see any particular difficulty with that. If it is simply a question of status, perhaps that is something that people should get over.

**The Convener:** The sheriffs are sitting right behind you—and they are sharpening knives. [Laughter.] No, they are not.

**Tom Marshall:** I do not know whether summary sheriffs will be admitted to the Sheriffs Association or whether there is to be a separate summary sheriffs association. One would hope that they are more collegiate than that.

**The Convener:** Well, they are certainly listening.

**James Wolffe:** We have expressed our reservation, which is around the question of how an inquiry would be perceived if it were held before a summary sheriff with the jurisdiction of a summary sheriff.
The Convener: I have a little follow-up question. Should sheriffs retain discretionary powers to award expenses in FAIs, under specific circumstances?

Tom Marshall: I see that the insurance companies are exercised about that matter. The discretion to award expenses seems to have been rarely exercised in the past. To rule it out of account altogether seems to go too far.

James Wolfe: May I reflect on that point and come back to the committee in writing?

The Convener: Thank you, yes. That concludes my questions. I thank you both for your evidence. I suspend the meeting for a couple of minutes to allow the sheriffs to take their seats.

11:06
Meeting suspended.

11:07
On resuming—

The Convener: I welcome the second panel of witnesses to our meeting. We have already previewed their attendance. I welcome Sheriff Gordon Liddle, who is vice-president of the Sheriffs Association, and Sheriff Nikola Stewart, who is also from the Sheriffs Association. I thank you both for your written submissions. I know that you heard a deal of the previous evidence, so I will go straight to questions from members.

Christian Allard: Good morning. I asked earlier about location. Should we include in the bill that the inquiry should be held locally, if possible? In the Government’s explanatory notes it is stressed that it is likely that most FAIs would still be held locally, however that is not in the bill. Do you think that there should be an amendment to that effect?

Sheriff Gordon Liddle (Sheriffs Association): There should be something on the face of the bill that makes it a presumption that the inquiry will be held locally. There are a number of interested parties in an inquiry, not least the family of the deceased. I appreciate that the family has a different role to play in attending an inquiry from those who might have to do something on the back of a finding. It can be difficult for families to travel long distances.

Another equally important aspect is that often cases that lead to an inquiry have a local flavour—the people in the local community are interested in what happens and what the outcome will be. Those people would be excluded from a public inquiry if it were to be held elsewhere.

Christian Allard: Some inquiries can be very complicated and focused on a particular subject, for which we might need a sheriff who has specific expertise, but it seems that there is still a complication regarding the mechanism to decide where the FAI should be held. Could there be conflicts between sheriffs principal about the location and the way in which they are consulted about the location?

Sheriff Nikola Stewart (Sheriffs Association): I am not aware that that is currently an issue. The bill may cause us some concern in that the Lord Advocate is effectively being given the power to locate the FAI in the first instance. We would be concerned that the local aspect could be overlooked in favour of a more centralised view.

Christian Allard: The submission says:

"However in practice this can only be done with the consent of both sheriff principals involved."

Could we end up having the contrary effect, with everything staying local and there being reason for an inquiry to be done by specialist sheriffs or to be held somewhere else? There is a balance to be struck.

Sheriff Stewart: That is the second stage. The first stage is the Lord Advocate choosing where the inquiry will go. I wonder whether that is, in effect, a safety net to avoid localising inquiries. I do not know whether that is the case. That in itself is potentially a fairly cumbersome procedure which—again—we are not entirely relaxed about.

Christian Allard: Do you think that sheriffs principal would automatically try to have the FAI held locally?

Sheriff Liddle: I would not want to make that assumption. I cannot see into the mind of a sheriff principal.

Christian Allard: I was more interested in the mechanism and striking a balance, as far as that would be possible, rather than there being a presumption that an FAI should be held locally or a that it should be held elsewhere. It is difficult, but do you think that the right balance has been struck in the bill?

Sheriff Liddle: It is difficult to see why it would be necessary to have an FAI outwith a sheriffdom, given that there is provision that says that an inquiry can be held outwith a court building. In a rural area where the court building might not be big enough—we all know about the Orkney inquiry that took place many years ago—we would find a
place where the inquiry could take place and take the court to that building.

Christian Allard: Thank you for that answer.

We have had a submission from Sheriff Principal Murray regarding the section that relates to repatriation of a body when death has occurred abroad. Sheriff Principal Murray seems to be saying that the bill could be changed to allow for exceptional circumstances. Do you have any comment to make on that?

Sheriff Liddle: We have to say that that enters the policy area and is not something on which we should comment.

Christian Allard: In that case, thank you very much for your answers.

The Convener: I understand that you raised concerns about the role of specialist sheriffs and about summary sheriffs presiding over FAIs. Why?

Sheriff Liddle: I know that a previous witness said that the appointment criteria for a sheriff and a summary sheriff are exactly the same, but if that is the case, why bother having sheriffs when we could just have summary sheriffs to do everything? Sheriffs have a separate jurisdiction: we have privative jurisdiction under the Courts Reform (Scotland) Act 2014. We could turn the question on its head and ask, “Why have privative jurisdiction?” The answer is that it is thought that some matters are more complex—that is the language that was used—or serious and therefore merit a sheriff rather than a summary sheriff. I do not mean to be disparaging, but summary sheriffs are meant to do more routine, and perhaps easier, work than sheriffs.

Families and even individuals who come to inquiries might expect that there will be someone with experience and weight dealing with the inquiry. An example would be the FAI in Glasgow into the bin lorry crash: the sheriff principal has decided to hear that inquiry.

I have lost track of what I was going to say.

11:15
The Convener: What you were saying undermines your argument, if you forgive my saying so, because you are saying that a determination has already been made that the inquiry in Glasgow is of such complexity and significance that it should be taken by a sheriff principal. Given that we have been told—and know—that some FAIs are pretty straightforward but are mandatory because of the circumstances, why could a summary sheriff not handle those inquiries if they are seen as such, in the same way as you have indicated a sheriff principal would handle a very complex case? A very straightforward case could be taken by a summary sheriff.

Sheriff Liddle: Thank you for putting me back on track.

If an FAI is simple and is going to lead to a formal finding, it takes very little time. I accept that that would not require a sheriff principal. However, one does not know how complex or serious an inquiry will be pretty well until the preliminary hearing. It is only then that the sheriff, having been presented with what the parties think is straightforward, might realise that the matter is not straightforward at all and will require further investigation. We have powers to say that we want to hear evidence in relation to one thing or another. The question would be, “Who is the gatekeeper?” However, it is a question that might not have much force or point behind it because if the case is simple it will not take up a great deal of sheriff time.

Sheriff Stewart: The system is inquisitorial. That rightly puts a lot of responsibility on the sheriff. It seems appropriate that the person who exercises that responsibility should have the experience, and the confidence that comes with experience—for example, to direct investigations in a way that was not anticipated. We have all experienced that; not infrequently sheriffs see something in an apparently straightforward case that grows legs, and it needs experience to see that and confidence to direct it.

The Convener: We appreciate that. It might be, however, that, if we went down the route of an early hearing, it would be pretty clear that there were no complexities—although I understand that the unexpected can happen—and a summary sheriff would be appropriate.

We will move on. You are not happy about summary sheriffs but you are not happy about specialist sheriffs either. Specialist sheriffs would seem to be even better than ordinary sheriffs. Why are you unhappy about specialist sheriffs, who will have expertise through dealing with matters day in and day out?

Sheriff Stewart: Will they? Both proposals are additions to what was anticipated when summary sheriffs and specialisation were mooted. There are new areas into which these beasts are heading. It is a decision for Parliament as to whether that is appropriate. We have reservations, in that it may create the feeling in the public mind that there are important and less-important fatal accident inquiries, that the decision is made when the Lord Advocate assigns a fatal accident inquiry to a particular sheriffdom, and that if a part-time summary sheriff takes up an FAI it may not get the attention that it would get if a more experienced sheriff got it.
The bill encourages judicial management. That is a good thing—we are absolutely happy about it—but it demands skills and experience. Of course, anyone who is given the position will have training, which is a good thing, but experience is harder to acquire.

I come back to the concern that training goes hand in hand with confidence—the confidence to say that a case does not have a link with the sheriffdom so it should be moved somewhere else, and the confidence to get in touch with the other sheriff principal. All those things put an enormous responsibility on the sheriff.

The Convener: We have judges in the Court of Session who specialise. I do not think that people have problems with that, so I do not know why there should be problems with specialisation for sheriffs in particular cases. The public understands that some cases are very complex and that others are less so. Its being less important does not diminish an inquiry. I find it difficult when you say that we cannot have summary sheriffs because—to put it in colloquial terms—they are not in the same league.

Sheriff Stewart: I am not saying that.

The Convener: You do not want summary sheriffs to hear such cases, but neither would you have specialist sheriffs because they would be another class of sheriff. It is as though you want just one class.

Sheriff Stewart: The analysis is more complex than that. We are considering the process and continuity of hearing cases. There are particular difficulties. The process gets easier if a local sheriff is allocated to deal with an inquiry locally—in that case the sheriff is in charge of the preliminary hearing and guides it through to the end of the process. Importing part-time sheriffs or summary sheriffs would raise difficulties for court programming. All those things become more difficult.

The Convener: I will leave it at that, but you can see that I am not convinced.

Sheriff Liddle: We have to keep in mind the size of our jurisdiction: there are only 140-odd sheriffs in the whole of Scotland and they are spread out all over the place. It would depend on how so-called specialists were selected. Within Edinburgh sheriff court where I sit, we have enough sheriffs to have several specialisations, which means that a sheriff might have more experience dealing with a certain type of work because they do it regularly. If a number of sheriffs in Scotland were made specialist sheriffs, they would not only be specialist sheriffs but would have other duties within their courts. That would probably lead to something that I think is undesirable—specialist centres. That would take away from the local aspect of inquiries.

Sheriff Stewart sits in Lanark, which has one and a half sheriffs. Of course, you cannot have half a sheriff, but there is enough work for one and a half sheriffs. Sheriff Stewart has dealt with a number of FAIs. If specialisation were to be introduced, I doubt that she would be designated as a specialist sheriff, because she would not be able to do it. However, she deals with FAIs locally and they have a local flavour and quality. There is a point to that.

Sheriffs do runs of specialised work. An example of that is the family sheriffs in Edinburgh, where we recently piloted domestic abuse sheriffs. The pilot came to an end and was rolled out so that we all became domestic abuse sheriffs. We all have that specialisation badge, but it simply means that we have been trained in that. I do not know whether that assists your understanding of how specialisation works.

The Convener: It is fair enough for you to put that out there and for your position to be challenged. It makes a change to challenge sheriffs—they are normally the ones who challenge everyone else and tell people when to be quiet. [Laughter.]

Alison McInnes: I know that you were both present when the previous witnesses were giving evidence.

Sheriff Stewart: We were here for part of the time.

Alison McInnes: You were here towards the end, so you will have heard the lengthy exchanges that we had about sheriffs’ recommendations. It is important to hear your views on whether the proposals in the bill will ensure that sheriffs’ recommendations will be taken seriously. Do you think that the bill goes far enough?

Sheriff Liddle: As judges, the nature of what we do leads to us being functus—that is the point. Therefore, what we have determined becomes no longer part of what we have control of. It would be very difficult if a sheriff had to maintain some sort of control over what happens, and try to case manage that in some way or deal with inquiries coming back in. It would be almost impossible to do that.

On the other hand, I fully accept that if I make a recommendation, I want and expect it to be implemented. There is such a wide variety of recommendations that could come out of an inquiry that it is difficult to be prescriptive.

I will give you a couple of examples of that from my experience. If an inquiry finds that there has been medical negligence, that is likely to lead to the appropriate organisation making inquiries
about that and, in the most severe cases, to a person being struck off from practice. If there has been an accident at work or something like that—a health and safety issue—and the recommendation that comes out of the inquiry is disseminated, any employer or organisation that knows about that recommendation but does not implement it will be placing itself at risk and the insurers are likely to be unhappy about that.

I am trying to illustrate that there are other people in the background who are interested in ensuring that recommendations are implemented. Unions and so on will take employers to task if recommendations are not implemented. However, I do not think that sheriffs have the resources to deal with case management beyond issuing a determination.

**Alison McInnes:** Do you think that, if you had the resources, it would be appropriate for you to follow up? Surely, you want to see your recommendations being implemented. Would you go so far as to want some of them to be legally binding?

**Sheriff Liddle:** I think that it is for others to do that. I do not think that the particular sheriff would be able to continue that sort of case management. As has been said before, you could deal with that in this place. It is for the Government to legislate if something requires legislation. I do not feel that I should be a law maker.

There is a difference between an inquiry and practically everything else that I do in court, which is adversarial. An inquiry is not about me making a ruling that people must follow; it is about my conducting an inquiry, which may involve asking other people to give evidence, until I am satisfied that I understand what went wrong, if something went wrong. The pronouncement is of what went wrong and what I think, on the basis of the evidence that has been presented to me, would have prevented that and might prevent its happening in the future. It is not a ruling against anyone; it is the result of my conducting an open inquiry into the facts.

**Sheriff Stewart:** The concern is that, if a recommendation becomes a ruling against someone, we will be looking at a very different animal.

**The Convener:** We understand the complexities; we are just trying to find out whether there is a way around them.

If Alison McInnes does not mind, I will bring in Patricia Ferguson, who has an example. Were you there when she gave her example previously?

**Sheriff Stewart:** Indeed.

**The Convener:** I think that she makes a fair point.

**Patricia Ferguson:** What I am proposing is that sheriffs should be able to make a recommendation that would be binding, when they feel that it would be appropriate to do so, and that there should be a mechanism whereby they can call their recommendation back, at a point in time that is laid down, to see whether it has been implemented. The person against whom the finding had been made would also have a right of appeal. That would be an attempt to make the process manageable and not drag on for ever.

The point that I made earlier is that if we are truly to learn the lessons and if it is quite clear that an accident or incident could have been prevented if a certain course of action had been taken—I gave an example of where that was the situation—surely we must find a way to make a recommendation binding to prevent further loss of life.

As I said earlier, I accept that in legal terms the organisation or the institution leaves itself open to all sorts of challenge, problems with insurance and so on. Surely, however, as a moral imperative rather than a legal one, we must try to prevent future deaths from happening if we know that we can. In the example that I gave to the previous panel, it would have been very clear that that was the case.

11:30

**Sheriff Stewart:** I suspect that the difficulty may be in getting to that certainty. That is where the whole process may become cumbersome, as was indicated earlier. I know that it is a concern of family members that an inquiry is held, dealt with and concluded. It seems to me that what you are anticipating potentially involves changing tack at a certain stage in the inquiry and going from an inquisitorial system into a more adversarial system.

In such a system one would perhaps have to think of pleadings and of bringing in a more involved form of process so that the person against whom the recommendations are made—or it could be many bodies; the implications could be fairly diverse—would potentially be involved in giving answers. It is the same as for the Parliament: if it were to take the responsibility and go down the legislative route, it would have a process for investigating all the potential difficulties.

A sheriff may not have that opportunity. Although in hindsight we can look at decisions and take the view that “If only that had been promulgated, lives could have been saved,” I am not sure, without that kind of inquiry, how often that certainty can exist. The issue is how we get to that; crossing the boundary might be difficult.
Patricia Ferguson: With all due respect, as the convener mentioned earlier, if the idea is that Parliament then legislates, that would mean another delay being put into the system. The incidents that would be looked at may have happened four, five or six years previously, and we do not know whether there could have been preventable deaths in that period.

Sheriff Stewart: Absolutely—I take your point.

Patricia Ferguson: My suggestion would be to give sheriffs the discretion to make binding recommendations where they think that it is appropriate. Those against whom the recommendations were made would have a timeframe within which to act, be brought back or exercise a right of appeal if they felt that the judgment had not understood the complexities of the matters before them.

The proposal is an attempt to get action moving and to get something in place in order to make sure that we prevent as many deaths as we possibly can. I accept that it is not perfect, but I think that we have to have that debate.

Sheriff Liddle: We of course can see the issue and have personal sympathies with it. The problem is that we would change the nature of the beast entirely by doing what you suggest, because any parties involved in the inquiry will have in the back of their minds that there might be a finding, as opposed to a recommendation, coming out of the FAI, and that will turn it into an adversarial process. Having an appeal mechanism on the back of it, which would extend the process, makes that especially so.

I fully understand that legislation takes time, but we cannot be legislators.

Sheriff Stewart: Another concern of mine, frankly, is that it may also expand every single fatal accident inquiry. Rather than having parties directly concerned with a specific death, there might be bodies coming in that are concerned that there may be binding determinations. It may become more cumbersome and more difficult for the family and for everyone from day 1.

The Convener: We see that it is not easy.

Elaine Murray: Perhaps the Government should be doing that so that it can learn the lessons from the recommendations that are made.

Sheriff Liddle: I think that that may go beyond what we should be discussing, from the point of view of our not entering into an area of policy, as that would be an area of policy. However, on a personal note, I would welcome that level of involvement—where something can be done.

Christian Allard: Turning away from policy to an understanding of the mechanism, after an inquiry do you sometimes make recommendations to the Scottish Parliament, the Scottish Government or the United Kingdom Government? Or are your recommendations never to a legal body such as a Government or a Parliament?

Sheriff Liddle: I am not sure that I fully understand the question.

Christian Allard: Sorry—I will rephrase it. Would it be possible that you might make a recommendation to the Government and to the Parliament as a way of passing the whole inquiry to another level, if you feel that it needs to be done?

Sheriff Liddle: No, we do not do that, because that would politicise what we are doing. Sheriff Stewart and I have both been involved in FAIs and we have experience of them. The exercise in an inquiry is to identify what has gone wrong and why it has gone wrong. The recommendation—on the back of finding all of that out—is a practical solution, informed by expert evidence, to prevent the same thing from happening again. It is for others to pick up on the recommendation and to take out what needs to be done to prevent the situation from happening again. It depends on what comes out of the inquiry—it would not be possible to legislate for the variety of things.

The Convener: Surely you would make recommendations to the Health and Safety Executive.

Sheriff Liddle: Yes.

The Convener: That must be almost mandatory.

Sheriff Liddle: Recommendations are made to professional bodies of all sorts.

The Convener: This is just to clarify matters—

Sheriff Liddle: Of course, thank you for that.

The Convener: You do not just make a recommendation at large; you point the recommendation at groups such as employers, the HSE and health boards.

Sheriff Liddle: But not to the Government—I would not want to do that.
The Convener: No, we make recommendations to the Government. Sometimes it pays attention and sometimes it does not.

Margaret Mitchell: I want to ask about delays in holding FAs, generally, and for your comments on whether preliminary hearings will help to prevent delays by making sure that the court is ready to go. I also ask for your comments on something that is not in the bill, which is the idea of an early hearing to ensure that within three months there would at least be some indication of whether an inquiry is going to go ahead or, if not, what the problem is.

Sheriff Liddle: A preliminary hearing is an important matter. From personal experience, the sooner that the sheriff can get a grasp of what the inquiry is about, the sooner they can take a view on whether it is something that is formal and can be dealt with quickly—everyone finds out what is happening. Alternatively, the sheriff may look at the matter and see that there are issues that had not been envisaged that need to be looked into, which may lead to a further preliminary hearing.

As far as time is concerned, I am conscious of the fact that a lot depends on the nature of the death, the nature of the inquiries that the Lord Advocate may make into that and how quickly those inquiries are made. We sheriffs do not have any control over that. I would like to see inquiries moved as quickly as possible into the court and I think that preliminary hearings are a great idea.

Sheriff Stewart: I am not sure what the other option is. Am I picking it up correctly that the suggestion is to bring the matter before the court in advance of the court being seized with the matter?

Margaret Mitchell: I have probably conflated things, which I should not do because they are quite distinct processes. The early hearing would be held to discover where things stand—in other words, to concentrate the minds of the Crown Office and Procurator Fiscal Service on the fact that, if it has not made progress, the relatives will be informed why and the sheriff will be asking what the position is. It would be about procedure, rather than looking at any facts in the case.

Sheriff Stewart: Would this take place after the application is before the court, or before that? That is what I am not clear about.

Margaret Mitchell: Not even then—the Crown Office and Procurator Fiscal Service would be looking into the facts of the investigation to decide whether, and when, they would hold a FAI.

Sheriff Stewart: The difficulty is that the matter would not yet be before the court. If that were to be the case—if I am right in this—a judge would in effect have to be a minute taker. Sheriffs have no power to do anything in that situation. Until the application is before the court, what can we do with it?

Margaret Mitchell: My point was that the hearing would be held within three months if an inquiry was not going ahead, but that would concentrate the minds of those in the Crown Office and Procurator Fiscal Service, who would come and explain where they were and whether the delay had been caused by the complexity of the case. Lord Cullen suggested that, if you did not have a clear idea of when an inquiry was going to take place, you could convene informally in the sheriff’s chambers and decide to meet again in another six weeks or two months to see where things stood. That way, the case would not disappear, and the Crown Office and Procurator Fiscal Service would be held to account.

Sheriff Stewart: Do we invite parties to that?

Sheriff Liddle: It is public.

Sheriff Stewart: One of the most important aspects of a fatal accident inquiry is that it is public.

The Convener: I see your point about the need for some kind of new court process, but the suggestion was not that it would be public. It would be for the family to be kept apprised of the process in chambers and in private.

I appreciate that you are asking where it would sit in the court process, if there has been no referral, but presumably what Lord Cullen had in mind was, through some amendment to the bill, to include an early hearing that would be dealt with in that fashion.

Such a hearing would be a belt-and-braces way for the family and relatives to know what the process was and what was happening. No substantial facts would be presented; it would just be a process, explaining why there was a delay, rather than someone phoning up from the Lord Advocate’s office or procurator fiscal’s office to tell people. However, I appreciate that you would need to know why you were there.

Sheriff Stewart: And what our powers would be.

The Convener: Yes, indeed.

Sheriff Stewart: Currently, we are discussing the idea in a vacuum. If you tell us what our powers would be, we can comment, but otherwise we cannot.

The Convener: We shall ask Lord Cullen for an amendment.

Sheriff Stewart: Perhaps making the Crown Office responsible to the family is an easier approach.
The Convener: Okay. I note your points on that.

Margaret Mitchell: On the same point, Lord Cullen also recommended that, to keep the Crown Office and Procurator Fiscal Service on its toes, it should be properly resourced and that maybe there should even be a unit within the Crown Office and Procurator Service—which I think he subsequently decided was already there under the deaths unit—to ensure that priority could be given to such cases and that they would not be allowed to slip.

Sheriff Stewart: We cannot comment on that.

Sheriff Liddle: That is because it is a policy matter relating to resourcing. We would certainly like fatal accident inquiries to be brought to court and dealt with as quickly as possible.

The Convener: Do you think that you should retain the power to award expenses in certain circumstances and have discretion over that?

Sheriff Stewart: Yes, I think that we should. Such a power is rarely used, as has been said, but to lose it would be unfortunate.

The Convener: Thank you for your evidence. That concludes this evidence session.

11:43

Meeting suspended.

11:49

On resuming—

The Convener: I welcome our third and final panel of witnesses: the Rt Hon Lord Gill, the Lord President; Roddy Flinn, legal secretary to the Lord President; and Eric McQueen, chief executive of the Scottish Courts and Tribunals Service. Thank you for your written submissions. I know that you were present for a substantial part of the previous evidence.

We will go straight to questions from members. I am looking for volunteers—or conscripts; I will take anything that is going.

Alison McInnes: One of the concerns about the system is the length of delays. Do you believe that the SCTS bears any responsibility for delays in the FAI process at the moment?

The Convener: Well, he was not volunteering, but you have volunteered him—or he is a conscript.

Eric McQueen (Scottish Courts and Tribunals Service): I am well and truly volunteered.

I can certainly give more information if that would be helpful to the committee.

As the Lord President says, we do not see a particularly prevalent picture of delays in the court system at the moment. Nevertheless, we realise that, as with any part of the justice system, there is a duty on us to try to make sure that there is continuous improvement in the process.

Once cases come to court, the important point is that there is a period before it is appropriate for an FAI to go ahead, because quite clearly the parties need time to prepare for the hearing. About six to eight weeks seems to be the minimum period for such cases. We have about 50 FAIs a year on average; obviously, the number varies, depending on particular accidents happening, on a yearly basis. About 45 per cent are one-day hearings, and they are largely held within three to four months of the fatal accident inquiry application coming forward. A further 45 per cent are hearings that last between two and 10 days. Most of those take place within three to four months, with some possibly taking place within seven months if they are particularly long or if more evidence is required. Only 10 per cent of cases are of long duration—of about 11 days or more—and most of those will be held within a four to five-month period, with some of the longer ones possibly taking place within nine to 10 months. We are certainly not aware of there being a problem for the parties involved in FAIs or of the issue being raised in the evidence sessions.

Let us take the first one first. There are many reasons why there should be a delay between a death and the FAI. It may take a very long time to ascertain the cause of death. For example, in the Clutha disaster, in which the air accident investigation branch has been involved, it has taken quite a long time to find out what happened. I would not describe that as delay.

However, if there is an unreasonable length of time between the application for an inquiry and the actual holding of the inquiry, there is legitimate cause for concern. My impression is that, in current practice, once the Crown applies for an FAI, the matter is dealt with expeditiously—I am not aware of any particular deficiency in our procedures in that regard. Mr McQueen probably has more practical detail.

The Convener: Thank you for your evidence. That concludes this evidence session.
A good example that was reported in the media last night relates to the tragic accident involving a bin lorry in Glasgow before Christmas. The FAI has been set up and was due to start in July but, because of issues with the parties in terms of taking evidence, there is now some doubt over whether it will proceed on its scheduled date.

That is quite the norm for complicated FAIs. There is no point in rushing things to meet a set date. It is a question of making sure that the parties are ready and prepared to go and that the evidence has been secured, so that we can be sure that we have an FAI that will start and be completed within the planned timescale.

Alison Mclnnes: Lord Gill, in your written submission you suggested some specific case management powers that would help move things along in relation to written evidence being tabled. Do you want to talk in a bit more detail about that?

Lord Gill: I would urge two points on the committee.

First, subsections (3) and (4) of section 1 are at the very forefront of our consideration. Sometimes it is quite easy to lose sight of what an FAI is all about. It is made very clear in subsection (3) that the purpose of an inquiry is twofold: to “establish the circumstances of the death”, which is a straightforward factual question; and to “consider what steps (if any) might be taken to prevent other deaths in similar circumstances”, and there may well be cases in which that second question does not even arise.

If we look at FAIs in the context of that subsection and the context of the next subsection, which says that “it is not the purpose of an inquiry to establish civil or criminal liability”,

we begin to see that, in fact, an FAI is not a free-ranging operation in which all forms of evidence are admissible and relevant. It has a fairly tightly circumscribed remit. That is the first point.

The second point is that, in any inquiry of this nature, effective case management is the key to the whole thing. There has to be effective case management in the preparatory stages, and then, once the inquiry starts, efficient and competent chairmanship is required to ensure that the inquiry addresses the relevant points and that other questions are not gone into. That makes considerable demands of the presiding sheriff but, as long as sheriffs keep it in mind, they should be able to conduct such inquiries expeditiously.

Margaret Mitchell: On delays, I note that Mr McQueen says that of the 50 inquiries that are held, on average, every year, only 10 per cent go beyond 11 days and may take four or five months. Lord Cullen recommended that an early hearing be held within three months, which would perhaps deal with cases where there are delays. The main point is to ensure that the relatives are kept informed. Do you have a view on that?

Eric McQueen: Sorry, but I think that there are two different things. When I talked about long hearings, I was talking about the court end of the process.

There are two perspectives on early hearings, and I know that the Lord President will want to make his views known, too. For me, we need to establish what their purpose would be. There is a suggestion that they would be about keeping the Crown on its toes and ensuring a good flow of information between the Crown and the family. To me, that sounds like management oversight of the COPFS, and I am slightly puzzled as to why that is seen to be best as a judicial role. There is a fundamental question about whether that would be a proper role for the judiciary and the proper use of judicial time. In essence, the issue is about the management of the Crown Office, and how it operates and communicates with the families. Lord Cullen said himself that, if there are improvements in the way that that happens, that would negate the need for early hearings, or at least lessen the argument for them. The first issue is therefore about whether the purpose is correct.

Secondly, there is a need to think about the numbers that might be involved. Currently, the Crown Office investigates about 5,500 cases per year. I presume that the suggestion is not that there should be an early hearing in 5,500 cases. If that was to happen, using simple arithmetic and assuming that each hearing would take 30 minutes, the equivalent of two and a half sheriffs would be needed every year simply to have the early hearings. I presume that, if the early hearings were to be introduced, they would happen only in cases in which there was a mandatory FAI. That would at least reduce the number to potentially hundreds, rather than many thousands.

The first issue is about whether the principle is correct and whether conducting early hearings would be a proper judicial role. As I said, I certainly have my doubts about that. The second issue is about volume. Early hearings could clog up the court system, depending on whether they were held in all reported incidents or just in cases in which an FAI was mandatory.

As I said, the Lord President might well have views on the propriety of there being a judicial role in that regard.
Lord Gill: Ms Mitchell, are we talking about an earlier hearing than a preliminary hearing, which will be conducted under section 15?

Margaret Mitchell: Yes. It is of a quite different nature. It is about trying to explain to the relatives what is happening; it is not to establish facts or to say whether the case is ready to go to court. It is to keep the relatives informed and to ensure that the Crown Office and Procurator Fiscal Service does that. We have heard in evidence that it does not always do that just now. If not the Crown, who will do that?

Lord Gill: I have to say that I am not really enthusiastic about the idea.

Margaret Mitchell: I can tell.

Lord Gill: It is not that I am not conscious of the need for expeditious conduct of the process, but I am just not sure that that would be the best way to go about it.

The court must be very careful not to trespass on Crown prerogative. The whole question of initiating an FAI lies with the Lord Advocate. I would not like the court to be put in the position of exercising some supervisory role over the Crown’s decision-making process, as that would give rise to a serious constitutional issue. In addition, it could be very expensive for such meetings to be held regularly. There would be a considerable public cost to that, particularly if lawyers were involved. There would also be a tendency to have meetings for the sake of it rather than to achieve anything.

The real answer would be for the Crown to establish good protocols of conduct whereby the relatives would be kept in touch and would know what was going on. We could achieve the same thing without the need for meetings.

12:00

Margaret Mitchell: Who would monitor that? If those protocols were not adhered to, who would pick that up? That is the problem.

Lord Gill: That is a difficulty, but I would not like to see the court attempt to exercise some supervisory authority over the Lord Advocate. That would be constitutionally wrong.

Margaret Mitchell: Could anyone oversee whether the Crown Office and Procurator Fiscal Service was adhering to the protocols in a reasonable timescale?

Lord Gill: My experience has been that, particularly in controversial cases, the relatives tend to be fairly vocal if there is delay or a failure to give answers to what they see as straight questions. There is a degree of scrutiny of the process in most cases. The answer is for the Crown to make plain its recognition of the need for expedition and to produce a regime for informing everybody with an interest of exactly where they are.

Margaret Mitchell: The tenor of what we have heard so far is that there is not really a problem with delays except in the odd one or two cases. Perhaps this is not the message that you intend to put over, but I feel that there is a bit of a glossing over of the real hardship that families face when they do not get information. That happens—they do not get information and they do not have the wherewithal to do anything about that.

Lord Gill: I sympathise with that point of view. It is difficult for the families of people who have been killed in accidents to accept that time is passing and nothing seems to be happening. However, as we all know, there are good reasons for that in many cases, and as long as the Crown is able to articulate those reasons, public confidence is maintained.

The Convener: We can ask the Solicitor General about that next week. The ball is in the Solicitor General’s and Lord Advocate’s court.

Eric McQueen: I want to confirm one point about delays. I am sorry if I gave the impression of glossing over. When I talked about delays at the court end, I was talking about delays from the point at which the court is informed that an FAI is proceeding until the time that the hearing takes place. I fully accept that there is a much longer intervening period, which goes back to Margaret Mitchell’s point about early hearings. I was not trying to suggest that that is not an issue—

The Convener: No. We accept that there are many reasons why there might be a long delay before a decision is reached if it is not a mandatory FAI—or even if it is a mandatory FAI. We concur with the point about complexity in some cases, but we thought that we would test the idea of early hearings. As usual, we have received contradictory evidence, but that is all jolly—it is all grist to the mill.

John Finnie: We keep hearing about families, who are absolutely at the heart of the matter, but there are also issues for work colleagues and the public. As elected representatives, we sometimes have to fend off press inquiries about deaths for many months while we wait for decisions on whether there is going to be an FAI or a criminal prosecution. You may say that the matter reaches you further down the line, but how can we address that? It is all very well to keep families involved, but how are the public kept involved?

Lord Gill: I am not sure that I can give you a satisfactory answer to that. So often the Crown’s processes are reserved to the Crown. There could very well be cases where the Crown would
consider it not to be in the public interest to be making announcements and statements. I can think of several very good reasons for that: there might be doubt as to the cause of death, or there might be a need to carry out confidential inquiries and obtain expert views. Sometimes, these things take a long time. If it is just a question of the Crown saying that, I cannot see any problem with it. However, there might be a perception that, because the Crown is not saying anything, in some way or another there is a culture of secrecy, which I think would be a wrong perception.

John Finnie: It is a challenge. I think that everything should be done in the public interest. The family is part of the public interest, but the most important thing is that things are done in the public interest.

Lord Gill: I take it that you accept that there are cases where it takes a very long time to find out the cause of death.

John Finnie: Yes, indeed. I would dearly love to share an example with you, but, for obvious reasons, I cannot. It is one where there are various layers of interest. There is a family interest, a community interest and an on-going interest. It becomes very complicated.

Lord Gill: Many years ago, I was one of the senior counsel in the Lockerbie inquiry. It took several years before the Crown was in a position to hold the inquiry, for very good reasons.

The Convener: We will not get into Lockerbie. John Finnie and I will back off from that—it is for another day.

I call Christian Allard, to be followed by Elaine Murray, Jayne Baxter and Rod Campbell.

Christian Allard: Lord Gill, you just spoke about the Lockerbie disaster, which comes into my question regarding—

The Convener: I do not know why I bother to breathe even—just go ahead, Christian.

Christian Allard: My question is about deaths abroad. Some people have asked whether, in cases of deaths abroad, the body should always come back to Scotland. Are you sympathetic to the idea that, in exceptional cases, a death could be investigated without the body coming back to Scotland?

Lord Gill: I have no strong views on the matter. I doubt very much whether there would be many cases where that would be a problem. If the Parliament wants to enact such a provision, I have no strong views about it. It could be very useful in some cases.

Christian Allard: Thank you for that answer.
Lord Gill: Yes. I have no criticism to make of the bill in that regard.

The Convener: So, there is no need to include a presumption that the inquiry be held locally, as the sheriffs suggested.

Lord Gill: No—I do not think that there is. The idea is to keep things as flexible as possible, because we never know when the unexpected will happen.

Elaine Murray: I come back to the sheriffs' recommendations. The bill proposes that the SCTS be delegated to collate and publish responses, whereas Lord Cullen's original recommendation was that the Scottish Government should do that, thereby charging the Government with responsibility for overseeing the process and determining whether legislation should proceed from recommendations if, for example, they could affect an entire industry. Are you happy with the role that the bill will give to SCTS? Does it have implications for the resourcing of SCTS? Would Lord Cullen's initial recommendation that the Government be responsible for the function be a better option?

Lord Gill: I submitted a memorandum on the bill, in which I was—to say the least—unenthusiastic about the idea. It seemed to me then that the SCTS was not the appropriate body to have that responsibility. On the other hand, I have to say that I can think of no other body that would be more appropriate. I have therefore come to the view—I think that Mr McQueen shares it—that as long as we are properly resourced to do the job, the SCTS undoubtedly has the skills to do it, so I am not opposing that provision any more.

Elaine Murray: I was not questioning the SCTS's skills to do the job. The question is whether, given that recommendations could require legislative change, it would be better for the Government to take that responsibility because it would be responsible for introducing legislation.

Lord Gill: The Government is always completely informed of the decisions and views of the SCTS. I do not see that as a big problem. Mr McQueen sees the issue from a management perspective.

Eric McQueen: Obviously, sheriffs' determinations and recommendations would be published and would be shared with the Scottish Government. As the Lord President suggests, we are being pragmatic rather than being particularly happy about the situation. Nevertheless, we see a logical link; the SCTS website would include the determinations, recommendations and responses to them. For openness and transparency the information would all be there for everyone to see. We do not have a particular skill in assessing responses, so we would need to put in place a function to deal with that aspect. We have made it clear to the Scottish Government what resources that would take and it is prepared to support us by providing those resources, if need be.

Elaine Murray: Is the financial memorandum adequate?

Eric McQueen: We have agreed that it would require in the region of £60,000 a year to provide a function to deal with responses to recommendations, with redaction, with legal advice that we require on recommendations, and with subsequent publication.

Jayne Baxter: I will follow on from that point—yet another link. What would be the practical implications for the SCTS if more mandatory FAIs were required? Would there be a resource implication?

Eric McQueen: As always with such things, it would depend. How long is a piece of string? The answer to your question would depend on how many mandatory inquiries there were and what the specific cases were. We do not believe that the types of cases that are specified in the bill will have a major impact; some can already be progressed as discretionary FAIs at present.

12:15

The Crown Office expects, having made an assessment, that the number of additional FAIs would probably be fewer than five in any one year. The average number is currently about 50 in any year, and ranges from 30 to 60. As long as the figure is within the tolerance zone, it will not be a major issue. If changes are made later to the bill that would lead to a much larger increase in mandatory FAIs, possibly with longer-running FAIs, there would quite clearly be a bigger resource issue. The provisions in the bill as it stands, however, do not give us any major concerns in that respect.

Jayne Baxter: We heard evidence on 5 May and again this morning about people who are the subject of mental health detention. If a person commits suicide while under such detention, should that, Lord Gill, trigger a mandatory FAI?

Lord Gill: I have to say that I am not convinced that it should. There are many fatal accidents in which the cause of death and the precautions that could have avoided it are completely open and shut. In suicide cases, there is very often no need for an inquiry because the circumstances are completely conclusive with regard to the cause of death. Additionally, it would be very difficult to legislate in such a way as to make FAIs mandatory only for those particular deaths. To be honest, I cannot see the justification for that.
Jayne Baxter: One of the justifications might be that risk to people who are in the care of the state should be minimised. If there are circumstances relating to a person’s accommodation or care that might have contributed to their suicide, those need to be identified and acted on.

Lord Gill: I see that point, but I think that we can rely on the good judgment of the Crown to identify exactly the cases in which such issues arise and cases in which they plainly do not.

The Convener: Section 2(4)(b) refers to “a child required to be kept or detained in secure accommodation.” Should that provision be broader to cover children who are in the care of the state rather than just those who are in secure accommodation?

Lord Gill: Here, again, I think that we are in danger of imposing unnecessary rigidity on the system. The system by which the Crown makes investigations and forms judgments is, I think, the best model, and—

The Convener: Why would you pick secure accommodation and say that that circumstance is special, while saying that there should not be a mandatory FAI for a child who is not in secure accommodation but is in the care of the state?

Lord Gill: I am not taking a rigid position on the matter. If that is what the Parliament wants, I am certainly not opposed to it.

The Convener: I am just seeking your view on what the distinction should be.

Lord Gill: At present, the Crown exercises its prerogative responsibly, and we can rely on that. If Parliament decides that it wants something stronger than that, I am not here to argue against it.

The Convener: I see. It may be that the committee takes the view that such children would be in a special circumstance, and that the state is in a different role from any other parent or foster carer and has duties.

Lord Gill: Madam convener, that is a perfectly tenable point of view.

The Convener: I love to hear that. I do not hear it very often, so I will write it down and commit it to memory. [Laughter.] You might tell my party leader that as well sometime.

Roderick Campbell: Good morning, Lord Gill—or good afternoon, I should say. We have heard concern that the creation of specialist sheriffs for fatal accident inquiries could lead to a possible centralisation of the FAI process. Do you have any comments on that?

Lord Gill: I do not think that that will happen. There is no immediate prospect of there being a centralised FAI system with a national FAI venue. It is not being contemplated at the moment and it is not even on the far horizon. I do not see any need for it, either.

The Courts Reform (Scotland) Act 2014—forgive me for mentioning it—broke down the rigid barriers in sheriffdoms; sheriffs now have the flexibility to sit wherever they are sent. If a small group of specialist FAI sheriffs were to emerge, they could be deployed anywhere in Scotland as need arose. That would be a much better solution than a centralised venue.

Roderick Campbell: You commented in your written submission on the powers that are available to a sheriff to decide who can participate in an inquiry. Can you expand on why you think it is important to give sheriffs flexibility to control participation?

Lord Gill: At the end of the day, the sheriff must conduct the FAI efficiently, which means making the most productive use of the available time, eliminating unnecessary or irrelevant evidence and eliminating unnecessary or irrelevant questioning. In order to do that, the sheriff must have discretion to decide who the inquiry participants will be. The sheriff must make a judgment on that based on the circumstances of the case and the representations that are made to him by those who claim to have an interest. That is a perfectly normal facet of effective case management.

Elaine Murray: We heard earlier in evidence from the Sheriffs Association that it is concerned about summary sheriffs dealing with FAIs. I think that the association’s argument was that it might not become apparent early on that a case would be complex and a summary sheriff might not have sufficient experience to deal with it as it developed. Do you agree?

Lord Gill: A summary sheriff will be perfectly capable of conducting a straightforward fatal accident inquiry. If the inquiry is more complex, a sheriff should do it.

In every case, we must trust the judgment of the sheriff principal, who will choose whomever he thinks is the appropriate person to conduct the inquiry, based on experience and expertise.

Elaine Murray: Should the bill allow sheriffs to retain the power to award expenses? It is a power that they currently have that does not seem to be replicated in the bill.

Lord Gill: I am not in favour of the power to award expenses. The awarding of expenses is a typical procedure in adversarial litigation, but an FAI is not adversarial litigation; it is simply a
concerted effort to find the truth. The only reason why one would ever wish to award expenses against a party at an FAI would be if the party had behaved unreasonably or vexatiously or had wasted time. The bill gives the sheriff the power to keep such people out of the inquiry, either by not letting them be participants or by efficient management of the case as it is being heard. Sheriffs know what they are doing; if the sheriff is in control of the proceedings, there should be no need for that problem ever to arise.

Elaine Murray: It was mentioned that that power is very rarely used. I presume that it has been used only in cases such as you just illustrated.

Lord Gill: Yes.

The Convener: I like it when lawyers disagree with each other. If the sheriffs disagree with the Lord President, that is par for the course.

Gil Paterson: I want to return to the idea of mandatory FAIs. Lord Gill touched on this, but what are the panel's views on mandatory FAIs for industrial diseases?

Lord Gill: I am not in favour of the idea of mandatory FAIs at all. First, there is a question as to the Crown's prerogative to decide when and in what circumstances an FAI should be applied for. If you make an FAI mandatory, you may trespass on the judgment of the Crown. Secondly, in many cases the holding of an FAI is completely unnecessary because the facts are staring us in the face and there is simply no need for it. That is where the Crown exercises judgment.

Thirdly, the proposal could be hugely costly to the public. I am not at all convinced that there would be any cost benefit to it. Lastly, before any judgment on the matter could be made we would need to know what difference the introduction of mandatory FAIs would make in terms of number. I do not know the answer to that. It rests with those who want to have mandatory FAIs to make some assessment of the number of additional FAIs there would be. At the moment, we just do not know.

Gil Paterson: Mr McQueen, do you want to comment or are you happy with that?

Eric McQueen: Not really. We do not have any information or data on what the potential cases could be, their volume or the impact of the proposal.

Gil Paterson: Would the Lord Advocate's discretion kick in? In the industry that I know well, lots of new processes and new substances are being used. Would the Lord Advocate’s discretion kick in in that regard?

Lord Gill: That is exactly the sort of consideration that the Lord Advocate takes into account.

The Convener: Lord President, you have raised this case management thing—this idea of keeping a grip on the FAI and keeping it to the straight and narrow, if I can paraphrase it in that way. In your written submission, you suggest amendments to section 10 of the bill that would confer

"discretion on the sheriff as to the extent to which any person should participate."

You also talk about agreement of the evidence before an inquiry and written statements being given to the sheriff in advance of an FAI. How do you see that working? Could it wrongly preclude people from participating? Would the statements have to be drafted by somebody with a legal background? An ordinary person who wanted to take part in a fatal accident inquiry might not know how to express stuff, or stuff may be missed out that might be relevant.

Lord Gill: I strongly favour the idea that, in an inquiry procedure, as much of the evidence as possible should be presented in written form. That eliminates unproductive use of time in the inquiry. The evidence can then be taken as read, and if anyone wishes to cross-examine a witness on that evidence they can indicate the topics on which they want to do so.

In practice, we find that a great deal of the evidence—probably two thirds or more of it—is completely uncontroversial and is taken as read. I fail to see what benefit there would be in having it read out; that would only prolong the inquiry and incur public cost. That is the first point to note about evidence in writing. The preliminary hearing procedure is the key to obtaining agreement on facts at an early stage, so there is no need to lead evidence that is completely uncontroversial.

Another aspect of efficient inquiry management is limiting the participation of certain parties to the inquiry where there are topics on which they have nothing to contribute. I do not think that there is anything unfair or unreasonable in that.

12:30

The Convener: I thought that I would raise the matter, as a quite substantial part of your written submission deals with tightening up on the evidence to go before an FAI. You state that the provisions would

"allow uncontroversial evidence to be lodged in the form of a report or an affidavit."

Would there be legal aid for an ordinary person who needs to swear an affidavit? Would that not be required?
Lord Gill: I do not think that that would ever be a requirement. I was merely suggesting ways in which things could be done.

I will give you an example from the Stockline inquiry. Admittedly, that was not an FAI, but the inquiry dealt with a series of fatalities. A great deal of the evidence was obtained by the procurator fiscal interviewing witnesses and getting their precognitions. The inquiry team then followed that up with their own interviews with certain key witnesses. That system worked quite well, I thought. I am not sure that there is any need for the formalities of affidavits.

The Convener: Your submission says:

"That would, for example, allow uncontroversial evidence to be lodged in the form of a report or an affidavit".

It goes on to say that evidence could be considered and

"treated as ... evidence in chief".

That is why I raise the matter of affidavits—it is in your submission.

Lord Gill: By all means, if someone wishes to make an affidavit on something controversial, then, yes. However, so much evidence is uncontroversial that affidavit procedure would be unnecessary.

John Finnie: Lord Gill, I do not know whether you were present when I asked two of the previous witnesses about your submission. I am concerned about anything that would appear to impose a limit. I understand that you do not want a free-ranging inquiry that goes all over the place, and that you want it to be kept to the specifics, but how would you establish whether someone has something of value to say without having heard from them, either in writing or in person?

Lord Gill: That is where good case management comes into the picture. Under section 15, the whole overriding purpose at the preliminary hearing is to identify the key factual issues. If other people come along and say that they have three more issues that they want to investigate, for instance, it is for the sheriff to decide whether they fall under section 1(3). If they do not, he says so, and that is that.

John Finnie: So you are talking about participation in the actual event, rather than in the entire process.

Lord Gill: Yes. It is possible to have quite a range of participants in an inquiry, but with some of them contributing only on certain issues.

John Finnie: I understand—thank you.

Elaine Murray: I seek clarification on something that you said a little earlier on, when you were talking about mandatory inquiries. Were you saying that you were not in favour of any mandatory inquiries, or just the extension of mandatory inquiries?

Lord Gill: What I am not in favour of is a blanket requirement that every fatal accident must result in an inquiry. I honestly do not see the point in that.

The Convener: We had thought that you were saying something devastating there, as a final blow to the legal system. [Laughter.]

Lord Gill: No, no.

The Convener: I am glad that that got clarified—well done, Elaine.

Thank you all for your evidence. As you know, this is Lord Gill’s last appearance here—he will be delighted to know—before he retires. Thank you for your very instructive and sometimes, if I may say so, entertaining answers. I really must pick up on the phrase "not enthusiastic", which is such a body blow to things.

We wish you well in your retirement. Thank you very much.

Lord Gill: Madam convener, it has always been a pleasure to appear before this committee, and I am grateful to you, your members and your predecessors for the great courtesy that I have always been shown.

The Convener: Thank you very much.

We are now going into private session, as previously agreed.

12:34

Meeting continued in private until 12:55.
Inquiries into Fatal Accidents and Sudden Deaths etc (Scotland) Bill

The Convener: We move to item 3.

We are taking evidence today from two panels of witnesses. I welcome the first panel: Lesley Thomson is the Solicitor General for Scotland, and Stephen McGowan is a procurator fiscal in major crime and fatalities investigation at the Crown Office and Procurator Fiscal Service—and has a longer title. [Laughter.]

We go straight to questions from members.

John Finnie: Good morning. In a lot of the evidence we have heard, there has been reference to family interest. Families take varied forms nowadays—there are extended families and other different types.

What is the “family” that you have in mind when you make decisions? Will you also comment, please, on the balance between the family interest and the public interest?

Lesley Thomson (Solicitor General for Scotland): We use a wide interpretation of “family”, because we have learned over the years not to be restrictive about that. In many families, there will be groups that we will require to meet and to provide information to separately. Although there is, in general life, what is understood to be a traditional family group, we do not apply that in-house.

We find on many occasions that families have different views on how much information they want, how they want to receive that information and, in fatal accident inquiries, whether they will attend or get their information via the Crown.

John Finnie: Regarding the public interest, what takes precedence?

The Solicitor General for Scotland: Are you asking whether the family interest takes precedence over the public interest?

John Finnie: Yes.

The Solicitor General for Scotland: The family interest is part of the public interest, and no decision is made on whether there will be an inquiry without the views of the family having been taken on board.

John Finnie: What would happen if the family said no to an inquiry, but the public interest was compelling?

The Solicitor General for Scotland: There would be a fatal accident inquiry. That does happen and it can be difficult—just as difficult as explaining why there is not to be an inquiry to families who want one.

John Finnie: We have received a late communication from Mr Marshall, who is the president of the Society of Solicitor Advocates. He writes about the different aspects of public interest—"the public interest in the enforcement of the criminal law by prosecution and ... in lessons being learned for the future by the holding of an FAI.”

Will you comment on that? Are there tensions?

The Solicitor General for Scotland: No, there are not tensions; rather, there are different decisions at different points. The public interest encompasses all those things at different times. Ensuring that someone who has been involved in criminality is brought to court is the public interest that takes precedence at that stage. That is why, if there are criminal proceedings, there is not always an immediate decision on whether there should be a further inquiry, because an inquiry relates to different aspects.

In the example that John Finnie gave—which we all have at the forefront of our minds—the question is what lessons can be learned.

The Solicitor General for Scotland: Do you mean while the investigation is on-going?

John Finnie: Yes.

The Solicitor General for Scotland: If there were compelling issues while the investigation was on-going, the Crown would feel bound to share those with various authorities so that steps could be taken. It is not unusual during an investigation for remedial steps to be taken.

At the start, it may be thought that a matter will have to be inquired into in public by a fatal accident inquiry. By the time that all the investigations, reviews and remedial actions have been taken, there may be nothing left that requires to go into the public domain for further public scrutiny.

John Finnie: Are such remedial steps advised to the public as and when they happen?

Stephen McGowan (Crown Office and Procurator Fiscal Service): Such remedial steps are regular occurrences. During investigations, the Health and Safety Executive or accident investigation branches and bodies of that nature regularly put out material on public safety in order that any public safety aspects can be taken into account quickly.
We also have an arrangement with Healthcare Improvement Scotland so that similar things can be done in the medical sphere. Although a criminal inquiry may be on-going, steps can be taken immediately if a particular issue of public safety needs to be addressed. That is fairly routine and happens regularly in the types of case that I have described.

**The Convener:** I cannot recall whether John Finnie asked a supplementary on the family in cases where there will not be an FAI. Under the bill, when certain parties ask why an FAI is not going to take place, the Crown is obliged to provide an explanation. Should that be automatic?

**The Solicitor General for Scotland:** Do you mean in relation to putting in the public domain reasons why there will not be an FAI?

**The Convener:** Section 8, which is entitled “Reasons for decision not to hold an inquiry”, says that the Lord Advocate must give reasons to a spouse, civil partner or nearest known relative, which basically means that relatives can ask why an FAI is not being held. I do not think that it is necessarily a public issue; whether it then goes public is another matter.

On the other hand, if you are not going to hold an FAI, you could just tell people why not, rather than have them request a reason. They may not be in a state to ask, or they may be unsure of things or unaware of their rights under the law.

**The Solicitor General for Scotland:** I have no difficulty with that.

**The Convener:** So you would not be unhappy if such a process was automatic.

**The Solicitor General for Scotland:** In practice, we currently provide the reasons. We have been considering other ways in which we could ensure that families are continually kept advised of progress.

**The Convener:** Do you mean keeping them advised in writing, which would be different?

**The Solicitor General for Scotland:** Yes.

**The Convener:** You have no problem with that being automatic: if you are not going to hold an FAI, you just tell the relatives.

**The Solicitor General for Scotland:** Yes. In practice, that is what happens.

**The Convener:** The bill does not need a section on a reason being requested.

**The Solicitor General for Scotland:** I do not think that reasons need to be requested—

**The Convener:** That is what the bill says at the moment.

**The Solicitor General for Scotland:** We do it automatically.

**Stephen McGowan:** Potentially, we would do that automatically to a wider group of people than the bill suggests. The Solicitor General described the dynamics of the family—

**The Convener:** The bill says:

> “the Lord Advocate must give reasons in writing if requested”,

but we do not need the words, “if requested”.

One of my colleagues, Margaret Mitchell, who is not here, was chasing the issue of early hearings, which Lord Gill—very convincingly, obviously—swiped to the side for various reasons. What is your view about early hearings to keep the Crown on its toes?

**The Solicitor General for Scotland:** I have been thinking about that. I, too, am of the view that it is not possible to use the court system for early hearings because it would require sheriffs to take control of cases that were never going to reach them. It is important—a lot of people have raised this—to have in place a set process so that families know what is happening at the various stages and so that there is an element of control over the timescale.

I have asked the Crown Office team in the Scottish fatalities investigation unit to produce a charter that would be in the public domain and would indicate the various milestones. In relation to early hearings, the equivalent at the investigative stage would be a hearing or a meeting—whatever you want to call it—set by the fiscal at a certain time. What I have in mind at the moment is three months from the date that the death was reported. At that point, the fiscal would be required to provide to the family specific information on the stage at which the investigation is and the timescale for it.

It would not be about saying, “This is the decision”. It would be about saying what has been done, what needs to be done and when the next meeting will happen. It would be up to families whether to turn up. It is important that the Crown sets that. We are working on that—we will consult on that milestone charter with the various victims groups and a number of the groups that have given evidence, and we will publish the results of that consultation.

**The Convener:** Would it be possible for that information to be available before stage 3 of the bill? I appreciate the timescale, but that would mean that Parliament would have an idea of progress by the Crown on the charter.

**The Solicitor General for Scotland:** When is that?
The Convener: Stage 2 is not until after the summer. It would be good to have the information before stage 2, but that might be a bit of a push.

The Solicitor General for Scotland: I have it in mind that we will have the consultation done by the end of the summer.

The Convener: In that case, it would be handy to have the information before stage 2, when we will consider amendments.

The Solicitor General for Scotland: I can give that undertaking.

The Convener: Thank you very much. Rod Campbell is next.

Roderick Campbell: Thank you, convener. You asked one of the questions that I was going to ask—

The Convener: I am sorry about that. It was because John Finnie had left that area of questioning.

Roderick Campbell: I move on to evidence that we heard from trade union representatives. When Mr Tasker gave evidence on 12 May, he expressed the view that

"new diseases or exposure to new industrial processes should be subject to mandatory inquiry."—[Official Report, Justice Committee, 12 May 2015; c 8.]

If we accept for the moment that the bill does not provide for that, but provides for a discretionary inquiry, can you advise on how the Crown would approach a new disease or new industrial process? What reassurance can we have that discretion would be exercised such that there would be a fatal accident inquiry in respect of a death in a new process?

The Solicitor General for Scotland: That is exactly the type of situation where discretion would be exercised on whether to have an inquiry because, irrespective of whether it was a new type of industrial process or a new disease, there would be public concern about the issues surrounding its not having been aired before. Our holding an inquiry would fall into the category of erring on the side of caution because there had not been previous public scrutiny, especially if there were serious concerns about a new industrial process. I do not feel that it would be necessary to have such cases in the mandatory category because there are all sorts of difficulties around definition, but those are exactly the types of situation that would lead to discretionary FAIs.

Roderick Campbell: We have also heard evidence—the issue was highlighted particularly by the trade union witnesses—about the importance of a statement of fact. Will you comment on that?

The Solicitor General for Scotland: I am not entirely sure what they meant by that.

Stephen McGowan: I, too, was not entirely certain what the trade unions meant by that. If I recall, the example that they gave was that that happens in aviation accident investigations. I think that our nervousness in relation to that would be about how reliable the facts would necessarily be after three months. Any comment at that stage that goes further than saying that an accident has happened could set expectations for the investigation, or set public expectations, in a way that would not be helpful, in respect of what had happened.

I am not entirely certain what the trade union representatives envisaged. There is a unique set of circumstances in aviation accidents: to say that such accidents have general application to deaths when the causes of the deaths in an aviation accident may not be known, because of the complexities that are involved, may cause difficulties in terms of prejudicing future investigations and, more important, pre-judging where investigations may lead once they have run their course.

The Solicitor General for Scotland: At the point when a decision is made to hold a fatal accident inquiry, the Crown's petition now includes the issues that will be raised; it does not just say that an inquiry should be held. The practice has developed—I will ensure that it is embedded under the new preliminary hearings system within the Crown—of providing a list of issues at the earliest stage of the inquiry hearing, which will be the preliminary hearing, and all parties can then add to that. There is therefore, when the FAI starts, a clear understanding of all the issues that everybody wants to be covered.

Roderick Campbell: Thank you.

11:00

Gil Paterson: To return to Roderick Campbell’s question about mandatory FAIs on deaths resulting from industrial diseases, would automatic referral impact on budgets? We know that lots of people who suffer from asbestos-related diseases require legal aid. Would that divert the finite justice budget and its resources? Is there a prospect that legal aid for other matters would be restricted?

The Solicitor General for Scotland: If FAIs on deaths from industrial diseases were mandatory, that would increase the number of inquiries. We consider that such a requirement would lead to a large increase, and that many would involve repetition of issues.

As far as legal aid is concerned, that is not a matter for the Crown Office beyond indicating that
were more demands to be made on the same resource, there would be a conflict.

**Gil Paterson:** It would have an impact.

**The Convener:** We are told that the issue is not about the money, but about having mandatory FAIs in respect of new industrial diseases. It is not to do with whether there would be more impact on funding; rather, it is to do with whether that would be appropriate.

**The Solicitor General for Scotland:** Yes—it is to do with whether that would be appropriate. I have talked about new industrial diseases or new industries. That is exactly the situation where we would anticipate that discretion to hold a fatal accident inquiry would be exercised.

**Jayne Baxter (Mid Scotland and Fife) (Lab):** Good morning. The committee has heard concerns that the systems for investigating deaths many not be human rights compliant. What steps does COPFS take to ensure that our obligations, under human rights legislation, to investigate deaths are met?

**The Solicitor General for Scotland:** The Scottish fatalities investigation unit, which is an independent unit in COPFS, investigates deaths. The unit ensures that all evidence is gathered, and that expert reports are prepared if necessary. Thereafter, if issues require public scrutiny, the matter would move to a fatal accident inquiry. Thus, the two strands of effective investigation and public scrutiny are ensured.

If there are issues that have been resolved and remedial action has been taken, the Crown Office would want to ensure that that action has been taken by the relevant organisation. I think that Mr McGowan made reference to our work with the national health service to ensure that any practices discovered during an investigation are taken forward. All that has the effect of ensuring that the investigation has been effective, that the matter has been scrutinised and that action has been taken, as a result.

**Jayne Baxter:** Should FAIs be mandatory for deaths involving looked-after children or people who are the subject of mental health detention?

**The Solicitor General for Scotland:** The balance in the legislation is appropriate. The purpose of mental health detentions is care of individuals. There would therefore not be the same public concern about, for example, people who are in police custody or prison, for whom there is an element of punishment as well as care.

If you look at deaths under mental health detentions, you will see that there are a large number of natural deaths. I expect that it would cause distress to families if an FAI were mandatory for all deaths. There must be an effective reporting system, such that all those deaths are reported to the procurator fiscal. We have been doing work to ensure that there is an effective reporting system.

Thereafter, there would be an independent investigation by the Lord Advocate, which would be independent of all the other organs of state. If there was also a review or some form of inquiry, for example by the Mental Welfare Commission, consideration would have to be given to ensuring that everything was in the public domain in order to ensure that the inquiry was human rights compliant. If not, it is for the Lord Advocate to ensure that the investigation and outcome are article 2 compliant. If the situation was not covered in any of the other ways, a fatal accident inquiry would be required. Ultimately, that is the final safeguard.

**The Convener:** I return to the subject of mandatory inquiries concerning “a child required to be kept or detained in secure accommodation” under section 2(4)(b). I posited to the Lord President a situation in which a child who was under state care by order of the court for their own good or for the good of the public might be out and about—they might not be physically within that secure accommodation. Would that provision apply in such a case? It refers to a child who is “required to be kept”. Does the child have to be physically in the secure accommodation for the provision to apply?

**Stephen McGowan:** They have to be “kept or detained”, so I think that a child who is otherwise with foster carers or who is elsewhere—

**The Convener:** No, I did not mean that; I mean a child “kept or detained in secure accommodation” who might be out and about and required to come back. Such things happen: the children are not kept in all day long. If they were out and about when something happened, would that provision apply?

**Stephen McGowan:** Do you mean out and about as in they go back and forth to school?

**The Convener:** Yes. They might have gone to school, for example, and might not have come back to the secure accommodation when they ought to have done. Would that provision apply?

**Stephen McGowan:** Section 2 talks about “a child required to be kept or detained”, so, arguably, it would apply.

**The Convener:** Even if they were not physically within the building.
Stephen McGowan: Yes, even if they have left it on the day concerned. It would be helpful to have in the bill clarity about the legislative intent with regard to the situation that you describe, where the child may be out for the day, whether at school or elsewhere.

The Convener: So it is not clear. There would have to be some other wording.

Stephen McGowan: You could interpret it in the way that you describe, but there may be challenges. You raise a very fair point, and in order to have absolute clarity it would be better to—

The Convener: I am thinking of a case of a child who was kept in such accommodation for their own protection and who broke out and wandered about for two days before they were retrieved. If something had happened in that period, that would not necessarily have—

Stephen McGowan: If the child broke out, I would be comfortable in interpreting the provision as if they were in the accommodation. I can imagine a situation in which a child who was being kept in secure accommodation was in mainstream schooling and therefore travelled to or from school. There is a shade of grey around such situations that may be worth clarifying. If, however, the child broke out and absented themselves from the place where they were being kept—

The Convener: Or if a door was left unlocked or something like that.

Stephen McGowan: Yes—

The Convener: It would be different if a door was left unlocked.

Stephen McGowan: I think so.

The Convener: And if something then befell them.

Stephen McGowan: Yes. Technically, the child should have been in the place where they were being kept.

The Convener: Okay. I might pursue that further.

The Solicitor General for Scotland: I think that it is the child’s status that is important.

The Convener: That is what I was thinking.

The Solicitor General for Scotland: I would like to think that we would interpret the provision in the way that you suggest. If it is necessary to amend the wording to clarify that, that should be done.

The Convener: Yes—I thought that the child’s status, rather than the place, was important, but the wording is more about the place. As I said, I will pursue the point further.

Elaine Murray: I turn to the issue of sheriff’s recommendations. As you will be aware, Patricia Ferguson’s proposed inquiries into deaths (Scotland) bill would make compliance with sheriff’s recommendations legally binding after a hearing to discuss any issues, whereas section 27 of the bill that is before us requires responses to such recommendations to be made to the Scottish Courts and Tribunals Service. I seek your comments on both proposed approaches.

The Solicitor General for Scotland: There would be a number of difficulties regarding sheriff’s recommendations if they were legally binding. Legally binding recommendations would widen the scope of an FAI; they might end up being unenforceable, given that the sheriff would have been looking at the particular circumstances of the death, or deaths, before him; and there is the danger that the inquiry would turn into an adversarial process. The important thing is that the recommendations are out there in the public domain and that those who are on the receiving end of them are required to say what they have done about them.

Elaine Murray: We have had evidence from witnesses who felt that the Scottish Courts and Tribunals Service was not necessarily best placed to publish the recommendations and that perhaps Scottish ministers should have responsibility for doing that, because if the recommendations required legislative change it would be ministers who would be responsible for bringing forward that legislative change. It was suggested, I think in a letter from the Sheriffs Association, that Scottish ministers could be given the power to bring forward subordinate legislation under the bill to promote compliance. Others have said that perhaps the Lord Advocate would be the best person to collate the responses. Do you have a preference?

The Solicitor General for Scotland: I have no particular preference beyond reiterating that, having worked in this area for many years, I think that it is extremely important for the families who want lessons to be learned from an FAI that those lessons be learned and any recommendations taken forward.

When it is not necessary to have an FAI but there are lessons that have been learned, the Crown takes seriously its duty to make sure that those who need to know, do know. If that includes the Government, the Crown will make sure that the Government knows. Beyond that, the Crown would assist with whatever method was thought to be most appropriate.
Elaine Murray: What can families do if they are not happy with the result of an inquiry? What is the recourse for families who are not content after an FAI?

The Solicitor General for Scotland: After an FAI? There is none.

Stephen McGowan: Their only recourse would be to seek judicial review of the sheriff's decision, which would have to relate to matters of law, rather than specific facts. There has never been a challenge to the facts as determined by the sheriff that I can think of.

The Solicitor General for Scotland: It has never happened.

The Convener: Might they bring civil proceedings?

Stephen McGowan: There are often civil proceedings in these cases in any event.

The Convener: Okay. I will come back to Gil Paterson, but Christian Allard and Alison McInnes have been waiting a long time.

Gil Paterson: I just have a wee point on sheriff's recommendations.

The Convener: I will come back to you.

Christian Allard: My question relates to section 6(1)(c), on inquiries into deaths occurring abroad where the person's body has not been brought back to Scotland. There have been some calls for that provision to be amended, for exceptional circumstances. Would there be any difficulties if the bill was to be amended?

The Solicitor General for Scotland: I will say a couple of things about the new power to hold inquiries in relation to deaths abroad. There are no powers for the Crown to investigate those deaths without co-operation. The reason why I mention that first is that the repatriation of the body is very important to the Crown, because it is evidence; in many cases, it may be evidence of the cause of death. There has been at least one occasion on which the information that the Crown got about the cause of death came from a post mortem, but it could be seen from the body that no invasive post mortem had been carried out.

That partly explains our thinking on the matter, but it is also entirely in line, as I understand it, with what the coroner does. Nobody likes to have rules to which there is one exception that makes them all look silly, so I would have no difficulty with there being exceptional circumstances when a body has not been repatriated, although such circumstances would require to be justified to allow the Lord Advocate to go down that route.

11:15

Christian Allard: In light of what you told us about co-operation with other countries, jurisdictions and police forces, could the bill specify more clearly that money should not be spent to double up an investigation—for example, by sending police officers abroad to do a job that is being done already? Is there a need to limit the bill's remit on that point? The financial memorandum suggests only £157,350 as the likely cost associated with revisiting deaths abroad, but if we duplicate what another jurisdiction has done, the sums could increase a lot. People work and live abroad a lot more than they used to.

The Solicitor General for Scotland: Such limitations do not require to be in the bill. The Crown has good relationships with a number of other countries and is well placed to decide whether we would be duplicating efforts in an investigation. That does not require to be in the bill.

Christian Allard: I am quite interested in that. Just now, we do not send investigators abroad and spend a vast amount of money to see or check what happened. What is the situation just now?

The Solicitor General for Scotland: We do not have power to send investigators abroad in relation to such matters, and the bill does not give us that power. We would do that as a result of co-operation with other countries through the Foreign and Commonwealth Office. We have powers in relation to criminal investigations to ingather evidence under mutual legal assistance, and we have a certain amount of knowledge of which countries will co-operate quickly and which might take longer, and of the unusual situations in which there is no method of co-operation. We have that experience.

Christian Allard: So you are happy with the financial memorandum.

The Solicitor General for Scotland: We do not have power to send investigators abroad in relation to deaths abroad, and the bill does not give us that power. We would do that as a result of co-operation with other countries through the Foreign and Commonwealth Office. We have powers in relation to criminal investigations to ingather evidence under mutual legal assistance, and we have a certain amount of knowledge of which countries will co-operate quickly and which might take longer, and of the unusual situations in which there is no method of co-operation. We have that experience.

Alison McInnes: Mr Finnie asked you earlier about the role of families and the importance of
their feelings and views about these situations. You responded fairly positively. Am I right that, at the moment, there is no formal mechanism for a family to challenge your conclusion as to whether a death is self-inflicted or accidental, for instance?

The Solicitor General for Scotland: There is none apart from judicial review.

Stephen McGowan: We come to certain conclusions but we do not make any determination as to whether a death is self-inflicted. An investigation might reach that point, we might have a discussion with the families about it and a certain statistical return might be put in, but we do not make a formal finding.

The Public Petitions Committee received a petition on the matter, on which I gave evidence.

Alison McInnes: I suppose that there would come a point at which the Crown would say that it did not think that there was any criminal activity and, therefore, the assumption would be that the death was accidental or self-inflicted.

Stephen McGowan: It would depend on the circumstances of the case. If there was any suspicion that it might have been homicidal, it would be likely to be an unresolved homicide. We treat some cases in which there is no clarity about the cause of death as unresolved homicides. It depends on the individual death.

In some cases, we might for statistical purposes send a return to the General Register Office, saying that, given the circumstances, we suspect that the death is a suicide. There might be other cases that are accidental and which might not be part of that return, while in other cases there might be a suspicion that the death is a homicide but that is not supported by the evidence at that point in time. There are various categories of death.

Alison McInnes: Is there also a category of unascertained deaths?

Stephen McGowan: Yes.

Alison McInnes: But if the family feels that there should be a further criminal investigation, there is no independent assessment of that in the system and no way for a challenge to be made at the moment.

Stephen McGowan: The independent assessment comes through the Lord Advocate and the procurator fiscal reviewing and directing the police investigation.

Alison McInnes: So you see no merit in having a sheriff’s inquiry to deal with such disputes. Is there any parallel with, say, the coroner’s inquest, which is used much more frequently down in England?

Stephen McGowan: I see no merit in that proposal, because there might well be a fatal accident inquiry to deal with that type of death.

The Solicitor General for Scotland: If there has been a request to review circumstances, we will carry out an in-house review, involving different people. We have held such reviews on a number of occasions. The same organisation looks the issue, but with a fresh pair of eyes, which is akin to the victim’s right to review under the new legislation.

Alison McInnes: Can you explain to me the role and operation of coroner’s inquests in England? Why have we not followed that system? Do you have any views on the merits of that approach?

The Solicitor General for Scotland: All I would say is that, constitutionally, we have a completely different system. The procurator fiscal was here first—so to speak—while, down south, they had the coroner and then the Crown Prosecution Service.

The Convener: Good for you for sticking up for Scots law.

The Solicitor General for Scotland: I am sorry—I could not help it.

Alison McInnes: We can sometimes learn from other places.

John Finnie: Can I come in here, convener?

The Convener: I was going to take Gil Paterson first, because I had parked him.

John Finnie: But it is on this particular point.

The Convener: Yes, but Gil Paterson has a question about a previous point. I will come back to you, John.

Gil Paterson: Would it be possible for sheriff’s recommendations on a specific point to be made binding without the need for legislation, or in making such recommendations do sheriffs look at the law as it is and base their recommendations on the fact that the law was not carried out properly?

The Solicitor General for Scotland: Sheriffs usually make recommendations about practices that can be changed rather than about changes to the law itself. Under section 6 of the Fatal Accidents and Sudden Deaths Inquiry (Scotland) Act 1976, they look at the system and any defects at work, and they make recommendations on what could have caused the death to be avoided, had it been in place.

Gil Paterson: Could a sheriff recommend a change in the law itself? If so, would that be only a recommendation and not something that a second
or indeed third party would be forced to act on without legislation?

**The Solicitor General for Scotland**: It would be just a recommendation.

**John Finnie**: Mr McGowan, I wonder whether you will clarify something that I perhaps misunderstood in one of your responses to Ms McInnes. I believe that you said that, if there were any dubiety, the independent assessment of whether an FAI should proceed would be made by the Lord Advocate.

**Stephen McGowan**: I was referring to the criminal investigation that I believe was mentioned in the question, which I think related to whether there was any means of independent assessment in cases where there is a criminal investigation if the family in question is not happy about that investigation.

In relation to decisions about a discretionary FAI, the Lord Advocate makes that decision independently, and there is the remedy of judicial review if the Lord Advocate decides not to exercise his discretion in favour of having that FAI.

**John Finnie**: Crime in Scotland is investigated at the behest of the Lord Advocate.

**Stephen McGowan**: Yes.

**John Finnie**: Is there not a conflict between the two?

**Stephen McGowan**: Between having an FAI and—

**John Finnie**: I am suggesting that someone who is saying, “I’m not going to have an FAI,” could also be the person who has directed any criminal inquiry that may have taken place.

**Stephen McGowan**: I do not think that there is any conflict of interests in relation to that. It comes down to the points that the Solicitor General made.

**John Finnie**: Is “independence” the appropriate term?

**Stephen McGowan**: Yes, I think that it is. The Lord Advocate independently investigates crime, prosecutes that crime, and investigates deaths, so “independence” is the appropriate term in that regard.

It comes back to the Solicitor General’s point about all the factors that make up the public interest, and I do not think that we can disaggregate those factors and say that there is a different public interest, or family interest, in a particular aspect of an FAI or a criminal prosecution. All those factors, when taken together, make up the public interest.

**The Solicitor General for Scotland**: It is how that is done in-house that is important. It is done by separate teams of specialists. As I indicated earlier, different aspects of public interest are considered at different stages. For example, if there is the potential for proceedings in the High Court, the circumstances will be considered by the prosecutors at that stage, sometimes within the health and safety division, and then the matter will go to Crown counsel for a decision on criminal proceedings.

It is not the same group of people who will then consider whether or not a fatal accident inquiry is appropriate, or what further investigations there should be in relation to a fatal accident inquiry. Although those groups work together, there is a separate process and a separate report, and there are two specialist Crown counsel now within the team who deal with deaths-type matters. I think that “independence” is the right word to use, but I have to satisfy you that within the one organisation that independence exists.

**John Finnie**: Ultimately, it is still the same person who makes the decision and who has oversight of both those functions.

**The Solicitor General for Scotland**: No, the duty to investigate in those two areas is invested in the Lord Advocate constitutionally. What I am indicating is—

**John Finnie**: There is no personal criticism.

**The Solicitor General for Scotland**: I understand that.

**John Finnie**: I want to understand the process, and ultimately it is the same person who is in overall charge of both of those decisions.

**The Solicitor General for Scotland**: It is the same person who is in overall charge, but the individual decision making on those two aspects will be done by different people. They are two different sets of considerations.

**John Finnie**: But someone has to have overall responsibility.

**The Solicitor General for Scotland**: Yes.

**John Finnie**: Thank you very much.

**The Convener**: We have got there.

I want to ask about section 7, as nobody has asked about it. It concerns inquiries into deaths occurring abroad, but it is about service personnel. We have received Stephen McGowan’s letter, which is an excellent legal treatise on why the current state of affairs means, somewhat to our surprise, that people serving in the armed forces are not considered to be employees and therefore cannot go to employment tribunals or anything like that.
Let us look at section 7, which concerns the current status. The provision refers not to a mandatory inquiry but to a discretionary one, and it can apply only if the death of the serviceperson occurs abroad. Section 7(2) refers to being in custody, but section 7(3), which is an alternative, states that a death is within that subsection if it "was sudden, suspicious or unexplained, or ... occurred in circumstances giving rise to serious public concern."

Why cannot we extend the provision, without bothering about whether or not someone has employee status, to service personnel per se? If it applies to somebody abroad, I do not know why we cannot do it for somebody in Scotland if the same kind of circumstances arises, without even going down the road of considering whether somebody is an employee and an inquiry is therefore mandatory.

Stephen McGowan: The genesis of section 7 is section 1A of the Fatal Accidents and Sudden Deaths Inquiry (Scotland) Act 1976, which was added in the past few years to deal with matters abroad. I do not have the answer to your question, and it is a matter for Parliament itself. There may be legislative competence issues around such deaths in relation to the military.

Section 7 of the bill simply deals with the military. The issue that the committee discussed at the previous meeting relates simply to whether or not it is mandatory in the United Kingdom to have a fatal accident inquiry into the death of service personnel. It is not; it is discretionary, as it is abroad.

The Convener: So it is discretionary in the UK. I do not understand: notwithstanding an internal inquiry, could you hold an FAI if something happened to service personnel in Scotland that gave rise to a suspicion that there was something not quite right?

Stephen McGowan: Yes, we could hold one.

The Convener: You could still hold one.

Stephen McGowan: Yes, but the point is that it would be discretionary rather than mandatory.

The Convener: I understand that.

Stephen McGowan: Nothing disbars us in any way from holding a fatal accident inquiry.

The Convener: So I am really bothering about nothing.

Stephen McGowan: Yes. It would be a discretionary inquiry.

The Convener: Have you held any of those?

Stephen McGowan: I cannot think of one off the top of my head, but I have not checked—we can check that.

The Solicitor General for Scotland: We will check that out.

11:30

The Convener: I have a wee feeling that there is not the protection for service personnel that there is for other people. I appreciate from your explanation what their status is, but I still have that feeling. Perhaps this is not the place to deal with it—we can ask the minister. In any event, you are telling me that, if something happened here with Army recruits who were out training, an FAI could be held even if there was an internal Army inquiry.

Stephen McGowan: Absolutely.

The Convener: Would you get all the material from the Army?

Stephen McGowan: Yes.

The Convener: You would get absolutely everything.

Stephen McGowan: Yes, we would get that material. We have done so in the past with the incidents that I am thinking of in which we have not had an inquiry, so we would get all that information from the military for an FAI.

The Convener: Okay. I just thought that I would ask about that—and I will find out more about it, because it is still bothering me a wee bit.

Stephen McGowan: Nothing bars us from holding such an FAI, and we have no particular view one way or the other on the provisions. That is simply the law as it stands.

The Convener: It is just the word “mandatory” that is in our way.

Stephen McGowan: I was trying to clarify whether there must be an inquiry or whether the Lord Advocate has discretion to order one.

The Convener: But one could make inquiries mandatory. There could be mandatory inquiries into the deaths of service personnel that occurred in Scotland, and there would just be a separate section in the bill. That would be nothing to do with being an employee.

Stephen McGowan: In principle, we have no difficulty with that. There are legislative competence issues to explore around the matter that I do not pretend to have the answers to today—

The Convener: No—neither do I.

Stephen McGowan: But in principle there is no difficulty with that.

Christian Allard: If you come back to us to let us know whether you have held discretionary
inquiries, can you say whether you have been asked to hold one?

Stephen McGowan: Yes.

The Convener: Is John Finnie waving at me to come in?

John Finnie: It was a fond wave.

The Convener: It is about time.

John Finnie: I know that you will be uncomfortable discussing cases, but there was the tragic loss of life of a young Army cadet in the Western Isles. Would that fall into that category?

Stephen McGowan: There was an FAI in relation to that case, but the person in question was not employed by the military. That was a discretionary inquiry that came out of different circumstances.

The Convener: So we do not necessarily need to bother with the employment status. I do not know whether we want to pursue that.

We will move to questions from Elaine Murray.

Elaine Murray: You are probably aware that Patricia Ferguson’s proposed member’s bill would introduce time limits, which could be flexible, for the holding of FAIs. Will you comment on that and, in doing so, give us an indication of the average timescales for holding FAIs—families have raised concern about timescales—and whether there are particular reasons why delays occur?

The Solicitor General for Scotland: I share concerns about the length of time that it takes to conclude such investigations and inquiries. A lot of work has been done to try to shorten those periods without compromising other things.

I will take some time to deal with the question, as a number of issues impose on the timescale.

First, the date that the death came to the attention of the Crown can occasionally impact on the timescale if that was not immediate. Secondly, on many occasions criminal proceedings may have to be considered. As I indicated, criminal proceedings will, in the public interest, take precedence over a fatal accident inquiry. That adds to the length of time.

The third aspect is the involvement of other regulatory authorities that have duties to carry out their own investigation and inquiry. Such bodies are not necessarily subject to timescales; more importantly, though, they are not subject to the control of the Crown in relation to the ingathering of that information, in the way that the police are when the Crown instructs the police to carry out inquiries. You will be aware that I wrote last year in order to ensure that sort of co-operation from the

air accidents investigation branch on the Clutha incident. The First Minister also had to write.

The fourth aspect is that most fatal accident inquiries will require expert evidence of some sort, frequently from medical experts. It is not for the Crown to set priorities within its own organisation, so in many respects we are subject to how long the experts take to produce those reports. I am not saying that we do not have a good relationship with experts, but that all adds to the length of time that an inquiry takes.

As I indicated, it is important that, if the bill controls the timescale from the point at which it is decided to have an inquiry, the Crown has information out there—in the form of the charter that I mentioned—to indicate timescales from the point at which the internal timescale of 12 weeks to make a decision on a straightforward matter stops until the final decision is made.

Over the past three years, the specialists in the SFIU have been working on an approach that involves dealing with the older cases and trying to ensure that they do not compromise more recent cases—it involves working on cases in tandem. It is one of the reasons why there were so many FAIs last year—there were 68 FAIs last year, which is probably double the number in the previous year.

I share Elaine Murray’s concern, and that of families. We are continually actively working on timescales.

The Convener: If the Crown is under pressure with the number of FAIs, it is a horrible word but do you rank them in order of priority? I wonder whether FAIs that are not as complex are pushed further down the timescale by bigger FAIs.

The Solicitor General for Scotland: If you are thinking about examples in the past when things were not dealt with as effectively and quickly as they should have been, it was either before the SFIU was set up or before two years into the SFIU, when all the cases began to be project managed. The new approach means that we can work on the older ones and the newer ones to compress the timescales and eventually have an acceptable timescale going forward without ever compromising the effectiveness of the investigation—which, ultimately, is what leads to the appropriate recommendations.

The Convener: I was asking about prioritising FAIs. I can appreciate that there would be circumstances where you must stop certain things happening PDQ by making a statement about what has happened. I think that you illustrated that earlier, when you talked about changes that are made during an FAI. How do you prioritise? It may be that some FAIs slip further down or take longer, not because they are complex but because more
complex and urgent inquiries go further up the pecking order.

**The Solicitor General for Scotland:** That has not been the experience in relation to project managing the FAIs.

**The Convener:** My last question—because nobody has asked it—is this: in what circumstances should trade unions be included in the list of those automatically allowed to participate in an FAI? Is that what you do? The trade unions put that question to us.

**The Solicitor General for Scotland:** The bill says that it is at the sheriff’s discretion whether a person has an interest in the inquiry. I think that that covers those areas where the trade unions would have a specific interest.

**The Convener:** So there is no role for the Crown in recommending which witnesses you want to come forward to elicit evidence in the inquiry. There is not a circumstance in which you would say, “We have to have someone from the trade unions.” That would be a matter for the sheriff.

**The Solicitor General for Scotland:** That is correct. If there was a particular set of circumstances in which it was important, as part of the investigation, for information to be sought from the trade unions, I would expect that to be done. To be frank, I cannot think of one off the top of my head. Usually, the experience is that trade union involvement is to ensure representation for certain people involved in the inquiry.

**The Convener:** I will leave it at that. Thank you for your evidence.

11:40

*Meeting suspended.*

11:47

*On resuming—*

**The Convener:** We now have our second panel on the Inquiries into Fatal Accidents and Sudden Deaths etc (Scotland) Bill. With us are Paul Wheelhouse, the Minister for Community Safety and Legal Affairs, and his Scottish Government officials. Hamish Goodall and Marisa Strutt are policy officers in the civil law and legal system division and Greig Walker is a solicitor in the directorate for legal services.

Good morning. I understand that you wish to make an opening statement, minister—unlike the cabinet secretary. I do not want to put pressure on you.

**The Minister for Community Safety and Legal Affairs (Paul Wheelhouse):** If you are pressed for time, convener, I do not need to—

**The Convener:** No, no. I would not want to curtail you. Just go ahead.

**Paul Wheelhouse:** Thank you for the opportunity to address the committee. We believe that it is right that the system of fatal accident inquiries was reviewed by Lord Cullen to ensure that it provides in the public interest an effective and practical system of judicial inquiry into deaths, and that the legislation should now be updated to make it fit for the 21st century. The dean of the Faculty of Advocates told the committee in evidence that he believes that the bill will modernise the system of FAIs.

Lord Cullen made 36 recommendations for reform of the FAI system. Some of those recommendations were addressed to the Crown Office and Procurator Fiscal Service and have already been implemented through the establishment of the Scottish fatalities investigation unit. The Government carried out a consultation on the legislative proposals to build on the changes that the Crown Office has already made and to further consider some of the main areas that were identified as requiring attention.

For example, 74 per cent of consultees agreed that the aim of independent investigation into the death of a person who was subject to compulsory detention by a public authority should be met by independent investigation by the procurator fiscal and exercise of the Lord Advocate’s discretion on completion of that investigation. Some 80 per cent of those who responded agreed with Lord Cullen that mandatory timescales for the opening of an FAI are not practical or realistic due to the diversity and complexity of FAIs.

The bill takes forward the principle of Lord Cullen’s recommendation on requiring responses to sheriffs’ recommendations. The chief executive of the Scottish Courts and Tribunals Service has acknowledged to the committee that it is logical and transparent that responses to recommendations should be posted on the SCTS website as sheriffs’ recommendations are already available there. The Scottish Government considers that proposal to be a proportionate and transparent way of ensuring that recommendations are taken seriously, and that was echoed by the dean of the Faculty of Advocates when he said that the policy strikes “the right balance”.

Section 26 ensures that a sheriff’s determination will be disseminated to not only any person to whom the sheriff is addressing a recommendation but any person who has an interest in the
recommendation, which will include regulatory, professional and trade bodies.

The bill will build on Lord Cullen’s recommendations, implemented by the Crown Office, to make the system more efficient, for example through greater use of preliminary hearings and other procedural measures. The Lord President suggested that as much evidence as possible should be in writing and the bill provides for the agreement in writing of non-controversial evidence by the participants.

The bill will permit more flexible location and accommodation arrangements for FAIs, which may permit FAIs to take place more quickly than they do if people have to wait for court capacity to become available. It will permit discretionary FAIs into deaths of Scots abroad; ensure that FAIs remain inquisitorial fact-finding hearings as set out in sections 1(3) and 1(4), to which the Lord President drew attention; and permit FAIs to be reopened if new evidence arises or, if the evidence is substantial, permit a completely new inquiry to be held.

I would like to reflect on some aspects of the evidence that the committee has received and I look forward to seeing the committee’s stage 1 report. I am happy to answer any questions that the committee may have.

The Convener: Let us hope that your happiness continues.

Roderick Campbell: Good morning, minister. I will kick off with a question about deaths of people who are detained compulsorily for mental health reasons. The policy memorandum, at paragraphs 116 and 117, details the graduated scale of investigations under which the Royal College of Psychiatrists operates. We have heard from a large number of witnesses concerns about the human rights aspect of that, and the Scottish Human Rights Commission and the Mental Welfare Commission for Scotland had concerns that requirements of article 2 of the ECHR are missing from the graduated scale of investigations. Can you add anything to reassure people on the human rights implications of continuing as we are?

Paul Wheelhouse: That is an important point. As Roderick Campbell said, the Mental Welfare Commission and others have a role in this. Such deaths are subject to investigation by the procurator fiscal, and the Lord Advocate has discretionary power to hold an FAI into such deaths when it is considered to be in the public interest.

As I said in my opening remarks, 74 per cent of consultation respondents favoured the retention of investigation by the procurator fiscal and exercise of discretion by the Lord Advocate on completion of that investigation to instruct an FAI, if he thinks that one is required.

We are aware that the Lord President agreed that the current discretionary power is sufficient. He said:

“I think that we are in danger of imposing unnecessary rigidity on the system. The system by which the Crown makes investigations and forms judgments is, I think, the best model”.—[Official Report, Justice Committee, 19 May 2015; c 43.]

However, I take on board people’s serious concerns about human rights when someone is taken into a setting that is not a normal facility, such as the Carstairs facility. More commonly, facilities that deal with people with mental health issues who are sectioned under the Mental Health (Care and Treatment) (Scotland) Act 2003 are medical environments. We are satisfied that there are triggers to allow the Mental Welfare Commission to flag up any pattern of concern regarding the deaths of individuals in those settings and the Crown can raise criminal investigations if it believes that something of that nature has happened.

We recognise the concern that has been expressed by a number of witnesses and committee members regarding the need to ensure that inquiries are held when the circumstances are justifiable, but we do not believe that FAIs should be mandatory in every case.

Roderick Campbell: I accept that. I refer you to paragraph 117 in the policy memorandum, which says:

“It may be that there is a case for these various inquiries and investigations to be formalised and rationalised, though not necessarily in legislation. The Scottish Government does not, however, believe that this Bill is the vehicle for this.”

Do you want to add anything to that?

Paul Wheelhouse: I accept that there might be a need to improve the clarity of the procedures that are in place and the role of different agencies in flagging up concerns about a death that occurs in a mental health situation. It might be possible to make the flow diagram—as it were—of how the system works clearer to ensure that families and the individuals affected are aware of it.

However, I know that stakeholders have called for mandatory inquiries to be held in such cases, but I hope that they will accept that not every family wants an inquiry to be held in every case. It can often be quite apparent what has caused the death. It could, for example, have happened through natural causes; after all, logic suggests that people in such situations are just as vulnerable to diseases as those outside those settings. I therefore think that we need a flexible and adaptable system.
If the committee is concerned about a lack of clarity about how the system works in practice, we can certainly address that issue, but I am looking to Mr Campbell for guidance as to whether I have understood his point correctly.

Roderick Campbell: The written submission from the Equality and Human Rights Commission touches on some of the problems in the existing system, where clearer guidance would be helpful. For example, it says:

“The current system is confusing eg Crown Guidance to medical practitioners specifies that deaths in legal custody should be notified but does not specify that deaths under mental health detention should be notified. There is a separate system of notification for Health Improvement Scotland and a local case review for clinical services”.

Paul Wheelhouse: The member makes a fair point. If those in the sector at the sharp end are concerned about clarity in the procedures and guidelines, we can take that away from today’s session and come back to the committee on it, if that would be helpful. It is certainly our intention to avoid mandatory inquiries but I accept that people need to know whether there are sufficient triggers to call for an inquiry and how the Lord Advocate would exercise discretion if it came to that. I am happy to look at any weaknesses in the guidelines that the committee might flag up.

Roderick Campbell: I am simply looking for reassurance so that, even if we accept that there is not a case for mandatory inquiries, the discretionary system—for want of a better phrase—and the add-ons are compliant with article 2.

Paul Wheelhouse: I take Mr Campbell’s point that we need to reflect on any gaps in the guidelines that might raise human rights concerns. However, I hope that we will be able to come back to the committee and address any concerns that it might raise in its stage 1 report. I will look at the detail of the evidence that you have received from witnesses and address any specific matters that there might be. Nevertheless, as I have said, I take Mr Campbell’s point.

The Convener: With regard to specific issues about mandatory inquiries, I draw the minister’s attention to section 2(4), which I also raised with the Solicitor General. It says:

“The death of a person is within this subsection if, at the time of death, the person was ... a child required to be kept or detained in secure accommodation.”

Does that mean that the child in question is literally in the secure accommodation or does it simply refer to the child’s status?

Paul Wheelhouse: I will bring in Hamish Goodall to respond to your question, convener.

Hamish Goodall (Scottish Government): Are you asking whether the child in question would be within a building?

The Convener: Section 2(4)(b) refers to

“a child required to be kept or detained in secure accommodation.”

Does that mean that the child is literally in secure accommodation or does it refer to the fact that, notwithstanding where they might be, the state has said that they have to be kept for their own protection or the protection of society in secure accommodation?

Hamish Goodall: That provision would apply if the child was actually in secure accommodation.

The Convener: Is there a flaw in that respect? If a child happens to die while they are out of secure accommodation, say, for a couple of hours, should there not be a mandatory inquiry to examine why they were out when there might very well have been reasons why they should not have been out? After all, the state is in charge.

Paul Wheelhouse: It might be helpful to bring in Greig Walker at this point.

Greig Walker (Scottish Government): First, I should say that I sat in on the previous evidence session. I note that the phrase “required to be” appears a few times in section 2. The intention in drafting the bill, to take the example of prisoners, would be that if they are being taken out on a day trip, or if they are going to hospital, they require to be detained. They are not at liberty, even if they are outside the prison walls. The intention in all those cases, including for secure accommodation, is that the provision does not only apply literally within the building. However, if it is felt that there is a lack of clarity we will certainly take that away and reflect on it.

12:00

The Convener: I think that there is a lack of clarity, because I have had to ask about it. The question is whether they are within or outwith.

Section 2(5) states:

“For the purposes of subsection 4(a), a person is in legal custody if the person is—”

and there is a list. I do not know off the top of my head what

“section 56 of the Criminal Justice (Scotland) Act 2015”

says. Does that mean that someone could be in custody but not necessarily within premises? The rest of the provisions all relate to premises. Say someone has been arrested on the street and the police say that they are taking the person into custody. Is that what is meant?
Hamish Goodall: Yes. The purpose of that provision is to widen the scope of when the mandatory fatal accident inquiry would apply. We are not just talking about someone who dies in a police cell or in a police station. If they have been arrested at a football match or in the street, and they suddenly die, that would trigger a mandatory fatal accident inquiry.

The Convener: Is that what section 56 says?

Hamish Goodall: I cannot—

The Convener: I do not know whether that is what the section says, because the rest of the provision refers to places.

Hamish Goodall: That was the intent. I cannot—

The Convener: Section 2(6) says:

“For the purposes of subsections (4)(b) and (5)(a) and (d), it does not matter whether the death occurred in secure accommodation, a penal institution or, as the case may be, service custody premises.”

Does that take care of my two problems with the children in secure accommodation and someone out in the street, perhaps under arrest by the police, who dies? Would an inquiry be mandatory in both cases?

Hamish Goodall: It certainly takes care of the matter regarding police custody. The amendment was made to the legislation in line with Lord Cullen’s recommendation and at the request of the former Association of Chief Police Officers in Scotland. The association pointed out that there was a slight discrepancy in the law. The existing legislation applied only to police cells and police stations. The bill widens the definition to police custody outwith police stations.

The Convener: Section 2(6) says

“For the purposes of subsection (4)(b),”

which was the one that I mentioned in relation to secure accommodation. It then says that

“it does not matter whether the death occurred in secure accommodation, a penal institution or, as the case may be”—

That does not cure the first issue, which is the child who may be out and about, does it?

Hamish Goodall: I think that Greig Walker has already—

Paul Wheelhouse: Greig Walker will help the committee’s understanding of that issue.

Greig Walker: I will pick up on two points from that exchange. Where section 2(5)(b) refers to the “Criminal Justice (Scotland) Act (2015),” that is the bill that this committee has been scrutinising. It is contingent on that—

The Convener: We have been scrutinising an awful lot, so you will have to remind me what that section actually says.

Greig Walker: To take first things first, if that bill is enacted, as Hamish Goodall described, the intention is for it to cover roadside detention and such like.

The Convener: Right. So that is that issue sorted.

Greig Walker: Section 2(6) has just been referred to. My interpretation, and that of the bill team, is that it does not literally mean within the secure accommodation wing or within the prison. It includes when the person is out on a day trip or on the way to hospital or whatever.

As I said, the bill team will consider all the points on drafting if the committee feels that—

The Convener: But it may cure the issue? You think that it does.

Greig Walker: I do personally, but we will reflect on that.

The Convener: That is fine. You have sorted that out for me.

Paul Wheelhouse: To clarify, it also covers prisoner transport, convener.

The Convener: I followed that, but the bit about secure accommodation was not clear. The provision seems also to deal with that, so that it does not matter whether the child is outwith the secure accommodation—he or she is still under the control of the state, for the protection of the public. That might cure it. I am happy now and do not want to know any more about it.

Christian Allard: Good afternoon. I would like to ask about something that was a surprise to members—the fact that the service personnel in the armed forces are not employees. We found that very difficult to accept, but we have had a letter from the Crown Office and Procurator Fiscal Service that explains the detail. Could you not draft the bill differently to try to include service personnel in a better way?

Paul Wheelhouse: I am happy to address that point. I must confess that I, too, was surprised to learn that service personnel are not considered to be employees, but I appreciate that that represents long-standing legislative practice.

The issue of FAIs into deaths of service personnel in Scotland was not raised in Lord Cullen’s review or during the consultation on the legislative proposals last year, which is why it is not dealt with in the way that Mr Allard seeks in the bill. It is therefore a new issue that we have had to consider in the light of the representations that have been made to the committee and,
out with the committee, those that have been made by Mr Angus Robertson, who is the MP for Moray.

Given the defence reservation, any change to the law would have to be achieved by means of a section 104 order, which is already being contemplated for the bill, and agreed by the UK Government. We have had some initial informal discussion with the Ministry of Defence on the matter, and we believe that there might be room for further discussion in an effort to bring deaths of service personnel in Scotland within the scope of the bill. After the meeting, to be fair to the MOD—instead of relying on the informal discussions that my officials have had—we will write to the MOD to make that point and to invite it to respond formally on the scope that exists in that regard.

I certainly recognise the point that Mr Allard makes, and I will be happy to come back to the committee as soon as we have heard formally from the MOD whether it is willing to allow deaths of service personnel in Scotland to fall within the scope of the bill under a section 104 order.

Christian Allard: Thank you very much—that would be very helpful.

The Convener: What is the timescale for that, bearing in mind that stage 2 will take place after the summer recess?

Paul Wheelhouse: We will get a letter off as soon as we can—certainly before the summer recess—and we hope that the MOD will get back to us in time for the stage 2 process in committee.

The Convener: Jayne Baxter wants to come in on the issue of military personnel.

Jayne Baxter: We discussed the topic in a previous evidence session and I am now confused. Is the wording of section 2(3) wide enough to encompass service personnel and other Crown servants, or are you saying that that is not the case?

Paul Wheelhouse: I will invite Hamish Goodall to comment on that. The issue is a new one, so we have not addressed it in the bill. We believe that, because it is a reserved issue, we will need UK Government consent for a section 104 order. We will be happy to consider amending the bill at stage 2 if the MOD is happy for us to proceed on the basis of a section 104 order in due course. That is the plan.

Hamish Goodall: It is an order under the Scotland Act 1998. I ask Greig Walker to explain the detail of section 104 orders.

The Convener: The buck gets passed to Mr Walker a great deal of the time—I hope that Mr Goodall’s buying the buns later.

Greig Walker: Section 104 orders are quite common for the more complicated bills. Essentially, they are for consequential things that are within a bill’s policy intentions but which, for technical reasons, the Parliament does not have the competence to deal with.

I will make two related points. There has not been an intention on the part of the bill team to change the meaning of the wording that appears in the 1976 act. The bill uses a slightly different form of words, but it was not the intention to change the meaning. Of course, the issue of military employment has come up very recently. We will reflect on all that.

It is also worth mentioning that section 7 deals with service deaths abroad. Such provisions can appear in the bill, even though elements of the issue relate to a reserved matter, because they simply restate existing law. It is a slightly clunky picture, but that is why we have ended up—

The Convener: That is discretionary. We understand that bit. It is mandatory inquiries that we are asking about.

I do not particularly want to help the MOD, but would there be unintended consequences for it if service personnel were treated as employees in legislation? We would be opening up the MOD to a whole load of other legal issues, such as the status of service personnel at employment tribunals and their rights.

Paul Wheelhouse: Indeed. I guess that that is one of the issues that we need to consult the MOD on. Informally, it has been willing to discuss the issue—no doors have been closed on us so far.

The Convener: Could service personnel be treated as employees just for the purposes of a fatal accident inquiry?

Paul Wheelhouse: We will have to be careful in drafting the provisions so that we do not, as you say, undermine existing provisions elsewhere. If we can work with the MOD to find a suitable fix for the issue, we will certainly do so, and we will keep the committee informed of progress.

The Convener: We are quite interested in that status, are we not?

Roderick Campbell: We are always interested in fixes.

The Convener: That is an advocate for you.
Paul Wheelhouse: Yes, indeed.

Christian Allard: There has been a change since the Fatal Accidents and Sudden Deaths Inquiry (Scotland) Act 1976 was passed. The text has been amended, and the word “or” has not been placed in the same place.

In the bill that is before us today, section 2(3)(b) refers to
"the person’s employment or occupation."

The 1976 act referred to a
"person who has died ... in the course of his employment or, being an employer or self-employed person, was engaged in his occupation as such."

That changes the sense a little bit, but I would not want us to go back to 1976. On the contrary, the change is an improvement.

Greig Walker: We will certainly reflect on all those points.

Christian Allard: My second question is about deaths abroad. Many people who have come before the committee have told us that they have no problem whatsoever with an amendment removing the requirement for the body to be brought back to Scotland in order for there to be a fatal accident inquiry. Would the Government be willing to move on that point?

Paul Wheelhouse: I certainly recognise the issue. I have had the honour of meeting some of the parents, such as Mr and Mrs Beveridge who lost their son, Blair Jordan. I am very grateful to them for explaining the process from their point of view and the weaknesses in that process.

In that particular case, Blair’s body was found, although I recognise that there are circumstances in which a body may not be found. The issue is a difficult one for us to address. The requirement that the body should be repatriated has been raised as an issue with the committee, but it was not challenged during the Government’s consultation, which is why we have not addressed it in the bill. Indeed, the consultees, including the group Death Abroad—You’re Not Alone, which gave evidence to the committee, seem to want a system that is similar to the coroner’s inquest in the south, in which an inquest is held only if the body is returned.

We can consider the matter again, but the Crown Office believes that, if there is to be no examination of the body, it may prove very difficult in practice to produce evidence in court that provides a satisfactory explanation for the cause of death. We must recognise the limitation in certain cases of not having a body, and the limit that would therefore be placed on any value that would be added by a fatal accident inquiry.

The reason why the Crown Office wishes to have a body repatriated is that there is no guarantee that there has been a proper examination of the corpse and a proper determination of the cause of a death that occurred abroad. If the body is disposed of and not repatriated—

The Convener: Can you prosecute for murder without a body?

Paul Wheelhouse: Indeed. The difficulty for authorities here is that, if a death has been reported abroad and the investigation is being conducted abroad, any physical evidence is therefore abroad and we have no body on which to conduct a post-mortem for toxicology or for some other reason to explain what may have happened. In the circumstances, that limits the ability of an FAI to add any value.

In the absence of a body and the absence of pathology and toxicology tests, there is no way of knowing whether the individual was intoxicated or affected by drugs or alcohol, which may have played a part in their death, so the cause of death may remain undetermined.

I have asked officials what would happen in circumstances in which a child had died as Blair Jordan did, but the event had been witnessed—or a child had fallen overboard and died and, although the body had not been found, the event had been witnessed.

I am happy to have a look at that issue and see whether there is anything that we can do to address it. I am simply raising the fact that there are some limitations, and asking what that might mean for the outcome of an FAI and whether there would be any value added.

The decision to hold an FAI would still be at the Lord Advocate’s discretion. He may have to take the decision that an inquiry would not add value for the family or for anyone else without the presence of a body.

Perhaps Hamish Goodall can come in at this point—I know that he has looked at the area closely.

Hamish Goodall: There are additional problems. If someone simply goes missing in a foreign country, would that trigger a fatal accident inquiry? People also occasionally seek to fake their own deaths. A fatal accident inquiry would not be appropriate in those cases. There are undoubtedly circumstances in which there can be no doubt that a death has occurred and, because of the kind of accident, the body might simply not exist any more.
12:15

**Christian Allard:** That is exactly the point I was making. To be clear, those are exceptional circumstances, but that is what people are asking for.

**The Convener:** You cannot just hold an FAI if someone goes missing; the bill says that the death has to be

"sudden, suspicious or unexplained, or

(ii) occurred in circumstances giving rise to serious public concern".

It would not happen for someone who has gone missing.

**Paul Wheelhouse:** We should remember that, in that situation, the Lord Advocate would have discretion, as he would if a body was repatriated. The Lord Advocate could say that there was a case for investigation but we would have to be realistic about what information that might yield. The absence of the body would inevitably limit the scope of an investigation back home because physical evidence is very helpful in determining cause of death.

If I may, convener, I will just bring in Greig Walker—

**The Convener:** We have missed you, Mr Walker. It is your turn again.

**Paul Wheelhouse:** He has some expertise with deaths at sea and, indeed, in the North Sea and the offshore sector where similar issues can arise. It might be helpful and instructive to have a look at that.

**The Convener:** I think that Christian Allard was thinking of that kind of thing: a fishing vessel, not in Scottish territorial waters, and a body that could not be retrieved.

**Greig Walker:** This point has not come out in evidence yet. Section 5 is on the North Sea oil and gas area and, unlike section 7, it has no requirement for repatriation, which is continuing with the provisions of the 1976 act. The committee should be aware that if, heaven forbid, there was a North Sea accident and the bodies could not be recovered, that would not preclude an FAI under current law. I imagine the factors that distinguish that situation from one that happens abroad abroad, so to speak, is that it deals with an area of Scots law, eyewitnesses who speak English and can speak to the fiscal and so on. It is quite different from an oil operation on the other side of the world.

**The Convener:** On the other hand, having reformed the law—if the bill is passed—you would not want to be in the position where a death abroad fulfils all the criteria for an FAI, but there wouldn’t be one because there was no body. It might be possible to establish a cause of death and to have an inquiry. You would not want to be in the position of not being able to do that. Such circumstances might be very rare, but the law tends to throw up the unexpected just when you think that everything is in place.

**Paul Wheelhouse:** I agree. I heard so much testimony from Mr and Mrs Beveridge about Blair’s case that it sprang to mind that a British-registered vessel could mean a good prospect of getting co-operation from the company involved, which we probably would have had in that situation. There was an unexplained death, but if an eyewitness had seen something or heard a splash or heard someone shouting as they fell overboard, it would have helped us to understand that it was likely that a death had occurred. It would then be worth investigating how that death had occurred and the nature of the incident that led to the individual falling overboard.

We are flexible about the bill and will look at what we can do. We want to be realistic with the committee and not raise expectations that an inquiry would automatically lead to an explanation for the death; it will be more difficult without the body, unfortunately.

**Elaine Murray:** In your opening statement, you gave some indications about why you think that the sheriff’s recommendations should be published on the SCTS website rather than on the Scottish Government’s website. Would you expect the SCTS to monitor compliance with the sheriff’s recommendations?

**Paul Wheelhouse:** You are correct that I made that point in my opening remarks and I firmly believe that it would be advantageous for the SCTS to publish the response to the sheriff’s recommendations. I do not want to overstate the point but it would probably give more credibility to the process if the sheriff gives recommendations and response is made to the sheriff about whether those recommendations will be taken forward and if not, why not. That would help the process.

On the point that you made about the monitoring of those recommendations, that would probably be a resource issue that the SCTS would face. Section 26 provides for the dissemination of the sheriff’s determination to each person to whom a recommendation is addressed and any other person whom the sheriff considers has an interest in the recommendation. That could clearly include any regulatory body with power to implement change, possibly on a UK-wide basis. I would hope that if a recommendation had implications for health and safety or environmental issues, the regulatory bodies would monitor the performance of the person or persons to whom the
recommendation was addressed in respect of whether they took the steps recommended by the sheriff. So, in some way, shape or form, a relevant organisation or body would monitor progress. As a whole, on the issue that you might be getting at as to whether the SCTS should monitor overall performance and how many recommendations are followed through, I do not think it would be realistic for us to expect the SCTS to do that within its resource.

**Elaine Murray:** In that case do you envisage the Lord Advocate or the Scottish ministers having an oversight role?

**Paul Wheelhouse:** The difficulty with the Government or indeed the Lord Advocate as Scotland's senior law officer doing that is that there is no policy intention in the bill to monitor recommendations centrally. Each set of recommendations is made with respect to an individual inquiry and is particular to that situation, albeit that if recommendations are disseminated to a regulatory body they probably have wider implications that are being flagged up to that body. I would hope that they would be addressed at that point by that body, rather than through the Lord Advocate, myself or another minister pushing the case. Clearly we would have an interest in anything that had implications for Scottish Government policy. Indeed, it is possible that the sheriff would disseminate recommendations to the Scottish Government or UK Government where it is relevant to do so. We would have an interest at that point.

**Roderick Campbell:** I have a supplementary question, convener.

**The Convener:** I do not know whether Elaine Murray has finished.

**Elaine Murray:** Not completely, but—

**The Convener:** Just proceed—do not let Rod Campbell barge in.

**Elaine Murray:** Patricia Ferguson proposed that the sheriff's recommendations be legally binding. I understand from the explanatory note why ministers have chosen to reject that suggestion. Would you be prepared to consider legal sanctions against those who fail to respond to a sheriff's recommendations, as a sort of contempt of court-type process?

**Paul Wheelhouse:** I do not believe that that would be helpful. I will try to explain why, although I am happy to look at the issue. What we are trying to have is an inquisitorial inquiry and to get as much help as possible from all the parties involved who might have a role in helping us to understand how somebody has died, the circumstances and what lessons we can learn. The more potential we create for an inquiry to be seen as threatening for those bodies to be involved or to be engaged with, the more we might undermine the process of trying to get to the truth.

However, I take the point; clearly, if there was something that had the potential to save lives, I would hope that that would be flagged up to the Health and Safety Executive, the Scottish Government or UK Government as necessary and that we as legislators could take it forward. If an issue was as fundamental as that, whichever appropriate Government or agency could regulate to ensure that action happened more widely. That is one of the reasons why it would be useful to disseminate sheriffs' recommendations to the regulators to ensure that they take on board those messages and ensure that regulation is kept up to date, with evidence of potential dangers to people at work. I would hope that we could achieve the outcome that Dr Murray wants without having to threaten anyone with a legal sanction for failing to deliver on recommendations.

**Elaine Murray:** Is it your principal concern that a legal sanction would make the process more adversarial?

**Paul Wheelhouse:** We are certainly trying to avoid it becoming adversarial and getting to a situation in which everyone has to be tooled up with lawyers to take part in an inquiry. Clearly there are circumstances in which lawyers need to be present and to act on behalf of families if they need someone to advocate their concerns or raise their questions. Equally, we do not want it to become a gladiatorial or adversarial environment. We want people to be able to speak freely and get to the truth as to what happened to that individual or individuals and to answer why they died, how they died and what could be done to prevent those circumstances from happening again. The less legalistic we can keep it, the better—although we have a sheriff overseeing the process to use their legal knowledge to ensure that it is conducted fairly and with rigour. We want to avoid the inquiry being seen as a challenging setting in which people close up the doors, bring down the shutters and do not want to participate.

I do not know whether Hamish Goodall might be able to add anything about the consultation responses on that point.

**Hamish Goodall:** There was fairly strong support for the proposals in the Government's bill, which basically require that a party to whom a recommendation is addressed is obliged to respond.

They do not have to comply with a sheriff's recommendation, which, after all, is only a recommendation—it does not bestow rights and obligations. They have to respond to say what they have done in relation to compliance, what
they intend to do or, if they are not going to comply, why they are not going to comply. If they do not respond at all, that fact will be noted beside the sheriff’s determination on the SCTS website. That is as far as we think we can go. It will become public knowledge that a body has not responded.

The Crown Office tells us, however, that in the vast majority of cases the people to whom recommendations are addressed take them very seriously. I suggest that it is unlikely that there will be many instances in which parties choose not to respond at all.

Paul Wheelhouse: The other aspect of this, which I add for Dr Murray’s benefit, is that we were trying to arrive at a situation in which sheriffs did not feel reluctant to make recommendations because they might be too onerous or difficult for the organisation to respond to. If we allow the sheriffs freedom to recommend, using their best judgement, what they think would be helpful to avoid a similar situation arising in future, that would give the sheriffs maximum scope to make their points.

We hope that organisations can respond in the manner that Hamish Goodall has set out. They can either respond positively, in that they take forward the recommendation, or, if that is not practical or is economically unfeasible for some reason, they can respond as to why that is the case, and that will help to inform the process. In turn, that may inform the regulators as to what is realistic and practical for that company, or even that sector, to do across the board. We hope that it will keep the information flowing and that even a negative response may yield useful information that might be used by regulators or others to inform future policy.

Roderick Campbell: In his evidence on 19 May, Mr Tom Marshall called for responses to be made to the sheriff rather than to the SCTS, as a way of keeping the inquiry process open. I am not sure whether you have fully touched on that.

One of the other things that Mr Marshall put forward in his written submission of 22 May is that the Justice Committee itself could monitor recommendations and responses as part of Parliament’s policy of assessing the effectiveness of legislation.

Do you have any comments on those points?

Paul Wheelhouse: I do not want to determine the role of the Justice Committee; it is for the Justice Committee to determine what it feels is its appropriate role in this area.

The point about reporting is an important one. Since Roderick Campbell mentions him, I make the point that even Tom Marshall has said that “it is unrealistic to have a mandatory inquiry in every case of industrial disease”. — [Official Report, Justice Committee, 19 May 2015, c.9.]

He has also made points that are supportive of the reporting process.

I think that it is important that we have scrutiny of the individual decisions that are made by companies or organisations in response to sheriffs’ recommendations. My personal view is that it would not necessarily be appropriate for the Justice Committee to do that, but if the Justice Committee felt that it should have that role, I would not prevent it. Post-legislative scrutiny is a very important function of the Parliament and is perhaps something that we should do more of.

The sheriff’s role is finished after the determination. That is because it would probably be time consuming for sheriffs to oversee the process of responses to recommendations coming back, and it would perhaps be inappropriate for them to do so when they have to take on other cases.

Clearly, as Hamish Goodall has said, if information is presented that suggests why an organisation has not been able to take forward a recommendation, it is open to regulators and others, including those concerned about the practices in that organisation, to flag the matter up. Of course, reputational issues would be raised, too. I hope that the process will be effective in driving change in the organisations to which recommendations have been made. It will not necessarily be appropriate for sheriffs to continue to play a role after that, given that they have a judicial rather than a monitoring and evaluating function.

12:30

The Convener: I understand that you might not have seen Tom Marshall’s response, given that we received it only this morning. Is that correct?

Paul Wheelhouse: I have not seen it, convener.

The Convener: I am sorry—I was a bit distracted by whether responses had to be published. I see that, under section 27(5)(a), they have to be, which is important.

Jayne Baxter: I want to ask about delays, minister. Do you think that Lord Cullen’s proposal of an early hearing would speed up proceedings and have a positive impact on the process?

Paul Wheelhouse: I certainly recognise Jayne Baxter’s point about the need to avoid unnecessary delays. The bill is designed to make the process of delivering an FAI more efficient and effective, and anything that we can do to smooth things and ensure that the process happens as effectively as possible will be helpful.
I was not present for the Solicitor General’s evidence, but I have been made aware of the point that she made about a milestone charter. I think that that is a constructive suggestion, and I understand that she is going to come back to the committee on it. In a sense, it would mean that, in the three-month interval that the Solicitor General referred to, the Crown Office would review where it was at with an inquiry and what needed to be done to ensure that it happened and that any delays were kept to a minimum. As I have said, that is a very constructive suggestion that will, I hope, largely deal with the intent behind Lord Cullen’s recommendation.

It is also worth stating for the record that the Crown Office has in recent years made significant efforts to keep families themselves better informed about the progress of death investigations. We are obviously open to any points that the committee might make in its report, but we believe that, as a result of those efforts, there is no need to hold in every case the hearings that Lord Cullen suggested. Moreover, the Lord President made a valid point when he said:

“I would not like the court to be put in the position of exercising some supervisory role over the Crown’s decision-making process, as that would give rise to a serious constitutional issue.” — [Official Report, Justice Committee, 19 May 2015; c 37.]

The Convener: Can I just stop you there, minister? This morning, the Crown said that it would bring a charter—

Paul Wheelhouse: Yes—the milestone charter.

The Convener: —to the committee before stage 2. That should be helpful.

Paul Wheelhouse: I believe so, convener. It is a very positive move by the Solicitor General, and I think that it will help to deal with what I am sure is the intention of committee members to ensure that families are kept well informed and that everything is done to bring forward inquiries as quickly as possible. The flexibility that the bill provides with regard to accommodation should also help in that respect.

Jayne Baxter: Do you think that the COPFS is adequately resourced to take on what are not necessarily new roles but enhancements to its existing role? Will there be resource implications in that respect as time goes on?

Paul Wheelhouse: I hope that the Crown Office will raise with the justice board any problems with resourcing the provisions, that problems will be dealt with at that level and that recommendations for any changes that might be necessary are made. However, the proposal that the Solicitor General has made is an efficiency measure that will help to ensure good co-ordination with regard to the commencement of an inquiry and minimise any risks of potentially unnecessary costs arising as a result of delays or any problems in the initial process. In some ways, the costs involved can be seen as preventative spend, as they will ensure that the inquiry happens more smoothly, that it happens in the appropriate location and that it is resourced appropriately.

I hope that the approach will not be particularly onerous for the Crown Office, but we will keep things under close watch, see whether any issues arise as the legislation is applied and help the Crown Office if necessary. I should point out, though, that the Crown Office is obviously aware of the bill, has looked at the financial memorandum and is comfortable with the figures in it.

Alison McInnes: The committee currently has in front of it a couple of active petitions relating to how the COPFS carries out death investigations. Have you given any consideration to whether there is scope for introducing a review process that families can use if they are unhappy about the way in which a death investigation has been carried out?

Paul Wheelhouse: I would be happy to take on board any points or specific concerns that have been raised on that matter. We have seen the Crown Office bring in family liaison positions, although the extent to which they are deployed in local sheriffdoms may vary from one area to another. We would like to ensure that there is consistency in that process.

Judicial review is the due legal process in these situations. We can certainly address that in due course. Perhaps once we have had a chance to reflect on the evidence that the committee has received, we can come back.

Alison McInnes: As part of that reflection, will you consider whether it would be appropriate for a sheriff to be invited to adjudicate on whether it was appropriate that an investigation had been closed?

Paul Wheelhouse: If I may, convener, I will ask Greig Walker to address that point. He is earning his crust today, as you can see. [Laughter.]

The Convener: We are missing you already, Mr Walker.

Greig Walker: There are two points. Alison McInnes used the word “scope”, but this is a bill about inquiries; it is not about the investigation stage. Perhaps the charter that will be published can address that point, but I suggest that it is not for inclusion in the bill.

The point about a sheriff having a greater role sits squarely in the territory of the Lord President’s concerns about constitutionality. The Scottish tradition—which, as we heard, predates coroners—is to have discretion in investigating
deaths; a sheriff review of that is something that the judges are not comfortable with. As the minister said, although I would not encourage this to happen routinely, Crown decisions can be judicially reviewed under the ordinary grounds for judicial review.

**Alison McInnes:** Thank you.

**The Convener:** I think that this is the final question. I do not expect you to pull this rabbit out of the hat just now, minister, but can you provide the committee with information about the cost to the legal aid fund of supporting families at FAIs in the past three years? Although an FAI is in the public interest, families have a great interest themselves in what takes place, and they quite often require legally aided representation. It would be helpful to know what the costs of legal aid are and to hear any other comment that you might wish to make about legal aid for families.

**Paul Wheelhouse:** I agree that the issue is important. The inquiry is there to establish, in the public interest, what has happened to an individual or individuals; to find the cause of death; and to learn lessons and disseminate those lessons and recommendations.

Although this is not their statutory purpose, we recognise the very important role that inquiries play in providing a service to families that helps them to understand what happened to a loved one. In many cases, families may wish to raise questions that a procurator fiscal would not raise, because the procurator fiscal has a specific role and is acting for the public interest.

The role of the Scottish Legal Aid Board is to make legal aid available where a person entitled to be represented at an FAI can show that they have concerns that a procurator fiscal would not otherwise raise. Any application for legal aid will be subject to the usual three statutory—which

**The Convener:** I know all that stuff; sorry, minister, but time presses on. The Government has said that it will not go ahead with Lord Cullen's recommendations on legal aid on cost grounds. We would like you to spell that out. We need to know what has been given in the last three years and why. I know about the reasonableness test, but these circumstances are very difficult from a civil case.

**The Convener:** I know all that stuff; sorry, minister, but time presses on. The Government has said that it will not go ahead with Lord Cullen's recommendations on legal aid on cost grounds. We would like you to spell that out. We need to know what has been given in the last three years and why. I know about the reasonableness test, but these circumstances are very difficult from a civil case.

**Paul Wheelhouse:** We will certainly look at trying to provide the figures that you seek for the committee's benefit. The Scottish Human Rights Commission acknowledged in its evidence to the committee that there was no ECHR issue with the current provision of legal aid for FAIs. We have not seen any changes in circumstances that would cause the Scottish Government to revisit its attitude to the provision of legal aid for FAIs. As I think you know, we are doing work on legal aid at the moment, and I will take your point into the remit of that work and look at whether there is any scope—

**The Convener:** This is a sweeping-up question. The bill removes the sheriff's power to award expenses. Why does it do that when people might feel that, if someone abuses process, expenses should be awarded against them for costing the court and everybody else time and money?

**Hamish Goodall:** Expenses are awarded in civil litigation, and a fatal accident inquiry is not civil litigation. We believe that, if someone is behaving vexatiously at a fatal accident inquiry, the sheriff has sufficient case management powers to be able to deal with that, without any award of expenses—

**The Convener:** Is it not the case that sheriffs can award expenses if someone has been vexatious?

**Hamish Goodall:** I believe that there was one case recently, which—

**The Convener:** So you are changing the position. Why?

**Hamish Goodall:** Because we do not feel that it is appropriate. As I say, expenses are awarded in civil litigation, and a fatal accident inquiry is not civil litigation.

**Greig Walker:** There is a wider picture in the background, which concerns the Courts Reform (Scotland) Act 2014. The civil courts review moved all the civil courts, with all their hats on, towards much more active case management, so the power to make court rules has been expanded. The power in the bill before us for the Lord President to make FAI rules is, again, expanded, with the expectation that there will be much more in the way of active case management at all stages than has been the case to date.

We are saying that, rather than let parties get away with murder and punish them later, the sheriff will, from the outset, be able to stop people wasting time, so there should be no wasted costs or expenses for anyone.

**The Convener:** We will hold you to that, if it is not going to be in the bill.

Thank you very much for your evidence. I am conscious of the time, minister, so once you have had the opportunity to look at the evidence from our earlier witnesses this morning, if there is anything that you have not had the opportunity to discuss and which we have not questioned you on, please feel free to give us your comments.

**Paul Wheelhouse:** Thank you, convener.
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The remit of the Delegated Powers and Law Reform Committee is to consider and report on—

a. any—
   i. subordinate legislation laid before the Parliament or requiring the consent of the Parliament under section 9 of the Public Bodies Act 2011;
   ii. [deleted]
   iii. pension or grants motion as described in Rule 8.11A.1; and, in particular, to determine whether the attention of the Parliament should be drawn to any of the matters mentioned in Rule 10.3.1;

b. proposed powers to make subordinate legislation in particular Bills or other proposed legislation;

c. general questions relating to powers to make subordinate legislation;

d. whether any proposed delegated powers in particular Bills or other legislation should be expressed as a power to make subordinate legislation;

e. any failure to lay an instrument in accordance with section 28(2), 30(2) or 31 of the 2010 Act; and

f. proposed changes to the procedure to which subordinate legislation laid before the Parliament is subject.

g. any Scottish Law Commission Bill as defined in Rule 9.17A.1; and

h. any draft proposal for a Scottish Law Commission Bill as defined in that Rule.
Committee Membership

**Convener**
Nigel Don
Scottish National Party

**Deputy Convener**
John Mason
Scottish National Party

Margaret McCulloch
Scottish Labour

John Scott
Scottish Conservative and Unionist Party

Stewart Stevenson
Scottish National Party
Introduction

1. At its meetings on 28 April and 19 May, the Delegated Powers and Law Reform Committee considered the delegated powers provisions in the Inquiries into Fatal Accidents and Sudden Deaths etc. (Scotland) Bill (“the Bill”). The Committee submits this report to the lead committee for the Bill under Rule 9.6.2 of Standing Orders.

2. The Bill was introduced by the Cabinet Secretary for Justice on 19 March 2015. It makes provision to reform and modernise the law governing the holding of fatal accident inquiries (FAIs) in Scotland. It largely implements the legislative recommendations made in the 2009 Review of Fatal Accident Inquiry Legislation, led by the Rt. Hon. The Lord Cullen of Whitekirk KT, the former Lord President of the Court of Session.

3. The current law on FAIs is contained in the Fatal Accidents and Sudden Deaths Inquiry (Scotland) Act 1976 (“the 1976 Act”). The Bill repeals the 1976 Act and re-enacts it with modifications. It continues to provide for the Lord Advocate to be head of the system of investigation of deaths in Scotland, and for mandatory public inquiries to be held in relation to certain deaths. It also continues to provide that a discretionary inquiry may be held under certain circumstances, and for public inquiries into deaths to be held in the sheriff court.

4. However, the Bill also makes a number of changes to the current system, including adding a further category of mandatory FAI (where a child dies while in secure accommodation), and permitting a discretionary inquiry to be held into the death of a Scottish person abroad (other than service personnel), where the person’s body has been repatriated to Scotland. Procedural changes include provision enabling an FAI to be held in any sheriffdom in Scotland regardless of the place of death or any accident causing the death, and enabling the Lord Advocate to initiate further judicial proceedings into a death which has already been the subject of an FAI.

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i Inquiries into Fatal Accidents and Sudden Deaths etc. (Scotland) Bill [as introduced] available here: http://www.scottish.parliament.uk/S4_Bills/Fatal%20Accidents%20(Scotland)%20Bill/b63s4-introd.pdf
Delegated Powers and Law Reform Committee
Inquiries into Fatal Accidents and Sudden Deaths etc. (Scotland) Bill at Stage 1, 31st Report,
Session 4, (2015)

Delegated Powers Provisions

5. The Scottish Government provided the Parliament with a memorandum on the delegated powers provisions in the Bill ("the DPM"). The Committee first considered the Bill at its meeting on 28 April 2015. At that meeting, the Committee agreed that it did not need to draw the attention of the Parliament to the following powers:

- Section 11(1) – Places at which inquiries may be held
- Section 39(1) – Ancillary provision
- Section 40(2) – Commencement
- Schedule 1, paragraph 2(1) – Transitional arrangements

6. At the same meeting, the Committee agreed to write to the Scottish Government to raise questions on the powers in section 34(1) (power to regulate procedure etc.). The correspondence was considered by the Committee at its meeting on 19 May 2015 and is reproduced at the Annex.

iii Inquiries into Fatal Accidents and Sudden Deaths etc. (Scotland) Bill Delegated Powers Memorandum available here: http://www.scottish.parliament.uk/S4_Bills/FAI_DPM.pdf
Recommendation

7. The Committee comments on the powers in section 34(1) as follows:

Provision

8. Section 34(1) confers wide powers on the Court of Session to make rules by act of sederunt to regulate (a) the practice and procedure to be followed at FAIs in the sheriff court, and (b) matters which are incidental or ancillary to such FAIs. Section 7 of the 1976 Act currently confers power on the Scottish Ministers to make rules about FAIs. Section 34 of the Bill widens the rule-making powers and confers them on the Court of Session, with a view to enabling the Court “to make the kind of comprehensive and self-contained powers envisaged by Lord Cullen”.

9. Section 34(2) contains an illustrative list of examples of the provision which may be made under the general power in subsection (1), but subsection (1) is not limited by those specific examples. The examples include: provision about the process by which a person becomes a participant in an inquiry; action to be taken by the procurator fiscal before the start of an inquiry; and the giving and publication of responses to any recommendations made by a sheriff in the course of his or her determination.

10. Other sections of the Bill set out additional matters which an act of sederunt under section 34(1) must or may make provision about. Provision must be made under section 34(1) about matters to be dealt with at a preliminary inquiry hearing and about things that the procurator fiscal and participants in the inquiry must do before such a hearing (section 15(4)). Provision must also be made about the agreement of facts before an inquiry (section 17(1)). Provision may be made about a number of additional procedural matters including: categories of persons who must be given notice of the hearing of an inquiry (section 16(2)(b)); the powers of the sheriff in relation to inquiry proceedings (section 18(2)(b)); and the process which a sheriff must follow in deciding whether part of a determination is to be withheld from publication (section 26(5)).

11. By virtue of section 34(3), an act of sederunt under subsection (1) may make the full range of ancillary provision, i.e. incidental, supplemental, consequential, transitional, transitory or saving provision.

12. Before making the act of sederunt, the Court of Session must consult the Scottish Civil Justice Council (“SCJC”), and take into consideration any views expressed by the SCJC. Those requirements do not apply where the act of sederunt embodies draft rules submitted to the Court by the SCJC.

13. The power is subject to the ‘laid only’ procedure provided for under section 30(2) of the Interpretation and Legislative Reform (Scotland) Act 2010. Regulations are not subject to further Parliamentary scrutiny.
Comment

14. The Committee notes that this is an extremely wide power to make provision about practice and procedure in FAI proceedings, and matters incidental or ancillary to FAIs. It mirrors the powers conferred on the Court of Session by the Courts Reform (Scotland) Act 2014 ("the 2014 Act") to make rules of practice and procedure in the Court of Session (section 103 of that Act) and in the sheriff court (section 104). The DPM explains that in the Government’s view, it is appropriate for rules of practice and procedure at inquiries to be set out in secondary legislation made by the Court of Session, as is the position for the rules of courts and tribunals.

15. The Committee is content in principle with delegation of the power to the Court of Session, to be exercised by act of sederunt. Regarding the scope of the power however, the Committee notes that the Parliament is being asked to confer a much wider power on the Court than is currently conferred on the Scottish Ministers by section 7 of the 1976 Act. The Committee also notes that while it is appropriate for the Court of Session to regulate practice and procedure at inquiries without parliamentary interference, the Bill should also respect matters which are properly reserved to the legislature and Ministers.

16. In correspondence with the Committee, the Scottish Government explained that maximum flexibility is required to deliver Lord Cullen’s recommendation regarding inquiry powers. It pointed out that the power is in the same terms as the powers conferred on the Court of Session in sections 103 and 104 of the 2014 Act.

17. The Committee considers however that the Scottish Government has not explained why the 2014 Act powers constitute a relevant precedent. Those powers were conferred in the context of giving the Court of Session far-reaching powers to reform its own procedures and practice as part of a radical overhaul and modernisation of the civil court system. The Committee notes that the same powers may not be needed to bring about the more modest reforms to inquiry proceedings which are contemplated by this Act.

18. The Scottish Government also explained its view that the power in section 34(1)(b) is limited by the implicit requirement that there must be a material connection to fatal accident inquiries. While the Committee agrees that this is the case, it notes that it is not only matters of practice and procedure which might have a material connection to FAIs; matters of substance might also have such a connection.

19. With regard to the boundary between matters which go beyond practice and procedure but are related to it, and matters which are more substantive in nature, the Scottish Government does not consider that the substantive rights of persons at an inquiry could be incidental or ancillary to an inquiry. What is designed to be caught by section 34(1)(b) are matters relating to proceedings at an inquiry. Given that section 34(1)(b) currently refers to "matters which are incidental or ancillary to an inquiry", the Committee accordingly recommends that the wording of section 34(1)(b) be tightened to more accurately reflect that policy intention.

20. Further, in the Government's view, "the courts are well placed to determine which matters relate to practice and procedure (e.g. the conduct and management of inquiry proceedings) and matters which are of a more substantial nature". The Committee notes however that there will be no-one, other than the courts themselves,
to enforce the manner in which the Court of Session uses the powers to make rules. Exercise of the powers will not be subject to parliamentary scrutiny, and the executive cannot require the powers to be used in a particular way because the Scottish Ministers are, by statute, independent of the Court.

21. Separately, the Committee notes the additional power in section 34(3) of the Bill to make incidental or supplemental provision in an act of sederunt made under section 34(1)(b) of the Bill. That power is being taken in addition to the wide power discussed above to make provision for or about any matter incidental or ancillary to an inquiry. The effect is that power is being conferred on the Court of Session to make provision which is incidental or supplemental to provision for or about a matter which is already incidental or ancillary to an inquiry. In the Committee’s view, that substantially widens the scope of matters about which provision can be made in inquiry rules, and potentially extends it even further beyond matters of procedure and practice.

22. The Scottish Government's response explains that section 34(3) is a narrower power than section 34(1)(b) in that provision made under it must be linked to other provision made by the act of sederunt itself, which must in turn be limited to matters which are incidental or ancillary to an inquiry. The Committee accepts that section 34(3) is narrower in scope than section 34(1)(b). However, the Government's response does not address the point that section 34(3) widens the scope of section 34(1)(b), and the Committee was seeking some justification for that. In particular, the response does not explain why the extra flexibility is required, beyond once again referring to the precedent in the 2014 Act.

23. The Committee does not therefore consider that the Scottish Government has made a convincing case about why the court also needs to be able to do things which are incidental or supplementary to matters which are in themselves already incidental to inquiry proceedings. Accordingly the Committee draws this matter to the lead committee’s attention.

24. The Committee accordingly (a) recommends that the power in section 34(1)(b) is narrowed so as to limit the ancillary power to matters ancillary to inquiry proceedings in line with the policy intention explained in the Scottish Government’s response and (b) draws the lead committee's attention to the general breadth and scope of section 34(1) of the Bill.

25. The justification given for the width of the power is the need for maximum flexibility to implement the recommendations arising from Lord Cullen’s review. A further justification is that the 2014 Act confers powers in the same terms on the Court of Session to make rules about proceedings in that court and in the sheriff court. However in the Committee’s view the Scottish Government has not explained why the 2014 Act powers constitute a relevant precedent. Those powers were conferred in the context of giving the Court of Session far-reaching powers to reform its own procedures and practice as part of a radical overhaul and modernisation of the civil court system.

26. The Committee notes that the same powers may not be needed to bring about the more modest reforms to inquiry proceedings which are contemplated by this Bill.
27. The powers in section 34(1) are supplemented by power in section 34(3) to include in an act of sederunt provision which is incidental or supplemental to provision for or about any matter incidental or ancillary to an inquiry.

28. The Committee draws the lead Committee’s attention to the fact that this provision widens even further the scope of matters about which provision may be made in inquiry rules, and that in the Committee’s view the Scottish Government has not provided a satisfactory reason for taking the additional power.

29. Lastly, the Committee draws the lead committee’s attention to the proposal in the Bill that inquiry rules made by act of sederunt under section 34(1) of the Bill would not be subject to any parliamentary procedure, and as such were the Parliament to be concerned about the Court’s interpretation as to what was incidental to an inquiry, provision made under these powers could not be subject to annulment by the Parliament.
Annex

Correspondence with the Scottish Government

On 29 April 2015, the Delegated Powers and Law Reform Committee wrote to the Scottish Government as follows:

Section 34(1) – Power to regulate procedure, etc.

Power conferred on: the Court of Session
Power exercisable by: act of sederunt
Parliamentary procedure: laid, no procedure

Provision

1. Section 34(1) confers wide powers on the Court of Session to make rules by act of sederunt to regulate (a) the practice and procedure to be followed at FAIs in the sheriff court, and (b) matters which are incidental or ancillary to such FAIs. Section 7 of the 1976 Act currently confers power on the Lord Advocate to make rules about FAIs. Section 34 of the Bill widens the rule-making powers and confers them on the Court of Session, with a view to enabling the Court “to make the kind of comprehensive and self-contained powers envisaged by Lord Cullen”.

2. Section 34(2) contains an illustrative list of examples of the provision which may be made under the general power in subsection (1), but subsection (1) is not limited by those specific examples. The examples include: provision about the process by which a person becomes a participant in an inquiry; action to be taken by the procurator fiscal before the start of an inquiry; and the giving and publication of responses to any recommendations made by a sheriff in the course of his or her determination.

3. Other sections of the Bill set out additional matters which an act of sederunt under section 34(1) must or may make provision about. Provision must be made under section 34(1) about matters to be dealt with at a preliminary inquiry hearing and about things that the procurator fiscal and participants in the inquiry must do before such a hearing (section 15(4)). Provision must also be made about the agreement of facts before an inquiry (section 17(1)). Provision may be made about a number of additional procedural matters including: categories of persons who must be given notice of the hearing of an inquiry (section 16(2)(b)); the powers of the sheriff in relation to inquiry proceedings (section 18(2)(b)); and the process which a sheriff must follow in deciding whether part of a determination is to be withheld from publication (section 26(5)).

4. By virtue of section 34(3), an act of sederunt under subsection (1) may make the full range of ancillary provision, i.e. incidental, supplemental, consequential, transitional, transitory or saving provision.

5. The Committee therefore asks the Scottish Government:

In the context of providing a broad discretion to the Court to regulate inquiry practice and procedure without parliamentary interference, but also to respect matters properly reserved to the legislature and Ministers—
The limits of the power in section 34(1)(b) to make provision for or about any matter incidental or ancillary to an inquiry;

whether such power permits the Court to make provision in relation to matters other than procedure and practice in inquiry proceedings, including issues of substance relating to inquiry proceedings;

the interaction between the power in section 34(1)(b) and the power in section 34(3), and in particular why the Court requires the power in section 34(3) to make provision which is incidental or supplemental to matters which are in themselves incidental or ancillary to inquiries.

On 8 May 2015, the Scottish Government responded as follows:

As a preliminary point, the Scottish Government would point out that the functions of the Lord Advocate referred to were transferred to the Secretary of State by virtue of the Transfer of Functions (Lord Advocate and the Secretary of State) Order 1999 (S.I. 1999/678), and from the Secretary of State to the Scottish Ministers by virtue of section 53 of the Scotland Act 1998. Therefore the most recent revising instrument in relation to the current inquiry rules (S.S.I. 2007/478) was made by the Scottish Ministers. The Scottish Government also makes the general point that consistency has been sought with the rule-making powers in the Courts Reform (Scotland) Act 2014.

In response to each of the 3 points put to the Scottish Government:

• The power in section 34(1)(b) is limited by the implicit requirement that there must be material in connection to fatal accident inquiries. It would not be sufficient to rely on section 34(1)(a) only because there may be a need for rules about matters that are not strictly matters of practice or procedure. Relevant precedents are sections 103(1)(b) and 104(1)(b) of the Courts Reform (Scotland) Act 2014. The Scottish Government considers that the approach proposed allows for maximum flexibility to deliver Lord Cullen’s recommendation concerning inquiry rules – the broadening of rule-making powers is deliberate in this regard whilst remaining limited by the main purpose of the power.

• The Scottish Government does not consider that the substantive rights of participants in an inquiry, or other persons, could be considered to be incidental or ancillary to the inquiry. The Government’s view therefore is that the power in section 34 could only be used to regulate matters relating to proceedings at an inquiry. The courts are well placed to determine which matters relate to practice and procedure (e.g. the conduct and management of inquiry proceedings) and matters which are of a more substantial nature.

• Section 34(3) is the narrower power in that provision made under it must be linked to other provision made by the act of sederunt itself; further the power is also limited by the main purpose of the power in subsection (1). The power in section 34(1)(b) is more substantive in that it enables provision to be made about matters that are incidental or related to procedure or practice, even where the act of sederunt might not otherwise be making provision about practice or procedure. Again, the relevant precedents are sections 103(3) and 104(4) of the Courts Reform (Scotland) Act 2014.
We hope that the Committee will find the information provided helpful.
Inquiries into Fatal Accidents and Sudden Deaths etc. (Scotland) Bill: The Committee agreed its approach to the delegated powers provisions in this Bill at Stage 1.
Inquiries into Fatal Accidents and Sudden Deaths etc. (Scotland) Bill (in private): The Committee considered further the delegated powers provisions in this Bill at Stage 1.
Inquiries into Fatal Accidents and Sudden Deaths etc. (Scotland) Bill (in private): The Committee agreed the contents of a report to the Justice Committee.
PRESENT:

Nigel Don (Convener)  James Kelly (Committee Substitute)
John Mason (Deputy Convener)  John Scott
Stewart Stevenson

Apologies were received from Richard Baker.

**Inquiries into Fatal Accidents and Sudden Deaths etc. (Scotland) Bill:** The Committee considered the Scottish Government's response to its Stage 1 report.
Inquiries into Fatal Accidents and Sudden Deaths etc (Scotland) Bill: Stage 1

11:55

The Convener: The purpose of this item is for the committee to consider the delegated powers in the Inquiries into Fatal Accidents and Sudden Deaths etc (Scotland) Bill at stage 1. Members have seen the delegated powers memorandum and the briefing paper.

The committee is invited to agree the questions that it wishes to raise with the Scottish Government on the delegated powers in the bill. It is suggested that those questions are raised in written correspondence. The committee will have the opportunity to consider the responses at a future meeting before the draft report is considered.

Section 34(1) confers wide powers on the Court of Session to make rules by act of sederunt to regulate: first, the practice and procedure to be followed at fatal accident inquiries in the sheriff court; and, secondly, matters that are incidental or ancillary to such FAIs. Section 7 of the Fatal Accidents and Sudden Deaths Inquiry (Scotland) Act 1976 currently confers power on the Lord Advocate to make rules about FAIs. Section 34 of the bill widens those rule-making powers and confers them on the Court of Session.

Section 34(3) provides that

"An act of sederunt under subsection (1) may make ... incidental, supplemental, consequential, transitional, transitory or saving provision"

and

"different provision for different purposes."

In the context of providing a broad discretion to the court to regulate inquiry practice and procedure without parliamentary interference, but also to respect matters properly reserved to the legislature and ministers, does the committee agree to ask the Scottish ministers to explain: first, the limits of the power in section 34(1)(b) to make provision for or about any matter incidental or ancillary to an inquiry; secondly, whether such power permits the court to make provision in relation to matters other than procedure and practice in inquiry proceedings, including issues of substance relating to inquiry proceedings; and thirdly, the interaction between the power in section 34(1)(b) and the power in section 34(3), and in particular why the court requires the power in section 34(3) to make provision that is incidental or supplemental to matters that are in themselves incidental or ancillary to inquiries?
Stewart Stevenson: We have had some of this discussion previously. I am content to allow this to go through without too much comment, but I suspect that this is the sort of thing that Parliament in future—our successors in office—should tuck away as perhaps being suitable for post-legislative scrutiny once it has seen how the legislation pans out and how the powers that we are highlighting are exercised in practice. I put that on the record for future generations.

The Convener: Do we agree to ask those questions?

Members indicated agreement.
Inquiries into Fatal Accidents and Sudden Deaths etc. (Scotland) Bill (in private): The Committee agreed its approach to the Financial Memorandum.
Note: (DT) signifies a decision taken at Decision Time.

Inquiries into Fatal Accidents and Sudden Deaths etc. (Scotland) Bill: The Minister for Community Safety and Legal Affairs (Paul Wheelhouse) moved S4M-14328—That the Parliament agrees to the general principles of the Inquiries into Fatal Accidents and Sudden Deaths etc. (Scotland) Bill.

After debate, the motion was agreed to (DT).
Inquiries into Fatal Accidents and Sudden Deaths etc (Scotland)
Bill: Stage 1

The Deputy Presiding Officer (Elaine Smith):
The first item of business this afternoon is a debate on motion S4M-14328, in the name of Paul Wheelhouse, on the Inquiries into Fatal Accidents and Sudden Deaths etc (Scotland) Bill.

14:32
The Minister for Community Safety and Legal Affairs (Paul Wheelhouse): I am delighted to open the stage 1 debate on the Inquiries into Fatal Accidents and Sudden Deaths etc (Scotland) Bill. I thank the Justice Committee for its consideration of the bill and of Patricia Ferguson’s Inquiries into Deaths (Scotland) Bill, which I shall speak about shortly.

In 2008, Lord Cullen, the former Lord President of the Court of Session, was asked to undertake a review of the fatal accident inquiry legislation and his review team undertook a comprehensive and thorough review, reporting in November 2009. Lord Cullen made 36 recommendations for reform of the system. Some were addressed to the Crown Office and Procurator Fiscal Service and have already been implemented, principally by the establishment in 2010 of the Scottish fatalities investigation unit, which now oversees death investigations in Scotland.

The SFIU provides advice to procurators fiscal who investigate deaths locally, liaises with Crown counsel on complex death investigations and liaises with the bereaved family or families. Approximately 11,000 deaths are reported to the Crown Office each year. Fiscals conduct investigations in around half of those cases—about 5,500 deaths—and an average of between 50 and 60 FAsIs are held per year. Thus, the overwhelming majority of deaths that are investigated by procurators fiscal do not result in a fatal accident inquiry because it is not deemed to be necessary.

Lord Cullen’s aim was to set out practical measures for an effective, efficient and fair system for inquiry. That is also the aim of the Scottish Government’s bill. It will build on Lord Cullen’s recommendations that were implemented by the Crown Office to make the system more efficient, for example by greater use of preliminary hearings and by more flexible accommodation arrangements for FAsIs. It will ensure that FAsIs remain inquisitorial fact-finding hearings.

FAsIs are not meant to hold people to account, as the media occasionally mistakenly suggest. They do not apportion blame or guilt in the civil or criminal sense; that is for civil or criminal proceedings. FAsIs are inquisitorial judicial inquiries that are held in the public interest to establish the circumstances of sudden, suspicious or unexplained death or deaths that have caused serious public concern. The sheriff will consider what steps, if any, might be taken to prevent other deaths in similar circumstances.

The bill will rationalise and extend the categories of death in which it is mandatory to hold a fatal accident inquiry and include deaths of children in secure accommodation and deaths under police arrest, irrespective of location. It will, for the first time, permit discretionary FAsIs into deaths of Scots abroad. I thank the family of Blair Jordan for sharing their experiences with me following Blair’s death off the coast of Japan in 2009.

With regard to deaths abroad, the Government is minded to take into account concerns raised by the Justice Committee to remove the requirement that the body must be repatriated before such an inquiry might take place. There might be occasions when a body has been lost or is otherwise not available for examination or post mortem. It is right that in such exceptional circumstances the possibility of a death investigation and potentially an FAI into a death abroad should not be lost. That will be an advance on English law and practice where there would be no coroner’s inquest in the absence of a body in those circumstances.

The bill will, for the first time, permit FAsIs to be reopened if new evidence arises or, if the new evidence is so substantial, to permit a completely new inquiry to be held. Sheriffs will be permitted to disseminate determinations to regulatory bodies, which can implement any recommendations made. Finally, and crucially, the bill will, for the first time, place a requirement on those to whom sheriffs direct recommendations at the conclusion of an inquiry to respond and to indicate what action they have taken or, if they have not taken action, to explain why not.

Sheriffs make recommendations in around a third of all FAsIs for precautions that might be taken to prevent deaths in similar circumstances in the future. The response, or lack of response, to a recommendation will be published along with the sheriff’s determination to create a public record. That procedure will replicate the system used under coroners’ inquests in England and will foster compliance with sheriffs’ recommendations in a transparent way.

The question of delays in holding an FAI has often been cited as one of the main concerns with the system of FAsIs. Lord Cullen opposed the introduction of statutory timescales. He believed that the complexity and diversity of FAsIs meant
that timescales would be counterproductive. Rigid timescales might mean that the FAI might not achieve the aim of finding out the cause of death and any recommendations by which it might have been avoided. That view was confirmed by 80 per cent of respondents to the Scottish Government’s consultation on legislative proposals.

There are very often legitimate and unavoidable reasons for delays between the date of death and the beginning of an FAI, such as the need to wait for the outcome of other investigations by bodies such as the Health and Safety Executive or the Air Accidents Investigation Branch; the possible need to obtain expert advice; the need to consider whether criminal proceedings are appropriate; and, above all, the overriding necessity of conducting death investigations thoroughly—that factor is of particular relevance in relation to the complexity of some investigations, especially those involving medical cases and of course helicopter crashes.

Like the Justice Committee, I welcome the commitment by the Solicitor General for Scotland to produce a charter for families. That will provide clarity regarding what information the bereaved family will be provided with at the different stages of a death investigation and how and when that information will be communicated to them by the Crown Office.

It is proposed that the Crown Office will offer to meet bereaved families within three months after the date that the death has been reported to it to give them an update on the progress of the death investigation, the likelihood of criminal proceedings and the possibility of an FAI. The charter will also explain the different stages of a death investigation and set out the commitments of the Crown Office in terms of keeping in touch with relatives.

The Scottish Government is minded that the bill should be amended at stage 2 with a provision that will underpin the charter, as helpfully suggested by Patricia Ferguson, whose interest in FAIs is, I know, driven by her experience of the Stockline tragedy. A charter with statutory status should address concerns over delays and communication, and it should complement the provisions in the bill to make the FAI system more efficient. I am happy to work with Patricia Ferguson on such an amendment.

The Scottish Government has been discussing with the United Kingdom Government proposals to permit deaths in Scotland of service personnel in the course of their duties to be the subject of a mandatory FAI. Following representations that I have made to the UK Government, I am delighted to be able to tell members that the UK Government has given its in-principle agreement that it should be possible for a mandatory FAI to be carried out for such deaths, in the same way that such deaths would be subject to a coroner’s inquest if they occurred in England or Wales. I commend Flt Lt James Jones for bringing that important matter to the attention of the Scottish Government and the Parliament.

That change to the law will not, however, be effected by amending the bill. The matter falls within the defence reservation, and thus the change will have to be achieved by means of an order under section 104 of the Scotland Act 1998. I have written to all relevant UK ministers to inform them of our intention to seek a section 104 order.

I would like to take a moment to explain why there are some matters that are not provided for in the Scottish Government’s bill.

There is no provision in the Government’s bill for mandatory FAIs for deaths resulting from industrial disease or exposure to hazardous substances. That is because, as the Solicitor General confirmed in her evidence before the Justice Committee, the Lord Advocate can exercise his discretion to have an inquiry, particularly in cases involving a new type of industrial process or a new disease, where there would be public concern about the issues. There is little, if any, value in terms of public interest in holding an FAI into a death resulting from an industrial disease where the dangers are already well known and well acknowledged.

There is no provision in the Government’s bill for mandatory FAIs for the deaths of detained or voluntary mental health patients. Neither the Mental Welfare Commission for Scotland nor the Royal College of Psychiatrists believes that it is necessary or even desirable to hold mandatory FAIs in such cases. Indeed, there is concern that doing so might prove distressing to the bereaved family. The Royal College of Psychiatrists described the proposal as “unduly legalistic, in that it will impose large numbers of elaborate, expensive and drawn-out judicial procedures upon families, clinicians and services with no discernible benefit in prospect to justify it.”

Members will be aware that section 37 of the Mental Health (Scotland) Act 2015 requires ministers to carry out a review within three years of the arrangements for investigating the deaths of compulsorily detained mental health patients or those who were admitted voluntarily for treatment for a mental disorder. Section 37 arose from an amendment proposed by Dr Richard Simpson during parliamentary consideration of the bill, and the Government accepted the desirability of a statutory review in the context described in section 37. I do not believe that it would be appropriate or sensible to legislate to extend the mandatory category in relation to deaths of mental health patients in advance of the work of that review.
I turn now to Patricia Ferguson’s Inquiries into Deaths (Scotland) Bill. Although I do not support the bill, I pay tribute to the work that Patricia Ferguson has done over the past couple of years in relation to the system of fatal accident inquiries, which has been informed by her involvement with helping families affected by the Stockline tragedy. Although Ms Ferguson originally claimed that her proposals would implement Lord Cullen’s recommendations in his review, she now believes that they do not go far enough. However, I note that in some respects Ms Ferguson’s bill contradicts Lord Cullen’s conclusions.

The Government believes that its bill is a proportionate response to Lord Cullen’s recommendations to reform the system of FAIs. Criticism of the system has arisen from some high-profile and controversial cases, but some of them did not even result in an FAI, because the circumstances of death were established in criminal proceedings. Some of Ms Ferguson’s proposals are, in our opinion, inappropriate and unworkable, and we believe that they would have potentially a significant negative impact on the Crown Office, the Scottish Courts and Tribunals Service and the legal aid fund, which is why we urge members to resist them.

The Faculty of Advocates has said:

“The proposed Inquiries into Deaths (Scotland) Bill put forward by Patricia Ferguson could result in FAIs becoming longer, more complex and more expensive, when the aim was to make the process quicker and more transparent.”

The faculty goes on to say:

“We think certain aspects of the proposed Bill have the potential to encourage FAIs to become adversarial in nature as opposed to inquisitorial.”

I know that that is not what Patricia Ferguson intends to happen, but we share the view of the Faculty of Advocates, which also said:

“Other unintended and unwelcome consequences … are the increase in the length, complexity and additional expense of FAIs, and potential for injustice arising from the provisions relating to the enforcing of recommendations.”

I know that Patricia Ferguson has amended some of her original proposals, but the main planks of her bill remain largely untouched. In particular, there are two areas of it where, regretfully, the Scottish Government believes the reforms suggested might not be workable: first, the proposal to make sheriffs’ recommendations legally binding and appealable, with criminal sanction in the event of non-compliance; and, secondly, mandatory inquiries for deaths from industrial diseases.

I have already set out the Scottish Government’s position in relation to the latter; in terms of the former, I welcome Patricia Ferguson’s argument in the explanatory notes for her bill that a sheriff’s determination should be inadmissible in evidence and should not be founded on in other judicial proceedings—that is also what the Scottish Government’s bill provides. The Scottish Government entirely agrees that that is an essential element of the distinction between, on the one hand, the fact-finding, inquisitorial nature of an FAI, with the sheriff empowered to make recommendations; and, on the other hand, the fault-finding, adversarial nature of other legal proceedings.

It is not the purpose of an FAI to establish liability for negligent actions. As Ms Ferguson has suggested, if liability arises from a death, a civil case is the forum where those matters are examined. That statement of principle is, however, undermined by the provision in Ms Ferguson’s bill to make sheriffs’ recommendations enforceable with an appeal process.

The suggestion that an FAI might be held before the sheriff personal injury court is another example of where we disagree with Ms Ferguson. Personal injury actions are adversarial proceedings that seek to establish negligence as grounds for the payment of damages as redress, whereas FAIs are inquisitorial actions that do not apportion blame or guilt and are thus a completely different legal specialism.

Patricia Ferguson’s bill would effectively turn FAIs into preliminary hearings for subsequent civil action. That is opposed by many stakeholders, including Lord Cullen, Lord Gill and the Health and Safety Executive.

I have met Patricia Ferguson on a few occasions throughout the process to try to find common ground, and I am happy to continue to do so. I am pleased that we have found areas in which we can work together in taking forward the Government’s bill.

In summary, the law relating to fatal accident inquiries in Scotland has not been revisited for almost 40 years and therefore never before by the reconvened Scottish Parliament. Lord Cullen has identified areas for reform and, thanks to the charter that the Crown Office is introducing, bereaved families will be kept fully informed of the progress of a death investigation and the likelihood of criminal proceedings or the potential for an FAI. For those cases that proceed to an FAI, the Scottish Government’s bill provides for a coherent, proportionate and modernised system of fatal accident inquiries that is fit for the 21st century.

I will be lodging technical amendments at stage 2 to improve and clarify the bill, in the spirit of the inquisitorial principle that the Government is inviting the Parliament to endorse today. I intend to work closely with Patricia Ferguson to put the
Crown Office’s charter on a statutory footing. I commend the motion in my name, and I thank members for their time.

I move,

That the Parliament agrees to the general principles of the Inquiries into Fatal Accidents and Sudden Deaths etc. (Scotland) Bill.

The Deputy Presiding Officer: I note at the start of the debate that we have a little bit of time in hand this afternoon.

14:46

Christine Grahame (Midlothian South, Tweeddale and Lauderdale) (SNP): I welcome the opportunity to speak as convener on behalf of the Justice Committee, which is the lead committee considering the bill. As members are aware—I remind them for good measure—“on behalf of” means exactly that. I am not speaking in a personal capacity, so I will not veer off piste.

I thank all those who took the time to provide evidence to the committee and in particular those family members who told us about their frustrations with the justice system over the investigations into the tragic deaths of their loved ones. It is not easy to come before a parliamentary committee at any time, and especially not when pain at the death of loved ones is, as always, very near the surface. I also put on record my thanks to hard-working committee members and the hard-working clerking team.

I, too, acknowledge Patricia Ferguson’s ongoing and extensive work in the area of FAIs. As part of our consideration of the Government’s bill, we heard evidence on her related bill on FAIs, which has informed the committee’s thinking with regard to the current FAI process. We published a separate stage 1 report on Patricia Ferguson’s bill; I understand that it will be debated next week, so I will not explore it in any detail in my speech today.

I should make clear that our scrutiny of the Government’s bill predated the recent FAI into the tragic events that happened last Christmas, and therefore the issues that were raised in that FAI are not reflected in our report in any way.

The committee unanimously supports the general principles of the bill, which we consider to be essential in updating a law that was enacted almost 40 years ago. We hope that the bill will be used as an opportunity to provide more clarity and understanding around FAIs, especially for those who have lost loved ones in often tragic and unexplained circumstances. It cannot be emphasised enough, however, that an FAI is held by the Crown in the public interest, as indeed are criminal prosecutions under common law.

We have made a number of recommendations that are aimed at improving certain aspects of the bill. In the time available, I will refer to a few of them; no doubt other members will elaborate.

Johann Lamont (Glasgow Pollok) (Lab): Did the committee look at the definition of what is in the public interest? In my experience, the definition is drawn so narrowly that issues that people feel would be of public concern are excluded from an FAI.

Christine Grahame: No—I think that it would be very dangerous for us to interfere with the independence of the Lord Advocate, who takes the decision on what is and what is not in the public interest. I will refer to that issue when I come to my point about families who are told why there will not be an FAI.

The subject of delays and the role of families are important. In evidence, we heard about a real lack of clarity and understanding about the role of the bereaved family in an FAI. That cannot be emphasised often enough. Again, quite understandably, relatives may have the understanding that the FAI is on behalf of the deceased. We understand why that is, but I stress again that an FAI is held in the public interest. An FAI is not a trial, and if there is the prospect of a criminal prosecution the FAI may be delayed until a decision is made in that regard.

There was concern not just about those aspects, which are important, but about a perceived lack of communication with families at various stages of the often lengthy process, and about decisions not to hold an FAI when it is not mandatory. In that regard, we welcome the requirement that the Lord Advocate will provide written reasons for a decision not to hold a discretionary FAI, but we consider—I highlight to Johann Lamont—that reasons should be given whether or not a request is made. In other words, reasons should be given whether or not the family makes a request, so that there is some explanation to relatives of why it has been decided that it is not in the public interest to have an FAI.

Although one of the main criticisms of the current system was the lengthy delays between a death and the start of an FAI, we understood that there could be good reasons for that, not least, as I have said, to establish whether criminal proceedings are appropriate. However, families told us that they often received little communication or explanation about what was happening in the intervening period. I stress again that we should always bear in mind that families are grieving and that, for all sorts of reasons, an FAI will be an additional ordeal.

The committee was therefore encouraged when the Solicitor General for Scotland announced to us
that the Crown Office is working on the milestone charter—to which the minister referred—to clarify what the bereaved family should expect from the process. I welcome, too, the minister’s commitment in his response to the committee’s report that he will lodge an amendment to place the charter on a statutory basis.

As the minister said, mandatory FAIs are currently held when a death occurs in Scotland either as a result of a work-related accident or when the deceased was in legal custody at the time of death. The former does not apply to the armed forces or indeed to police officers on duty. To give some context, I will repeat what the minister said, which was that death investigations are carried out by the Crown Office and Procurator Fiscal Service in roughly half the deaths—about 11,000 a year—that are reported to the procurator fiscal. Only some 50 to 60 of those result in an FAI.

We heard from some witnesses that mandatory FAIs should be held in a number of circumstances in addition to those that are specified in the bill, for example after the death of a person detained under mental health legislation or after the death of a looked-after child, as such cases can involve some of the most vulnerable people in our society. Others did not think that it was necessary or proportionate to hold an FAI in each and every case.

The committee asked the Scottish Government to consider the issue further. I note that the minister has concluded that the decision in those cases should be left to the Lord Advocate, acting in the public interest.

We welcome the provision in the bill to allow FAIs to be undertaken when a death has occurred abroad, but we were concerned about the particular stipulation that, for an FAI to be undertaken into such a death, the body must be repatriated. We felt that there could be circumstances in which there would be sufficient evidence to hold an FAI without the repatriation of a body—for example when someone is lost at sea—and we recommended that the Scottish Government should lodge an amendment at stage 2 to allow for some discretion in that area. I therefore welcome the minister’s commitment to do just that.

The committee was surprised to hear that mandatory FAIs are not held into the deaths of military service personnel in Scotland. Such deaths would be subject to a mandatory coroner’s inquest if they occurred in England and Wales. FAIs can be held into the deaths of Scottish service personnel that occur abroad. The committee was therefore concerned about the situation in Scotland and was keen for the Scottish Government to look into the issue further. I note the minister’s response that a change would need to be achieved through an order under section 104 of the Scotland Act 1998, as the matter is reserved. I am encouraged—I think that the committee would be encouraged, too—that the UK Government has, in principle, agreed that such deaths in Scotland should be treated in the same way as they are in England and Wales. That issue was raised with the committee by a member of the public and I commend him for his resolve in pursuing the matter.

The committee welcomes the proposals in the bill to require sheriff’s recommendations to be published and to oblige those to whom they are directed to respond. There was general agreement among witnesses that the recommendations should be published on the Scottish Courts and Tribunals Service website, as proposed in the bill.

Patricia Ferguson (Glasgow Maryhill and Springburn) (Lab): Like the committee convener, I would welcome that move. However, does she agree that the final report of perhaps a yearly return should be laid before the Parliament?

Christine Grahame: I return to what I said as a caveat at the beginning of my speech, which was that I speak with my convener’s hat on. Members have that on the record but I cannot comment on it today. However, I have no doubt that the minister heard it and can comment.

Some witnesses felt that the Scottish Government or another body should take a more active role in ensuring that the recommendations are implemented, while others highlighted the difficulties in placing a duty on a particular body to do that. On balance, the committee considered that the requirements in the bill were sufficient. I note that the minister, in his response, highlighted that the bill’s provisions in that area broadly replicate the system in England and Wales, which he believes is appropriate and workable.

I have touched on some of the issues that were raised in evidence during the committee’s stage 1 consideration of the bill, but I am sure that other committee members will wish to pick up some of the areas that I have not had time to cover. I look forward to hearing other contributions in the debate and to debating Patricia Ferguson’s member’s bill next week.

Elaine Murray (Dumfriesshire) (Lab): On behalf of Labour members, I thank the clerks, the Scottish Parliament information centre and the witnesses who contributed to our stage 1 consideration.

On 7 March 2008 the justice secretary at the time, Kenny MacAskill, announced a review of the
Fatal Accidents and Sudden Deaths Inquiry (Scotland) Act 1976, which was to be conducted by the Rt Hon Lord Cullen of Whitekirk, a former Lord President of the Court of Session. A debate took place in the Scottish Parliament on 27 March 2008, led by the Lord Advocate, during which members of all parties expressed concern over the functioning of the 1976 act. Lord Cullen reported in November 2009, but it took until 2011 for the Scottish Government to publish its response, and it took a further three years for it to publish a consultation on proposed legislative change, which it did in July 2014. The Government bill was finally introduced on 19 March this year, five and a half years after Lord Cullen had reported.

The Justice Committee agreed to the general principles of the Inquiries into Fatal Accidents and Sudden Deaths etc (Scotland) Bill, which takes forward some, but not all, of the recommendations of Lord Cullen’s 2009 report on his review of fatal accident inquiry legislation. However, that was not the only bill to address the recommendations. While the committee took evidence on the Government bill, it also considered the alternative approach that was offered by Patricia Ferguson’s member’s bill: the Inquiries into Deaths (Scotland) Bill.

Members who, like me, sat in this Parliament in 2004 will recall the support that Patricia Ferguson gave to her constituents who were affected when ICI’s Stockline Plastics factory exploded on 11 May 2004, with the loss of nine lives. Her experience of supporting her constituents and her frustration at the lack of action by the Scottish Government following Lord Cullen’s review in 2009 led her to draft a proposal for a member’s bill in August 2013 and, following consultation, to introduce her bill in November last year.

The Justice Committee’s stage 1 report makes reference to the member’s bill and the ways in which it differs from the Government bill, but it does not make recommendations about the member’s bill. Instead, the committee published a shorter stage 1 report on Ms Ferguson’s bill and it anticipated that both bills’ stage 1 debates might take place on the same day. I do not know whether we made a formal recommendation to that effect, but it certainly seemed to be the favoured way forward when we discussed our reports on both bills. I understand, however, that Scottish Government officials thought that it might be too confusing for members to consider two bills that cover the same area of policy on the same day. In the Justice Committee we frequently have more than one bill before us on the same day.

Labour members are disappointed that we are not debating both bills on the same day. I tabled an amendment to the stage 1 motion on the general principles of the Inquiries into Fatal Accidents and Sudden Deaths etc (Scotland) Bill, which reflected the Justice Committee’s recommendations on how proposals in the two bills might be considered together. Unfortunately, my amendment was not selected for debate today, despite assurances from the chamber desk that it was competent.

The current legislation—the Fatal Accidents and Sudden Deaths Inquiry (Scotland) Act 1976—limits mandatory fatal accident inquiries to deaths in work-related accidents or deaths that occur in legal custody. The Lord Advocate has discretion to decide not to hold a mandatory FAI into deaths in work-related accidents or deaths that occur in legal custody if the circumstances of the deaths have been established during criminal proceedings. If it is in the public interest and lessons can be learned to prevent similar deaths from occurring in future, the Lord Advocate can also decide to hold a fatal accident inquiry in other circumstances if a death is sudden, suspicious or unexplained.

The bill does not take forward a number of Lord Cullen’s recommendations. For example, he recommended that the scope of the bill be extended to include children who die in residential care, other than secure accommodation, and deaths of people during compulsory detention by a public authority.

The Scottish Human Rights Commission agreed with Lord Cullen that fatal accident inquiries should be mandatory for deaths of persons who are held in mental health detention. However, in a case in which the Mental Welfare Commission for Scotland’s investigation had established the circumstances of the death, the Lord Advocate would have discretion not to hold a fatal accident inquiry. Families against corporate killers agreed with the position of the Scottish Human Rights Commission, considering that people who are held in compulsory detention are amongst some of the most vulnerable.

In order to keep families informed of progress, Lord Cullen suggested that an initial early court hearing be held shortly after the reporting of the death to the Crown Office and Procurator Fiscal Service. In evidence to the Justice Committee, he went even further and suggested that an earlier meeting take place to inform family members about process and timescales. However, the status that such a meeting would have was unclear, and, given that the Solicitor General’s recently published milestone charter should cover the information that would be included in such a meeting, the committee felt that this early meeting would not add anything.

Under the bill, fatal accident inquiries remain mandatory where someone dies in a work-related accident or in legal custody; the mandatory
category is extended to children who are kept in secure accommodation; and discretionary fatal accident inquiries are extended to deaths abroad where the body is repatriated. A number of witnesses including the National Union of Rail, Maritime and Transport Workers, which represents workers employed at sea, argued that the bill should give the Lord Advocate discretion to hold an FAI without the body being repatriated, as lessons could still be learned in such circumstances. We welcome the Scottish Government’s response that it intends to lodge an amendment at stage 2 to allow the Lord Advocate discretion to permit a fatal accident inquiry in some circumstances when it has not been possible to retrieve the body. We also welcome the provisions in the bill that enable an FAI to be reopened under certain circumstances.

As has been mentioned, a strange anomaly was uncovered during the bill’s consideration as a result of evidence from a member of the public. I think that it came as a surprise to committee members and the ministers that fatal accident inquiries cannot be held for service personnel on active service who die in Scotland, even though in England and Wales coroner’s inquests can be held in such circumstances. We were advised that that was because service personnel are appointees of the Crown, not employees. I welcome the minister’s announcement that the UK Government is considering what I think is called a section 140 amendment, because of the reserved aspects, and I hope that the matter will soon be resolved to enable the families of service personnel who die in Scotland to have the death of their loved one investigated in the same way that it would be if the person had died in England and Wales.

Addressing delays in holding fatal accident inquiries and keeping families informed of progress were major concerns for committee members, who heard a number of possible routes in that respect. Bereaved families should be central to the fatal accident inquiry process and they and the appropriate trade unions and staff associations must be kept informed and enabled to participate. The draft milestone charter, which has already been referred to, sets out commitments to bereaved families on the timescales by which certain communications with families should take place at various stages in the process. Bereaved families must be better included in the inquiry process and I look forward to the stage 2 amendments that, as the minister indicated, will place the charter on a statutory footing and improve accountability to families.

In its briefing on the bill, the Law Society voices concern that Lord Cullen’s recommendation regarding the provision of legal aid to families without their having to demonstrate reasonableness is not reflected in the bill. It points out that because FAs are fact-finding inquiries in the public interest they can be very complex and families might be in particular need of legal advice.

The Government bill requires that, where the Lord Advocate decides not to hold an FAI, whether it be discretionary or mandatory, written reasons be provided to families on request. In its stage 1 report, the committee recommended that the requirement that the information be requested be removed and that the information be provided to families as a matter of course.

Lord Cullen suggested that the Scottish Government publish sheriff’s recommendations, and the Government bill proposes that that be done via the Scottish Courts and Tribunals Service website, instead of the Scottish Government publishing the material itself. However, it is not clear on whom the duty to monitor the implementation of such recommendations would rest. That is a particular concern; for example, in its briefing, the Law Society comments that no sanction appears to be proposed against parties that fail to comply or co-operate with the sheriff’s recommendations.

Patricia Ferguson hoped to address the matter in her bill by enabling a sheriff to make legally enforceable recommendations where appropriate; in other words, the party at which the recommendation was aimed would be within Scottish jurisdiction and the recommendation would be capable of being enforced. As currently drafted, Ms Ferguson’s bill does not make that as clear as it could be but, during the committee’s evidence-taking session on her bill, Ms Ferguson mentioned amendments to the bill, and I think that that would have been the effect of those amendments. If that solution is not enforceable, we urge the Government to consider how enforceability can be strengthened under its own proposals, because we believe that that is still an omission in the bill that will lead to the distress of families whose loved ones have died in those particular circumstances.

Scottish Labour will vote for the bill at stage 1, but we do so very much in the hope that some of the suggestions that have been made by our colleague Patricia Ferguson in her bill will be included as amendments at stages 2 and 3.

15:05

Margaret Mitchell (Central Scotland) (Con): I welcome the stage 1 debate on the Inquiries into Fatal Accidents and Sudden Deaths etc (Scotland) Bill. I thank the many witnesses for their valuable contributions and the Justice Committee clerks for their work in delivering a comprehensive report.
It was the evidence that was provided by one witness, Flt Lt James Jones, that highlighted that no mandatory FAIs are carried out in Scotland following the deaths of service personnel abroad. I am therefore pleased that agreement in principle has been reached with the UK Government to ensure that a mandatory FAI can be held in those circumstances, in the same way as investigations into such deaths are carried out by a coroner in England and Wales.

I acknowledge and pay tribute to the extensive work that Patricia Ferguson has done on her bill, which covers the same policy area and which we will discuss more fully next week.

In 2008, in recognition of the fact that FAIs required significant reform and modernisation, Lord Cullen carried out a review. The treatment of bereaved families and the lengthy delays to the commencement of inquiries, aggravated by patchy communication from the Crown Office and Procurator Fiscal Service, formed the basis that prompted many of the review recommendations and the subsequent provisions in the Inquiries into Fatal Accidents and Sudden Deaths etc (Scotland) Bill. The affected families have already endured the distress and pain of losing a loved one and, although FAIs are undertaken in the public interest, they undoubtedly significantly help to offer resolution and much-needed closure for relatives.

However, some important recommendations that Lord Cullen made in his review are not in the bill, including the suggestion of holding an early hearing when an FAI is mandatory. When he gave evidence to the committee, Lord Cullen said that he proposed such a procedure

“simply to let the families and other persons who are directly involved know what is going on so they can be satisfied that all proper steps are being taken to progress matters.”—[Official Report, Justice Committee, 5 May 2015; c 5.]

Stakeholders had mixed responses to that suggestion, with campaigners broadly in favour of the idea. Lord Gill, on the other hand, expressed doubts that formal meetings were necessary when the same outcomes could be achieved if the Crown established

“good protocols of conduct whereby the relatives would be kept in touch.”—[Official Report, Justice Committee, 19 May 2015; c 37.]

Significantly, Lord Cullen stated:

“If the COPFS has made improvements such that fears about the family not being kept fully in the picture are groundless, that makes an early hearing of the type that I described ... unnecessary.”—[Official Report, Justice Committee, 5 May 2015; c 5.]

In response to some of that evidence and the legitimate concern that there is a pressing need to reduce the unacceptable delays that adversely affect bereaved families, the Solicitor General committed to producing a milestone charter. It outlines what families can expect from the COPFS in relation to the timings of investigations and decision making. The priority must be to keep relatives informed while concentrating the minds of the COPFS on the work that must be done to avoid delays.

The committee has yet to receive a draft of the charter—perhaps the minister could give us some idea of the timescale for when it will be available—but, if it measures up to expectations, it will most certainly be a positive step forward.

I turn next to the Cullen review recommendation that a mandatory FAI should be held when someone was, at the time of their death, subject to compulsory detention by a public authority, which would include detention under mental health legislation. During evidence sessions, concerns were expressed about how the deaths of those who were detained under mental health legislation are investigated in practice. However, in considering its stage 1 report, the committee concluded that there is no need for mandatory FAIs in such circumstances, because some deaths of those who were detained under mental health legislation are straightforward—for example, they clearly result from natural causes.

Given that those who are detained under mental health legislation are some of the most vulnerable in our society, I revisited Lord Cullen’s review and noted that he states that

“even investigations into deaths by natural causes may reveal unsafe conditions ... it is in the public interest that an FAI should be held into the deaths of those detained by the state, especially those who are most vulnerable.”

Therefore, even in the case of so-called straightforward deaths, such as deaths from natural causes—and despite the comments from the Mental Welfare Commission and others, to which the minister referred—I believe that there are still many issues to consider before rejecting the need for a mandatory FAI to be carried out. There is merit in revisiting the issue at stage 2.

I would like to highlight two further areas. The first is the withdrawal of the reasonableness test—to which Elaine Murray referred—for legal representation for the deceased’s relatives. Although I appreciate that it is not an access to justice question in the conventional sense, Lord Cullen emphasised that the crucial question is

“whether there is a public interest ... in families having that degree of support.”—[Official Report, Justice Committee, 5 May 2015; c 8.]

I urge the Scottish Government to consider the question carefully at stage 2. Secondly, Lord Cullen recommended the creation of a central team to co-ordinate and monitor FAIs. That idea
seems sensible and there is a precedent for it in the form of the domestic abuse task force.

If the improvements to the bill are to be realised, it will be vital for the Crown Office and Procurator Fiscal Service, which is already under immense strain, to have the resources in place to deal with FAIs efficiently and effectively. I confirm that the Scottish Conservatives support the general principles of the bill.

The Deputy Presiding Officer: We are fortunate to have a little time in hand, so I can allow speeches of a generous six minutes.

15:12

Roderick Campbell (North East Fife) (SNP): I apologise to the chamber for the fact that I will not be able to stay for the full debate because I have another pressing engagement. I refer members to my registered interest as a member of the Faculty of Advocates.

In the light of recent events in another part of the country, it is fair to say that there is greater interest in fatal accident inquiries than there has been for many a long year. Accordingly, it cannot be overemphasised that the purpose of an FAI is not to address issues of criminal behaviour. Such issues really need to be resolved before an FAI can proceed meaningfully. An FAI should be about learning lessons from the past that can be applied in the future.

The bill is the result of Lord Cullen’s deliberations, but it does not follow his recommendations totally, as Margaret Mitchell said. For example, on matters such as an individual’s death in a setting where they have been detained, such as a mental hospital, he reaffirmed his view that it should be a mandatory requirement that an FAI take place, whereas the Government favours the Lord Advocate having discretion. In my view, the difficulty of having a mandatory requirement is that it would inevitably require procedures to be adopted that would have no meaningful impact, in most cases, on the key issue of learning lessons for the future.

What is important is that there is a clear understanding of matters such as what a graduated scheme of investigations means in practice. As Cathy Asante of the Scottish Human Rights Commission suggested in oral evidence, we need to ensure that article 2 of the European convention on human rights is properly respected. I am pleased by the minister’s responsive attitude to suggestions of optimal best practice in that area.

Whatever else there ought to be, there should be an acceptance that the families and friends of people who die in such circumstances need assurance that the demise of their nearest and dearest has not given rise to any issues that require answers. In most cases of death by natural causes, that will be true. Of course, we have to accept that, in considering article 2—the right to life—when an inquiry is required, case law suggests that any inquiry must be independent, effective, prompt and subject to public scrutiny, with the next of kin involved.

However, I am mindful that, since we took evidence, the Mental Health (Scotland) Act 2015 has been passed, with a requirement that a review of the arrangements for investigating the deaths of such patients be carried out within three years of the legislation coming into force. Any further information that the minister can give on that review would be welcomed.

On timescales for carrying out FAIs, we obviously need reasonable expedition, and I can see the case for statutory timetables but, in practice, that might lead simply to an extra hurdle without necessarily bringing matters to an earlier conclusion. We should therefore rely on a commitment to good practice from the Crown Office.

On the question of requiring the Crown to explain why no discretionary FAI will take place, I am encouraged by the milestone charter and the Government’s support for the charter having statutory underpinning. A strong commitment to keeping relatives informed about progress is essential.

On the question of the provision of written reasons to relatives as to why an FAI is not being held, I appreciate the Crown’s response to the committee’s recommendations but, for me, the key issue is that families know that they have a right to request FAIs.

In relation to suggestions that the sheriff’s recommendations should be legally binding, I am on the side of those who believe that, if that were adopted, it would fundamentally change the nature of an FAI. As Lord Cullen suggests, an FAI is not for the purpose of establishing rights, duties and obligations. As Tom Marshall of the Society of Solicitor Advocates said,

“One of the values of the inquiry process is that it ought to be an open process in which people should not be taking sides, because the object is to get the facts into the open and to bring as much information to light as possible, so that lessons can be learned.”—[Official Report, Justice Committee, 19 May 2015; c 13.]

As for issues of compliance and who has a duty, if any, to monitor, the aim must be for recommendations and responses to be easily available on the Scottish Courts and Tribunals Service website. Regarding a comment that Patricia Ferguson made, I am certainly open to a
wider dissemination of that information, although we ought to appreciate that that might have cost implications.

I turn to FAIs into the deaths of service personnel in Scotland. We heard evidence from Flt Lt Jim Jones about the difficulties of holding FAIs in Scotland for members of the forces who die in Scotland. The 1976 act refers to a requirement to hold an FAI when someone dies in the course of their employment or occupation, which has been held to exclude both servicemen and—I believe it is also argued—police officers. That led to the somewhat odd situation that an FAI took place into the helicopter tragedy in the Mull of Kintyre some 20 years ago only because there were also civilian deaths. That distinction, which is based on the royal prerogative, seems to have long outlived its usefulness. In civil cases it seems to be ignored, and it remains alien to the inquest procedure south of the border. In that respect, Scotland needs to learn from its southern neighbour.

I am grateful for the minister’s earlier comments on the matter, which I noted carefully. As I have servicemen in my constituency, some of whom I will be meeting tonight, it would be good to be able to advise them that, should they die unexpectedly in the course of their duties, a mandatory FAI would at least be a possibility.

15:18

Patricia Ferguson (Glasgow Maryhill and Springburn) (Lab): As we have heard, it is now seven years since the Scottish Government commissioned Lord Cullen to review the system of fatal accident inquiries, and it is six years since he delivered his report, so I am genuinely very glad that we are now in a position where a bill based on his report is being debated.

My member’s bill—the Inquiries into Deaths (Scotland) Bill, which also considers how FAIs should operate—was in part a reaction to the lack of progress from the Scottish Government, but it was also an attempt to make more radical reforms than those proposed by Lord Cullen or indeed by the Scottish Government. That has always been my position.

The most important people in the process should be the bereaved families. It is they who have suffered the greatest loss, and they deserve to know why the death of their loved one occurred and to know that everything possible is being done to prevent such tragedies in the future. It has been suggested to me—we have heard this view today—that FAIs should be about the public interest rather than about individual families, but how can an inquiry be in the public interest if it does not have at its heart those who are most directly affected by it?

It is fair to say that the Scottish Government and I differ on a number of areas and a number of points of policy, but I have no doubt that the minister sincerely wishes to make the system better. He needs to go further, and I will outline where the Scottish Government’s bill must be strengthened at stage 2.

As members know, the Justice Committee has recommended that the Scottish Government’s bill is the best vehicle to reform the system and has urged the Scottish Government and me to collaborate—that is a good word. As the minister indicated, we met yesterday to consider how that might be done. In the spirit of that collaboration, I wrote today to the Parliament’s clerk to withdraw my bill with immediate effect. I did not take that decision lightly, but I took it in the expectation that the Scottish Government will continue the collaboration that began yesterday and in the hope that it can still be moved on a number of points. I do not have time to comment on every issue that I have with the Scottish Government’s bill, but I will highlight some particularly important points.

I welcome the draft milestone charter drawn up by the Crown Office and Procurator Fiscal Service. It outlines various stages that follow from a sudden or unexpected death and provides a timetable within which family members will be informed of decisions being made. That is welcome. In the case of an FAI, the charter states that family members will be advised within 14 days of Crown counsel issuing instructions. That is a really welcome step forward but—this is a big but for me—the problem is often the time that Crown counsel takes to make the decision, not the time that is taken to communicate the decision once it is made.

I realise that the circumstances of a death are complicated and that other investigations must take place before an FAI is held, but families understand that too, which is why we must get the framework for that communication right. I appreciate that the minister now agrees with me that those provisions should be enshrined in law and I will work with the Scottish Government on amendments to give effect to them. However, whatever changes Parliament ultimately makes, there should be no situations in the future in which people are left for four or five years without even knowing whether an FAI will take place.

I accept that the Scottish Government is carrying out reviews of issues that are connected to the sudden deaths of patients who were detained under mental health legislation and to the situation of looked-after children. I am pleased that that work is being undertaken but—I do not want to make too much of a point of this, but I will make the point nevertheless—I hope that the findings of those reviews will be implemented more quickly.
than Lord Cullen’s review of FAIs was. I am not quite persuaded that we need to wait for those reviews to be completed, and I will reflect on that before stage 2. However, the approach is a step forward.

The Scottish Government and I still disagree on whether the findings of an FAI should be enforceable. The Scottish Government suggests, as others have done, that making the sheriff’s recommendations enforceable would turn an inquisitorial inquiry into an adversarial one. Can the minister really say that FAIs are never adversarial under the current system? The events of this summer suggest that some are extremely adversarial and, if we ask any lawyer, family member or trade union official who has attended an FAI, they will tell us that, when a worker and an employer are involved, FAIs can be very adversarial indeed.

The nature of an FAI should surely not be a reason for discounting enforcement when and if—and only when and if—a sheriff deems it necessary. I have cited before examples such as those at Bellgrove and Newton where, if the sheriff’s initial recommendations had been enforced, the second fatal accident would have been unlikely to occur.

Surely the Parliament should seek to do all that it can in the legislation that it passes to prevent such fatalities. We have heard a lot today about the public interest; I describe preventing fatalities as being in the public interest. I am pleased to note that the Law Society of Scotland seems to be coming closer to agreeing with me on that point, and I sincerely hope that the Scottish Government will accept the amendments that I will lodge on the issue at stage 2.

Given that I have withdrawn my bill, I hope that the Presiding Officer will allow me to thank the Justice Committee and its clerks for their consideration and scrutiny of both bills. It has been an interesting process to go through. As I have been on both sides of the table more than once, I know which side I prefer to be on. I also thank the non-Government bills unit for all its support through the process, the staff of my constituency office and Patrick McGuire of Thompsons Solicitors, whose advice to me was second to none, as is his commitment to the issue that both bills cover.

15:25

Christian Allard (North East Scotland) (SNP): Fatal accidents and sudden deaths are unforeseen tragedies. It is hard to comprehend how families and friends can deal with the aftermath of such tragedies. I have an insight into what they go through, as I lost a loved one who was aged only 33. We had to wait for the autopsy and for an investigation to take place before I could start to organise the funeral arrangements. That is an ordeal that many families have to go through. Anything that we can do to help people who are recovering from the sudden death of a loved one is very much in the minds of everyone who supports the proposed reform and modernisation of the fatal accident inquiry legislation in Scotland. The legal process must be clear and understood by all. Families must be at the centre of it, and it must be effective, efficient and fair.

As a member of the Justice Committee, I would like to add my thanks to everyone who participated in our consideration of the bill and helped to make the report what it is. I thank the people and the organisations that came to give evidence for their written submissions, and I thank the committee clerks for their work. I also thank all the members of the committee. The Justice Committee is a committee that works well. It is one on which the Scottish National Party does not have a majority—and I am not talking about the role of the convener. I see that Christine Grahame has left her seat. The strength of the Parliament lies in its committee structure. We scrutinised the bill, which is a proposed

“Act of the Scottish Parliament to make provision for the holding of public inquiries in respect of certain deaths.”

We challenged and questioned not only the Scottish Government but the judicial system and the UK Government.

I want to talk about a change in the bill that our report asked to be made and which the Crown Office and Procurator Fiscal Service has indicated it would be prepared to accept. I will go on to talk about an issue that was brought to our attention during evidence taking. It is an issue that gives rise to a lot of questions, the answer to which concerns a reserved matter, so the UK Government will need to help our Scottish Government to address it. Elaine Murray called it a strange anomaly; I would describe it as another example of Britain’s archaic system. In some areas, a great deal of modernisation is required to make sure that we are up to date. We were very surprised by what we learned from a member of the public who came to see us.

One of the bill’s aims is to strengthen the existing legislation by extending it to cover death abroad, as other members have said. For the first time, on the recommendation of Lord Cullen’s review, it will be possible to have fatal accident inquiries into the deaths of people who are resident in Scotland who die abroad. The bill also makes provision in relation to service personnel who die abroad.
All the witnesses welcomed that new power, but I was concerned that it would exclude cases in which the body could not be brought back to Scotland. I worked in the fishing industry for 30 years and now I represent many constituents from the north-east who work offshore, some of whom work abroad. My experience tells me that fatal accidents and sudden deaths happen—we know that they do—but, for obvious reasons, in those exceptional circumstances there is no way that the body can be brought back to the families. Jake Molloy of the RMT told us that much, and the Solicitor General for Scotland agreed that there should be some flexibility, so I am delighted that the COPFS has reconsidered its position, and I thank the Scottish Government for agreeing to consider the recommendation that we made on page 23 of our report that an amendment be lodged at stage 2.

The second issue, which has already been debated a lot, became a concern for us all in the committee. Flt Lt James Jones, who is a retired member of the Royal Air Force, brought it to our attention. He said in his written submission:

“The interpretation of the current Act, by the Crown Office, discriminates against members of the Armed Forces in that ... They are not regarded as ‘employees’”.

He added:

“Public interest is not given the same importance as in civil accidents”.

I have to admit that I was shocked to hear that members of our armed forces are not considered to be employed by the Ministry of Defence. Why on earth would boys and girls who choose one of the most dangerous vocations on earth, for which we are all thankful, not be given the same protection that we all enjoy?

When Flt Lt Jones came to give evidence in Parliament, he told us that, under the 1976 act, a fatal accident inquiry is mandatory only when the person was acting in the course of their employment or occupation. I asked him to clarify his comments about the MOD investigating itself. He replied:

“it is okay for the MOD or the Military Aviation Authority to do their own inquiries, and ... it is important for them to do that because any immediate problems can be put right, but such inquiries do not replace proper inquiries in the public domain. There is no input to a military inquiry. It is like asking a person who runs a factory in which someone has died because a machine was operated unsafely to carry out their own investigation and to make recommendations, and then taking the factory owner’s report and saying, ‘Thank you very much—that’s fine.’”

That is not fine. I agree with Flt Lt Jones. Members of the armed forces should be employees and have the same rights as employees.

I thank the Scottish Government again for looking at amending the bill to allow the deaths of service personnel in Scotland to fall within its scope. It is too early for me to thank the UK Government to redress the employment status of members of the UK armed forces, but I am very much encouraged by the discussions that are taking place between the two Governments. However, I do not yet share Margaret Mitchell’s optimism.

Modernising and reforming legislation that relates to these matters is our duty as elected representatives. A lot has already been achieved, as members can read in our report.

Families must remain at the centre of the legal process in dealing with fatal accident inquiries. I repeat what Roderick Campbell said. A fatal accident inquiry is what it is: it is an inquiry, not a trial. Let us ensure that members do not give the people of Scotland high expectations of what an FAI is. Understanding that legal process is a start. The Parliament needs to ensure that that process is effective, efficient and fair.

15:32

Johann Lamont (Glasgow Pollok) (Lab): We all recognise the importance of the debate. I congratulate Patricia Ferguson in particular on all that she has done to drive the agenda. I do not think that the bill would be in front of us if that work and the work that she has done on behalf of families who have suffered as a consequence of an inadequate system of FAI and inadequate redress for families had not been done.

I want to contribute to the debate from the point of view of the dreadful, tragic experiences of some of my constituents. I do not intend to tell their stories, although they are powerful in themselves; I want to make comments that are drawn from their experiences. All those families lost loved ones in a health setting or while accessing health services, so I am sure that members can understand concerns that the view is held that the national health service should take its own approach to unexplained deaths.

The Scottish Parliament information centre briefing says that the purpose of adverse event reviews is “to discover if any lessons for future practice can be learned.”

That is little comfort to those who seek justice for their loved ones. We must surely be concerned that, because NHS boards set their own policies in relation to adverse event reviews, practice varies from area to area. I urge the minister and the Scottish Government to look again at that matter. If there is a mandatory FAI for someone who died in prison, why is there no rigour or consistency for
unexplained deaths in hospitals? We need clarification on whether and when a procurator fiscal would be involved in an NHS case. What would be the nature of any investigation? What is the expectation of the standard of the investigation by the prosecution services in such cases? There is deep dissatisfaction. As I have said, if there is a mandatory FAI for a child who died in care, what is to be done if there is alleged neglect by public services as a result of which a child who was not in care died? We can see that contradiction.

We need reassurance that “public interest” is not narrowly defined. The test should stretch to include NHS processes not being followed, pressures on staff, untrained staff and perhaps the impact of the use of bank or agency staff on the quality of the care that is received.

In one case involving a constituent of mine, procedures to check the patient were not followed. The reason was not investigated; it was simply established that procedures were not followed. There was a reassurance that procedures would change, but no explanation of how it would be ensured that they would be followed. I am sure that the minister can understand how unsatisfactory that must be for the family concerned.

It is critical that families are at the centre of the process. When people are struck by grief and they have lots of questions, we cannot overstate the importance of making real a commitment to involve families. We cannot simply say, “Yes, we involve families,” when their experience is different. I have had very varied reports on the effectiveness of family liaison.

We need to have honesty and compassion at the heart of the process. If there is not going to be an FAI, we need to know and understand that. The reasons must be explained and they must emerge from the evidence that has been investigated rather than there simply being a presumption about whether a particular case fits into a particular box. I know of a family who waited more than a year to be told that they were not getting an FAI but who felt very strongly that that decision had been made on day 1. If that is the case, we should at least be honest with people about it.

In the context of very significant cuts to prosecution services, we need reassurances that the role is real and that it will be properly resourced. It is not good enough for people to be told that they are at the centre of the process if, all the time, they feel that they are excluded from it and it may simply be that people have too much of a case load to do their jobs properly. We should not have an institutional presumption against fatal accident inquiries. Where a fatal accident inquiry is granted, it is important to ensure that families have real engagement, and legal aid is a particularly important issue if families are to be respected.

Although we can improve the FAI system and I accept that the bill goes some way towards doing that, we need to reflect on why families want a fatal accident inquiry in the first place. They want the death of their loved one to be taken seriously. They want their day in court, and for those who made decisions to be held to account. That is entirely reasonable. It may not be for the current bill, but we need to look at how we address that hunger for justice. People are currently left despairing and with a feeling that their loved one was unvalued. They are told, “That is not what an FAI is for.” If that is the case, what is? How do we address the need? What needs to change in the system to leave people feeling that they are being attended to?

It is a particular cruelty that families who yearn for justice—for a proper investigation—in order to respect the memory of those whom they have lost are driven down the civil route and seek compensation as a way of challenging injustice. That is cruel. First, it creates the impression that they are driven by financial interest and not by grief, and very often institutions then shut up shop and refuse to engage with families. People struggle to secure legal aid, and even where they secure it, if an out-of-court settlement is reached and a financial offer is made, even where someone does not accept responsibility, the person may have no choice but to accept, because if they do not, legal aid will be withdrawn. In that situation, they still do not have their day in court.

Loss and grief do not make people irrational or unreasonable, but sometimes the system appears to dismiss rather than understand. In my experience, doggedness, determination and a drive for justice have forced public agencies to move and to understand that there is something that needs to be investigated, but the test of justice should not be the determination of individual families. We should have a system that understands the importance of response.

It is easy to say why we cannot do something, but I believe that it is important to look at these questions differently. In the face of loss, people are entitled to ask, “Why?” and to be heard and answered, yet the current system does not allow that.

We support the bill, but it is not enough. I recognise the steps that have been taken, and—like many members, I am sure—I will be happy to work with the Government and any agency beyond this Parliament to address the brutal truth for too many families, which is that, in the face of the loss of their loved one, there appears to be nothing that the system can do.
We must strengthen the FAI system, but let us also consider how we address such questions of injustice, so that we do not simply tell people, “Things will be better in future,” but say, “The one you loved and lost deserved better,” and we understand why we ended up in the situation in the first place. I support the bill, but I hope that the minister will reassure members that he will take those very difficult issues far beyond the bill itself.

15:40

Willie Coffey (Kilmarnock and Irvine Valley) (SNP): I am pleased to participate in the stage 1 debate on modernising the fatal accident inquiry legislation.

My experience of the system is in the context of the death of my constituent Alison Hume, who, as members might recall, died in the Galston mineshaft accident in 2008. The subsequent journey that her family has made—it is probably better to say “endured”—through the fatal accident inquiry process and the subsequent fire service inquiry, has not been a happy one. The reasonable expectation that an FAI and a fire service inquiry would deliver justice and much-needed closure has not been met.

It is in the light of that experience that I will consider the bill and offer comments that I hope will take us further along the road to justice. First, though, I recognise the efforts of the Scottish Government and members of the Justice Committee to begin to modernise the fatal accident inquiry process.

There will be a number of positive changes, many of which emanate from Lord Cullen’s review in 2009. The extension of categories of death that require an FAI is welcome, as is the discretion to hold FAIs for residents of Scotland who die abroad. The latter extension will be a welcome change for families who have to suffer the loss of a loved one abroad. I note the committee’s plea for discretion to hold an FAI even if repatriation of the body is not possible.

It was also pleasing to hear the minister say that the Scottish Government will consider including deaths of service personnel in Scotland in the new legislation. That is welcome. It is right to seek such extensions and I am confident that they will be supported by the public.

The new obligation to respond to a sheriff’s recommendations is also welcome. It is a long-overdue step in improving the system. That there was no previous obligation to respond to FAI recommendations was a severe weakness, the unintended consequence of which was that serious criticism of individuals was largely ignored.

I note the proposal to permit FAIs to be reopened if new evidence emerges that suggests that further consideration is required. That approach will be welcomed by many people as a further modernisation of our system to make it better serve the public interest.

I turn to Alison Hume’s family’s experience of the current FAI system, to consider whether the proposals will address their concerns. What we have to understand is that a family like Alison Hume’s are on a journey, and their destination is justice and final closure, whereas the end point in the FAI process is to establish the facts and cause of death and to identify defects in the system and reasonable precautions that might have been taken. The purpose is not to apportion blame or find fault.

As far as I can see, no powers are proposed that would ensure that recommendations are implemented or even require a response to severe criticism of individuals whom an inquiry has found wanting. Lord Cullen himself commented:

“an investigation of the circumstances of a death in an FAI may disclose grounds for criticism, from which a basis for alleging fault may be inferred.”

Although the new proposals will at least require responses to inquiry recommendations, the onward journey to securing justice still lies outwith the process. I would like to see a stronger approach taken to ensure that a sheriff’s recommendations are carried out and that any criticisms that a sheriff makes are responded to and dealt with.

Patricia Ferguson: I am grateful to the member for his comments and I sympathise entirely with him about the tragic constituency case that he is talking about. Will he therefore support the amendments on enforceability of sheriff’s recommendations that I intend to make at stage 2?

Willie Coffey: I am keen to hear what the minister will have to say on summing up. I understand the explanations that have been given by the minister and others about the difficulties in making such enforceability a requirement, but there must be a middle ground that might take us further in the direction that the member and I wish to go.

Those outcomes did not happen in the case of Alison Hume and her parents, Hugh and Margaret Cowan. The sheriff made serious criticisms of senior fire officers and their handling of Alison’s rescue. Sheriff Leslie commented that the evidence presented to him by two senior offers was “bullish, if not arrogant, in their determination to justify the subservience of the need to carry out a rescue to the need
to fulfil to the letter Strathclyde Fire and Rescue Service Brigade policy."

No apology was ever offered until the former First Minister ordered a fire service inquiry. No disciplinary action was ever taken that we are aware of. The family has been left pretty much on their own in their pursuit of justice. Had it not been for the tireless and unfunded work carried out for them by HALO, a specialist trauma support service led by Diane Greenaway in Ayrshire, I shudder to think what the outcome would have been for this family.

There is much to commend in the work that has already been undertaken and the changes that will come in to help modernise this process. However, I ask my colleagues in the Scottish Government to consider any way of further strengthening the powers in relation to recommendations that are made by sheriffs and of requiring a response from any agency or individual who is the subject of criticism.

We need to place surviving families, who we should remember are also victims, at the heart of any new process that assists them on their journey to achieving justice rather than parting company with them at the end of the FAI process and leaving them to make that onward journey alone.

Alison McInnes (North East Scotland) (LD):
Fatal accident inquiries provide an important opportunity to find out what went wrong and, ultimately, to learn in order that we can prevent something similar from happening again in the future. Although they are primarily carried out in the public interest, they also give families the opportunity to gain closure when a loved one is lost.

The bill will repeal the 1976 act and enact new provisions to govern the FAI system in Scotland. It has been a long time coming. Lord Cullen was invited to review the system in 2008 and he reported in 2009. I echo Johann Lamont's tribute to Patricia Ferguson. If it was not for her determined and principled campaigning, we might still be waiting for the Government to address the reform. I congratulate Patricia Ferguson on her effort.

Not all of Lord Cullen's recommendations have been taken up, but of those that have, three are particularly worthy of further serious deliberation at stage 2. Mandatory FAIs will be extended to cover children who die while in residential care, and to those who are subject to compulsory detention by a public authority. The Scottish Government will be responsible for publishing responses to sheriffs' recommendations. I will touch on those issues in a few moments. The bill provides an updated definition of "legal custody" to include any death in police detention. It also requires a mandatory FAI when a child dies in secure accommodation.

Scottish Liberal Democrats welcome the changes because the state is ultimately responsible for those whose liberty has been taken from them. Because of our European convention on human rights obligations under article 2 on the right to life, it is a responsible step for any Government to examine deaths in such situations.

Because of that responsibility, and because the current review system lacks independence, we believe that further consideration should also be given to extending the requirement for a mandatory FAI to include the death of any person who is subject to compulsory detention by a public authority at the time of death, and that that should include people who are detained under mental health legislation. It was one of the most contentious areas that the committee explored during stage 1 and we were presented with many conflicting views from witnesses. The committee's stage 1 report asked the Government to consider further whether the bill should be extended in this way, with the proviso that the Lord Advocate could have discretion not to hold an FAI in particular circumstances—effectively flipping the current arrangements.

The Government has indicated that it feels that that would be disproportionate. Nevertheless, it acknowledges that the Mental Welfare Commission for Scotland believes that the current system for investigation of deaths of detained mental health patients is confusing and has gaps. Furthermore, the Scottish Government accepts that improvements should be made to how deaths in detention are investigated in practice, in order to ensure that the process is effective and timely, that it supports learning and that reviews are of consistent quality.

I challenge the Government's view that the bill is not the vehicle for such change, and I am grateful for the work of Dr Richard Simpson during the passage of the Mental Health (Scotland) Act 2015. To rely on that alone and, indeed, by the Government's own admission, to wait up to three years for a review of the arrangements for investigating deaths in hospital, risks missing learning points from events in the interim and does the families who are affected a serious disservice. I will, therefore, consider further whether there is scope to amend the bill at stage 2 to give effect to a more robust system.

Similarly, the Government responded to Lord Cullen's recommendation about looked-after children by saying that a national child death review system is currently being developed. The Government went on to explain that it is
anticipated that the steering group that is in charge of that review will recommend that the deaths of all live-born children and young people up to their 18th birthday, and of care leavers who have been in receipt of aftercare or continuing care up to their 26th birthday and who are resident in Scotland, should be reviewed.

I ask the minister to justify taking that two-tier approach rather than including those deaths in the mandatory FAI system. In its submission to the Justice Committee, the centre for excellence for looked-after children in Scotland did not support making such deaths subject to mandatory FAI and said that there is no certainty that that would lead to improvements in services for looked-after children and those leaving care. The whole point of FAIs is to learn from the deaths and to improve matters. The lack of confidence in the system that was evidenced in CELCIS’s statement surely suggests that Lord Cullen’s recommendation on sheriffs’ recommendations needs to be reconsidered. That links back to Patricia Ferguson’s work.

Although the committee report noted that there are difficulties in placing duties on certain bodies to monitor the implementation of sheriffs’ recommendations, it also asked the Government to look at ways of ensuring that those recommendations are respected. I do not feel that the minister has sufficiently addressed that point this afternoon. I urge the minister to work very closely with Patricia Ferguson to improve the provisions at stage 2.

The bill goes quite some way towards putting the needs of families at the heart of the new system. An area of concern had been the requirement on families to submit a written request for the reason for not proceeding to an FAI, and it was suggested that the Government should amend the bill to remove that requirement. On reflection, I am content with the Government’s response to that.

Parliament today has an opportunity to reform and modernise the system of FAIs in Scotland, and the Scottish Liberal Democrats will support the principles of the bill.

15:53

Gil Paterson (Clydebank and Milngavie) (SNP): The bill is yet another example of the Scottish Government’s—and Parliament’s—bid to implement progressive policies for the benefit of the people of Scotland.

The reforms to the 1976 act will modernise the process and make it more effective, efficient and fair. Crucially, the bill will strengthen existing legislation to include cases of deaths abroad. I will say a bit more about that later.

The bill will surely help the process and help families to come to terms with the daunting and often upsetting process of an inquiry at perhaps the most devastating time in their lives, when they have to cope with a family bereavement due to a fatal accident or sudden death.

As we all know, legislation has to be updated and to keep moving with the times; in my opinion, after 40 years, the bill will do exactly that. It will minimise delays and prevent families from being caught up in red tape, as has happened so often in the past.

The Justice Committee has asked the Government to reflect, wherever it has scope to do so, on evidence that has been received on elements of the bill. This far-reaching bill will, for the first time, allow for discretionary FAIs to be held into deaths abroad of people from Scotland whose bodies are repatriated. I am pleased that positive dialogue between the Scottish and UK Governments has brought that about. An example of the kind of case that could have a discretionary FAI is the 2009 case of Blair Jordan, who died when he fell to his death aboard the tanker British Pioneer, off the coast of Japan. Despite six years of searching for answers, his parents still believe that they do not have the full picture of how Blair died, because no independent investigation has ever been carried out. However, the bill will mean that other parents might not have to go through a similar agonising struggle for answers regarding the circumstances surrounding the death of their child.

The bill will also make provision for discretionary FAIs for Scottish service personnel who die abroad, affording them the dignity and respect that they and their families are due and, indeed, deserve.

Those are just some examples of how the bill—which will, broadly, implement the recommendations of the Cullen review—will extend the categories of death for which it is mandatory to hold an FAI. Further, it will update the definition of “legal custody” to include the death of a person while they are detained by the police, and the death of a child in secure accommodation. The bill will also empower bereaved families to ask the Lord Advocate to give written reasons for a decision not to hold an FAI, which might help with their coming to terms with their situation. The bill will also help to minimise delays at an upsetting time for families by introducing a requirement to hold a preliminary hearing in advance of an FAI and by encouraging the sharing and agreeing of evidence in advance.

The bill will allow more freedom of choice about the location and venue for an FAI. It is also important that the bill will allow FAIs to be reopened or reconvened if new evidence comes to
light and will, in cases where the new evidence is substantial, permit a completely new inquiry to be held, which will remove the feeling of finality for families who feel that vital pieces of information have not been heard at an original inquiry.

To summarise this detailed and intricate bill in a short space of time is quite difficult, but I commend it in all its aspects as I believe that it will give greater access to justice for families who lose loved ones. Through the bill, the entire FAI process will become more accountable and efficient, and less harrowing for families who are going through a traumatic time. I am sure that I am not alone in believing that where legislation can do that, it should be done. I welcome the bill as a much-needed forward-thinking and modern piece of legislation that takes into account the terrible circumstances that families can find themselves in at times in their lives. Families who are looking for answers after the tragic death of a child will no longer face agonising delays waiting for answers, and the families of people who die abroad will not face mountains of red tape and delays as they struggle to cope with their bereavement.

Again, Scotland has shown that it can lead the way in modernising the justice system. After 40 years, the bill will create a fairer and more accountable process for the people of Scotland. I have no hesitation in backing this excellent bill and I fully expect it to have support from members of all political parties across the chamber. We in the Justice Committee have been taking evidence on the bill, which will bring FAIs into the 21st century and ease the pain of so many families throughout Scotland. I commend the bill whole-heartedly.

16:00

**Jayne Baxter (Mid Scotland and Fife) (Lab):** A discussion of fatal accident inquiries will inevitably be emotive. Families who have experienced the loss of a loved one often seek nothing more than an explanation for why that person died. We must ensure that public confidence in the system of FAIs is absolute, and that the systems surrounding FAIs are robust.

Lord Cullen’s report into the Super Puma tragedy was a significant milestone in the modernisation of the FAI process. It has taken a long time for his recommendations to be considered fully by Parliament, but at least we can now continue the process of modernising this important area.

To that end, my colleague Patricia Ferguson introduced a member’s bill. The Justice Committee recommended that her bill and the Scottish Government’s bill be considered in tandem, because there are many areas of overlap between the two, and the committee referred positively to many aspects of her bill. I am therefore very disappointed, for Patricia and for all those who worked with her on that bill, that she feels that she should withdraw it, although I completely understand her reasons for doing so.

Putting that to one side for the moment, we should look at the bill that is before us today, in which there is much to support. Introducing the ability to hold discretionary fatal accident inquiries into the deaths of Scottish people abroad when their bodies are repatriated to Scotland is a sensible change. Increasing flexibility with regard to the geographical locations for inquiries and the sorts of building that can accommodate them is also a positive step.

It is anomalous that FAIs cannot currently be reopened, and that a further inquiry cannot be held, when new and compelling evidence arises regarding a case, so it is sensible that that has been changed.

There are, however, some deficiencies in the bill. Lord Cullen recommended in his investigation into the Super Puma tragedy that relatives who are represented at an FAI should automatically receive legal aid without having to demonstrate that it is reasonable in the circumstances. That seems to be fair, in view of the circumstances from which fatal accident inquiries arise. It is understandable that families of deceased people will be unable to lead evidence in chief and to cross-examine witnesses in relation to the death of a loved one. That problem is often exacerbated by the circumstances in which many FAIs arise, given that complex health and safety regulations or technical details of machinery and workplace rules are often at the centre of such inquiries.

Although the Justice Committee’s report notes that FAIs are fact-finding processes and do not exist to establish guilt, I cannot support the conclusion that the committee has derived from that: namely, that deceased people’s families do not require automatic legal aid. I note that the Law Society of Scotland does not support the committee’s view in that respect either.

The milestone charter that has been proposed by the Crown Office, under which it will set out milestones at which it will give certain information to deceased people’s families, is a positive step. It is, however, insufficient. I have concerns that that will become a formulaic administrative task, with information tending towards generic responses to families, a number of whom have raised concerns over the years about why an FAI was not held after their loved one’s death. The Crown Office is resisting the introduction of a statutory right to request that it give reasons for a decision not to hold an inquiry.
However, it is clear that only a small number of families question such decisions each year, so the giving of reasons would therefore involve only a small administrative cost. In other contexts, the giving of reasons is a central plank of natural justice; it permits the public to understand the process that has been used to make a decision, and it increases confidence in Government systems. I do not think that the Crown Office has anything to hide in that context, so it should welcome the introduction of a statutory right for the families of deceased people who have not been granted FAs to request reasons for that decision. As the Law Society has made clear, such a move would have

“minimal economic impact, but reinforce public confidence in Scotland’s system for investigation of apparently self-inflicted deaths.”

Under section 27 of the bill, a person to whom a recommendation of the sheriff is addressed must, if that person was a participant in the inquiry to which the recommendation relates, give the Scottish Courts and Tribunals Service a response in writing. The Law Society has rightly raised the issue of the lack of sanction for parties who fail to comply or to co-operate with that requirement, and the possibility of a concomitant protracted correspondence with such parties well after the conclusion of the inquiry. The bill should provide for a more robust approach in order to minimise the risk that such a situation will arise.

In summary, although it is disappointing that the Scottish Government has rejected the Justice Committee’s recommendation that Parliament consider Patricia Ferguson’s bill and the Scottish Government’s bill together, the bill that is before us takes the FAI system generally in the right direction. The issues with the bill that have been raised by others, and which I have mentioned in my speech today, must be considered

16:05

Bob Doris (Glasgow) (SNP): On 29 January 2009, Colin Love went for a swim beside a beautiful beach on Margarita Island in Venezuela. I have mentioned Colin previously in the chamber. He was a young man, and a keen traveller. He did not return alive to Scotland. He drowned that day. It turns out that the waters where he swam were a notorious drowning spot. There were no warning signs, no lifeguards and no guidance from the Foreign and Commonwealth Office that the area might be a dangerous destination for travellers. No dangers were raised by the travel firms involved in Colin’s carriage to Venezuela and the cruise that he was on.

There was also no fatal accident inquiry. Although I do not know whether, in that instance, there should have been one, I know that it was wrong that it was against the law to give the Lord Advocate discretion to have one if he or she saw fit.

I read about Colin’s death in the Evening Times. One of the journalists there, Caroline Wilson, has since reported on the inspirational story of Colin’s mum, Julie Love, on many occasions. Julie has campaigned tirelessly ever since Colin’s death to improve support for families who have lost loved ones overseas. That includes her campaign to allow fatal accident inquiries to be held into the deaths of Scots who die abroad—not on every occasion, but at the discretion of the Lord Advocate. Her campaign and the work of the charity Death Abroad—You’re Not Alone that a

I thank Caroline Wilson for a number of reasons. After reading Julie Love’s story, I arranged to meet Julie to see how I could be of assistance. In the six years since then, I have got to know her incredibly well and I am privileged to call her a friend. I initially worked with her years ago to submit evidence to the Cullen inquiry. More recently, I have supported her with her petition to the Public Petitions Committee. In both cases, she sought to extend the scope of FAs to include the deaths of Scots overseas. Lord Cullen accepted the case that she made and, only this week, the Public Petitions Committee agreed to keep her petition open, awaiting the outcome of the Scottish Government’s Inquiries into Fatal Accidents and Sudden Deaths etc (Scotland) Bill. I am delighted that the Scottish Government, too, has accepted her proposals and that they are contained in the bill.

I understand why people get so dismayed at the time that these things take. It took six long years to get to this stage and it is understandable that people should have concerns about that. However, we are getting there and the system works—although sometimes, perhaps, it does not work as quickly as we would like it to.

I want to look in more detail at the bill’s provisions on discretionary FAs into deaths overseas. The Lord Advocate needs to have discretion, independence and flexibility. However, how can he or she make an informed choice about when to use that discretion? When should there be post mortems when bodies are returned to Scotland? I know from meeting many families through Death Abroad—You’re Not Alone that a post mortem that has been carried out in Scotland can often tell a very different story from the post-mortem that was conducted in the country where the loved one passed away. Surely a significant contrast between one post mortem and another indicates that something is not quite right.
may be lots of provisions that can better inform the Lord Advocate, but I am trying to stress to the minister that the Lord Advocate can use such discretion only if he or she can bring an informed opinion to bear.

Will families of those who lose loved ones overseas be made aware of the provisions as a matter of course? There is a balance to be struck, because we do not want to distress families any more than is necessary. Tragedies happen—because of misadventure, because people have been unlucky or simply because of old age—and we do not want to distress families. However, where families think that something may be amiss, they must be at the centre when the Lord Advocate is informed. I ask for more information on that.

In cases where the body is not returned to Scotland, I agree that the Lord Advocate should have discretion. I know of a number of cases where bodies have not been not returned to Scotland because the families could not afford to bring them back. Indeed, some families could not save up to bring their loved one’s body back because it was costing them money to keep the body in storage overseas. A cremation was their only option, because of financial constraints. We need to bear that issue in mind.

I would like to widen the debate a little. At the start of my speech, I said that I had no idea whether Colin Love’s tragic death would have triggered a fatal accident inquiry if the bill had already been enacted. We had the bizarre situation in which we had to write to President Chávez in Venezuela to ask him to put lifeguards and signs on that beach. The travel sector did not cover itself in glory then, and I still think that it does not cover itself in glory in relation to such issues. Could a fatal accident inquiry in Colin Love’s case have driven wider change? It might have identified that the treatment of my constituent by Foreign and Commonwealth Office link workers was pretty dismal, to be frank, and that there is no consistent way of delivering messages about a death to loved ones and next of kin in Scotland where bodies have not been returned to Scotland, I agree that the Lord Advocate should have discretion only if he or she can bring an informed opinion to bear.

I have campaigned with Julie Love for a number of years for the Scottish Government, Police Scotland, Victim Support Scotland and other Scottish agencies to give better support to families whose loved ones have passed away overseas. Death Abroad—You’re Not Alone does a lot of voluntary work with goodwill, passion and commitment, but it needs more assistance. I accept that significant reserved matters are involved, but as a devolved Administration we have worked with the UK Government in partnership during the progress of the bill. Let us extend that. Let us work with Julie Love, Death Abroad—You’re Not Alone and all the partner agencies to ensure that it is not just fatal accident inquiries that we get right for people who lose loved ones overseas, but the whole system, because right now it is not working.

16:13

Margaret McDougall (West Scotland) (Lab): I have just joined the Justice Committee, so I was not part of the bill’s stage 1 scrutiny. I have listened with interest to the debate, and I have found it very informative to hear the differing views and concerns that have been raised.

I welcome the bill and support its general principles, and I see the need to update, modernise and clarify this aspect of the law. I believe that the scope of the bill could be increased, in line with some of the changes that were proposed in Patricia Ferguson’s Inquiries into Deaths (Scotland) Bill, which was introduced during stage 1 of the Inquiries into Fatal Accidents and Sudden Deaths etc (Scotland) Bill. It would have been useful to compare and contrast both those bills in one debate, but the Government has decided that we should do otherwise. Patricia Ferguson withdrew her bill this afternoon, which I know was not an easy decision for her, but I am pleased to hear that she will lodge amendments to the Inquiries into Fatal Accidents and Sudden Deaths etc (Scotland) Bill.

I want to focus on two areas where I feel the Inquiries into Fatal Accidents and Sudden Deaths etc (Scotland) Bill could be improved: the family’s role in the process; and issues relating to those detained under the Mental Health (Care and Treatment) (Scotland) Act 2003 that were raised at stage 1.

Having come to the process late, I will start by saying that I agree with the committee’s view that we need greater clarity and understanding around fatal accident inquiries not only with regard to how everything fits together but in respect of the family’s role in what can sometimes be a very difficult and complicated process. Right now, I feel that the bill does not have the balance right.

One of the central aims of Patricia Ferguson’s bill was to make the investigation process quicker and more transparent and—critically—to give families a more central role. The two bills had similar themes with regard to keeping families involved in the process; that said, I believe that the Inquiries into Deaths (Scotland) Bill gave strength with its proposal to introduce timescales in order to cut delays. After all, some people can wait for more than five years to find out whether an FAI will be held. I note that not all the evidence to the committee supported that idea, but I would argue...
that we need a duty to keep the family updated every step of the way.

Communication with regard to work preceding an FAI also needs to be strengthened, and the family should be kept updated on that process. In addition, I agree with the committee’s view that the Lord Advocate should be required to provide in writing the reasons why an inquiry is not to be held without the family having to request that information. I realise that that might be more time consuming, but we must remember that the family, who will be grieving, might be the only ones who have the interests of the deceased at heart.

I find it odd that the minister seems to have rejected, flat-out, calls for mandatory FAIs for those detained under the Mental Health (Care and Treatment) (Scotland) Act 2003, even though the system has been described as confusing and as containing gaps. In fact, I find the rejection odder still, given that the bill will update the definition of legal custody to cover any death that occurs in police detention. I understand that, in a lot of cases, an FAI will be unnecessary and unwanted, but, interestingly, the Mental Welfare Commission for Scotland has proposed a two-tier system in which deaths that are clearly from natural causes or which show no cause for concern are not investigated while all other deaths are.

I wonder whether the minister plans to look at that issue again, keeping in mind the committee’s recommendation that the Scottish Government revisit the issue of mandatory FAIs for those detained under the 2003 act and taking into account the Scottish Human Rights Commission’s evidence that mandatory FAIs might help to deal with some of the human rights concerns that were raised at stage 1. I urge the Scottish Government to improve the system during the bill’s later stages and not only to introduce a robust investigation system that closes the gaps with regard to deaths of those detained under the 2003 act but to rationalise and formalise the current process, as suggested by the Justice Committee.

As I said, I welcome the bill’s general principles and will support them, but I feel that certain aspects could be improved. I hope that the Scottish Government takes on board the feedback from both the committee and today’s debate, and I look forward to seeing the amendments that it lodges to tackle the issues that have been raised this afternoon.

16:19

Mike MacKenzie (Highlands and Islands) (SNP): As a layperson—that is, a non-lawyer who is not a member of the Justice Committee—I do not propose to talk much about the technicalities of the bill. Instead, my focus will be on the effect that it will have, or that I hope it will have, outwith the Parliament and outwith the courts in which our lawyers labour.

The bill attempts to address two concerns, which both have much merit. The first is the grief and anguish that is suffered by families and friends who have experienced bereavement in tragic circumstances. I have lost family and friends in that manner, so I know at first hand how important it is to have some understanding of how the tragedy occurred. For many, their faith sustains them in such circumstances and provides some help. For others, there is a loss of faith. For all, there is a need to try to understand and find some explanation that will allow them to make at least some sense of what is often an apparently senseless tragedy.

The desire to understand the world in which we live, with all its uncertainties, is a very human trait—perhaps the most human trait. Burns expresses it well in “To a Mouse” when he says,

“Still thou art blessed, compared wi’ me!
The present only toucheth thee:
But och! I backward cast my e’e
On prospects drear!
An’ forward, tho’ I canna see,
I guess an’ fear!”

Perhaps the need to understand becomes all the more urgent when we suffer bereavement because the need to protect our remaining loved ones is thrown into sharp focus when we suffer tragedy; perhaps it is because we are reminded of our own mortality and of how precious life is; or perhaps the reason is that the understanding of such tragedy is a necessary part of the grieving and the healing that we hope that affected individuals can achieve. Whatever the exact reasons, the need to understand is part of the essence of our humanity. I therefore commend the bill as a humane bill. As imperfect as any of our legislation might be, it is a step in the direction of greater humanity and, as such, should be welcomed.

There is a community need to understand such tragedies, too. I have lost three friends over the years from the small rural community in which I live—they were fishermen and were all young men in the prime of life—and I know how whole communities are affected when we experience such tragedies. I remember only too well the tangible pall that has hung over my community for many days on each sad occasion. The sombre talk is always about how this might have happened and why. At a community level, there is a need to understand and to try to make sense of what is apparently senseless.

Part of the intent of fatal accident inquiries has to be about achieving public understanding of such accidents, with a view to learning lessons so
that we can avoid such tragedies. We have come a long way on better workplace health and safety practice over the period in which I have worked in the fishing and the construction industries, which are known to have high-risk aspects and in which more work needs to be done. I remember working practices that were common in my youth but which are quite unthinkable now. In fact, I shudder to think of the risks that we routinely took and thought nothing of—so much so that, in an entirely rational way, I regard myself as lucky to be alive.

There is no doubt in my mind that the better regard that we now have for human life and safety has been driven in no small part by lessons that we have learned from fatal accident inquiries. We should think a bit about that as we complain about regulation because, in our work to streamline regulation and to make it work better, we must not lose sight of everything that better regulation has done to lessen the possibility of tragedy and loss.

There are, no doubt, aspects of the bill that can be improved. I leave others to comment on that as the bill passes through Parliament. However, as I understand that it will replace and repeal an act that was passed in 1976, I can say that it is surely time that we updated our thinking. I am therefore pleased to support the general principles of the bill.

16:25

John Finnie (Highlands and Islands) (Ind): The bill is technical but, as Mike MacKenzie eloquently highlighted, no one in the debate has lost sight of its human element. We would do so at our cost—it is important to recognise that. The bill has been 40 years coming, and the minister talked about its needing to be effective, efficient and fair. I feel that, by and large, it is, and for that reason I will support its general principles.

I am grateful to all those who contributed to the committee’s stage 1 proceedings and appreciate that, for many, it cannot have been easy. We heard from families against corporate killers, for which Louise Taggart is a tireless worker. She told us of the tragic circumstances of her brother’s death.

Patricia Ferguson has been a very able contributor in getting us to where we are now and has voiced her frustration at the failure to act in a timely way on what seemed very apparent, which resulted in other lives being lost. I was looking forward to speaking in next week’s debate on her bill. Her bill had a lot to commend it, and I will return to elements of it later. I certainly commend her for her tireless work.

Members have talked about the notable exceptions in implementing Lord Cullen’s review, and I was sympathetic to the proposals that were made about extending mandatory FAIs to cover children who die in residential care, other than those who die in secure accommodation, as well as those who die while subject to compulsory detention by a public authority. We heard how the review process could, in some instances, cause families distress rather than reassure them, and we must appreciate those concerns. Importantly, though, I heard nothing to suggest that, when appropriate, an FAI would not be called.

The term “public interest” has been used a lot, and FAIs are undertaken in the public interest. However, at this time, only the PF can apply for a fatal accident inquiry. Like other members, I am pleased that the bill provides the opportunity to reopen an FAI if new evidence comes to light.

I have sat through an FAI, and it was not a pleasant event. It related to a death in custody, and various interests had to be served. There were various tensions, and I hope that lessons were learned from it.

I welcome the requirement that the Lord Advocate must provide written reasons for why an FAI should not be held.

On the proposals that relate to mental health legislation, our stage 1 report states:

“The Committee asks the Scottish Government to further consider whether the Bill should be extended to include mandatory FAIs for both these categories of death”—that is, deaths of persons who were detained under mental health legislation and deaths of looked-after children. It is important to put down a marker that we asked for that.

My colleague Alison McInnes talked about flipping, and it is pivotal that we get feedback from the Lord Advocate on the relationship between the causes for holding FAIs and whether those FAIs are mandatory or discretionary. It is clear that the existing arrangements are not understood and, because of that, many families have felt disenfranchised.

We are told that families have a point of contact in the PF’s office so that they can raise any issues or concerns directly, and the committee set great store by what we heard from the Solicitor General about the milestone charter and the undertaking to meet families and provide regular updates. As we know, it is the not knowing that causes concern—there is never an instance of having too much information on a subject as important as this. I therefore welcome the minister’s assurance that those matters will be put on a statutory footing.

Paragraph 51 of the committee’s report states:

“The Committee considers that, in the interests of those who have lost a loved one in often tragic circumstances and who must navigate the system, it is imperative that there be greater clarity and understanding around FAIs,
their purpose and how they relate to other death investigations and civil or criminal proceedings.”

That is important, and we have heard about the relationships between those.

Often in such instances—other members will have come across this—people ask who represents the family’s interests, and they do not understand the simple response that it is a PF acting in the public interest who represents the family’s interests. We heard compelling evidence from families against corporate killers about the implications of not having legal aid. It is often the main breadwinner of the family who is the subject of the fatality.

Paragraph 172 of our report says:

“We believe it is imperative that families, trade unions and staff associations are able to participate in a meaningful way in an FAI and that families are represented appropriately and are kept informed throughout the process.”

Trade unions play a pivotal role.

It is important that we make every effort to explain the relationship between the Health and Safety Executive, the air accidents investigation branch and the other bodies involved.

We are keen for the sheriff’s recommendations to be respected. When lives have been lost, lessons must be learned. The issue of delays is also very important.

I am pleased that the Scottish Government is keen to act on deaths abroad and not to have the requirement for the body to be repatriated. We also took reassurance on the issues around service personnel.

We are trying to achieve, at the moment and for the future, an understanding of where and when a death took place, the cause of that death, any reasonable precautions that could have been taken to avoid it, whether there were defects in workplace practice that contributed to it, and any other relevant factors.

I keep coming back to the point about delays. I understand Patricia Ferguson’s position, and I share the concern of other members that things could be lost, although I hope not. I will pay great attention to the amendments that Patricia Ferguson lodges next week, not least on how we take forward the actions that the sheriff determines.

A number of matters are reserved, but a number of them are devolved so, at the very least, we could start picking up on the things that we can do.

The Deputy Presiding Officer: Before we move to the closing speeches, I invite all members who have taken part in the debate to join us for them.

16:32

Annabel Goldie (West Scotland) (Con): I, too, welcome the opportunity to speak in this stage 1 debate on the Inquiries into Fatal Accidents and Sudden Deaths etc (Scotland) Bill. It is clear that the principle underpinning fatal accident inquiries is long-standing and still sound. They were introduced in 1895 but, as has been recognised by all of us in the chamber, there is a need to modernise and reform the system of fatal accident inquiries.

I am pleased that the Justice Committee has expressed support for the general principles of the bill at stage 1 and I, too, thank the convener, the clerks and the members of the committee for their contributions.

The bill is based on a number of sensible recommendations by Lord Cullen. I do not propose to consider them in detail, although I note with interest—Patricia Ferguson observed this—that his review started in 2008 and was completed expeditiously in 2009.

We know, and the Scottish Government has acknowledged, that FAIs are often beset by delays. One witness during the stage 1 scrutiny of the bill indicated that some families have had to wait for up to seven years simply to find out that an FAI is not to take place. In other instances, the commencement of an FAI has taken up to four years. The introduction of the bill is certainly overdue. I praise Patricia Ferguson for her spirited efforts in keeping this matter before the Parliament. She has metaphorically put a foot on the Scottish Government’s accelerator—not somewhere, I suspect, where a foot is often to be found, but all power to her for what she has achieved.

FAIs may be in the public interest but, as numerous members have observed, they also offer the deceased’s relatives crucial answers regarding the circumstances surrounding the death. It is deeply unfair to prolong that uncertainty unnecessarily, and the closure that such an inquiry could afford.

Two recent tragedies have crystallised the contradictions that are inherent in the current system governing FAIs in Scotland. It has been reported extensively in the press that the families of those killed in the Clutha pub helicopter disaster remain concerned that an FAI into the accident is not yet under way. Meanwhile, an inquiry into the circumstances surrounding the Glasgow bin lorry tragedy began just seven months after that accident took place.

We know that there may be good reasons for delaying the start of an inquiry in the case of the Clutha tragedy—I understand that the final report from the Air Accidents Investigation Branch is still
awaited—but such a system is confusing and seemingly contradictory from the point of view of the deceased relatives, who will understandably be unfamiliar with the necessary protocols and procedures.

In the light of those considerations, I join other members in welcoming the proposed milestone charter. It combines flexibility with specific points for sharing information with families. The charter must be robust, and I sincerely hope that the Scottish Government and the Lord Advocate will prioritise communication with bereaved families and keep it under proactive review once the bill is passed.

An FAI is an inquisitorial process that seeks to establish the facts that are relevant to the circumstances of the death. That is what the inquiry exists to do but, in his review, Lord Cullen emphasised:

“It is true that an investigation of the circumstances of a death in an FAI may disclose grounds for criticism, from which a basis for alleging fault may be inferred. That may be unavoidable if the FAI is to fulfil its function of investigating the circumstances of the death.”

That means that no witness who is involved in an FAI can be compelled to answer any questions that might imply that they are guilty of a criminal offence. Arguably, that might limit the usefulness of such inquiries in some circumstances.

That tension has been reflected in the FAI into the Glasgow bin lorry tragedy. Prior to the FAI, the Lord Advocate decided not to prosecute the driver but, because of the possibility of a private prosecution, the driver has declined to answer a number of questions on the ground that he might incriminate himself. Therefore, there is a risk that a process that should be inquisitorial becomes conflated with an adversarial one.

Fatal accident inquiries are undertaken to establish the facts—the where, the when and the why; whether any precautions could have been taken, whether there were any defects in the system and whether there were any other contributory factors. To learn the necessary lessons, we need a holistic picture, not an incomplete one.

That brings me to a matter to which Mr Finnie referred in his speech. The Law Society of Scotland has expressed concern that Lord Cullen’s recommendation that relatives who are represented at an FAI should be entitled to receive legal aid without having to demonstrate that it is reasonable in the circumstances is omitted from the bill. The society rightly observes how daunting it is for those who attend a quasi-court occasion to be subjected to cross-examination. It takes the view that the expense of increasing the availability of legal representation would be minimal in relation to the entire legal aid budget.

The minister should consider that carefully. We really want an exhaustive examination of facts and we may be much more likely to get that if people understand what they are doing, where they fit into the process and what exactly they are expected to contribute.

Some members, not least Patricia Ferguson, have mentioned the important issue of the sheriff’s recommendations following the conclusion of an FAI. The Law Society has expressed concern about the absence of sanction in the event of non-compliance or non-co-operation with the sheriff’s recommendations. That is a justifiable concern and I hope that the minister will reflect on that.

The bill does much to modernise and reform fatal accident inquiries. Those changes are to be commended. They represent a positive development of our legal system in Scotland. However, I urge the minister to consider how FAIs interact with other court proceedings. That seems to be a somewhat unresolved tension.

Those comments notwithstanding, the bill is needed, it does a good job and my party will support it at decision time.

16:39

Elaine Murray: Fatal accident inquiries are inquiries into the circumstances of a death that are undertaken in the public interest to determine the time, place and cause of death, and to establish whether lessons can be learned to prevent similar fatalities in the future.

A number of very thoughtful speeches have been made. As we have heard, fatal accident inquiries are intended to be inquisitorial rather than adversarial, although they can be adversarial at times, and they do not attempt to allocate guilt in the criminal or civil sense. However, as Willie Coffey said, they can often be critical of people and, as Patricia Ferguson said, they can be highly adversarial, particularly in employee-versus-employer situations. As John Finnie said on the basis of his experience of an FAI into the death of a person kept in custody, they are not a pleasant experience. There is not a box marked “inquisitorial” for nice little inquiries and one marked “adversarial” for what happens in court. There is overlap between the two. The position is not as simple as it might at first seem to be.

Several members made interesting comments about what “the public interest” means and how it is defined. That is a fundamental question. We all blithely talk about things being in the public interest, but do we really understand what that means?
Christine Grahame: I will give a hypothetical example. Let us say that a young mother who is suffering from severe postnatal depression and who has not been given the appropriate support and help takes the life of her child. A crime will have been committed, but the Lord Advocate might take the view that it is not in the public interest to prosecute, and I think that we would all agree with that. That is an example of a situation in which it is not in the public interest to prosecute in criminal proceedings.

Elaine Murray: Indeed—and I think that there was a recent case of that type. However, an example does not provide a definition. In that case, the public interest is easier to understand, but there are other cases in which what the public interest is is less easy to understand. As Patricia Ferguson said, preventing fatalities is surely in the public interest—that is about learning the lessons of fatal accidents.

As has been mentioned, the Inquiries into Fatal Accidents and Sudden Deaths etc (Scotland) Bill is not the only bill that has been introduced to address Lord Cullen’s recommendations. Patricia Ferguson told us that she deliberately intended some of the proposals in her bill to be more radical than some of Lord Cullen’s recommendations. The Justice Committee recommended that the general principles of both bills be supported. Because of the time constraints that exist as we come to the end of a parliamentary session and the priority that is quite rightly given to Government bills—that has always been the case—Labour members of the committee were prepared to agree that the Government’s bill was the best vehicle to progress modernisation of the legislation on the fatal accident inquiry process in the few months of the session that we have left.

As we have heard, Patricia Ferguson has accepted that recommendation and withdrawn her bill with immediate effect. I would like to pay tribute to her for the work that she did on her bill. It must have been extremely difficult for her to decide to withdraw the bill after all the hard work that she and her staff and Patrick McGuire of Thompsons Solicitors had put into drafting and explaining it, especially given her experience with her constituents. She must have had a strong emotional desire to try to sort things out after going through that experience. I pay tribute to her for that. I am not quite sure what her decision means for Tuesday’s debate—I would have thought that it can no longer proceed, now that there is no bill to debate. I suppose that that will be a problem for the business managers on the Parliamentary Bureau to resolve.

I assure Patricia Ferguson that members of the committee will make their best efforts to fulfil her expectation that aspects of her bill will be progressed in the Government’s bill. I think that that commitment would probably be made across the chamber, although there is not uniform agreement on the areas in which amendments should be made to the Government’s bill. I look forward to the Government working with Patricia Ferguson to make the necessary amendments.

Many members, including Johann Lamont, Christian Allard and Mike MacKenzie, have spoken about the importance of the families of the deceased. We all agree that they must be central to the FAI process. Although the purpose of an FAI is to determine what lessons can be learned in the public interest, families must be kept informed about decisions, and decisions have to be made timeously. We must see an end to people waiting years just to be told that a fatal accident inquiry is not to be held. As Johann Lamont said, families have a desire for justice and their day in court; they seek explanations, not the sort of recompense that a civil action may result in. Often that is not what people want. Willie Coffey spoke about the journey of the family of his constituent Alison Hume and the lack of closure that the process had for them.

As we know, the bill does not take forward a number of Lord Cullen’s recommendations, such as the extension to include children who died in residential care other than secure accommodation and the deaths of people in compulsory detention by a public authority. A number of members asked questions about that.

Johann Lamont spoke about people who died in healthcare settings. Medical procedures may not have been followed, for example. I think that many of us have had cases—I certainly have—in which constituents have been unhappy about the fact that the health service investigates itself and there does not seem to be any independent arbiter. The deaths may be those of elderly people in healthcare settings. Medical procedures may not be considered important enough to receive some of the treatment that they might have received if they were younger.

Alison McInnes and Margaret McDougall made an important point about people who are detained under mental health legislation. Perhaps we should turn the process on its head and have mandatory inquiries in those circumstances but give the Lord Advocate discretion not to hold an inquiry when the cause of death is known—if it was by natural causes, for example—or there is no cause for concern. That was the Mental Welfare Commission for Scotland’s suggestion.

Christine Grahame: Will the member take an intervention?
Elaine Murray: No, I am sorry. I have only a couple of minutes left. I would like to wrap up and refer to a few other things that have been said.

Johann Lamont, Jayne Baxter and Annabel Goldie in her summing up referred to the need for people who are represented at an FAI to be entitled to legal aid without having to show that that is necessary. From everything that we have heard today, the process is extremely complex. People will be cross-examined and will find themselves in unusual circumstances. I hope that the Government will look again at Lord Cullen’s recommendation about that.

Bob Doris spoke about his constituent Colin Love, who died in Venezuela. Colin Love’s mother, Julie Love, gave compelling evidence to the committee. I am pleased to hear that the bill will be amended at stage 2 to include deaths in respect of which it is not possible for the body to be repatriated. That will be welcomed by members across the chamber.

A number of members have spoken about the anomaly in relation to deaths of members of the armed forces serving in Scotland. We hope that that will be resolved.

John Finnie referred to the importance of including trade unions and staff associations. I also included that in my speech. That omission should be rectified at stage 2.

Jayne Baxter was probably the only member who welcomed the extension of the premises in which an FAI can be held. That will be of benefit to families and will enable them to attend fatal accident inquiries more easily. We look forward to hearing more about that.

To conclude, there is merit in both the Inquiries into Fatal Accidents and Sudden Deaths etc (Scotland) Bill and Patricia Ferguson’s bill. Many of us are looking forward to the amendment processes at stages 2 and 3. I hope that many of the points that members have made will be taken on board and progressed then. Meanwhile, we are happy to support the bill.

16:49

Paul Wheelhouse: I have listened to the debate with great interest. When I made my opening speech, I was not aware that Patricia Ferguson had withdrawn her bill. I again pay tribute to her for the hard work that she put into that bill, and I commit to working with her on the areas that we have already discussed where we believe that we have common ground.

With that in mind, I want to respond to an intervention from Patricia Ferguson in which she raised the issue of potential reports to Parliament. I am willing to look at that proposal sympathetically. Obviously, we would want a system that was as streamlined as possible—perhaps one that looked at areas by exception, where recommendations had not been complied with. I am willing to entertain discussion with her on that point.

The Scottish Government’s Inquiries into Fatal Accidents and Sudden Deaths etc (Scotland) Bill modernises the way in which fatal accident inquiries are handled in Scotland. I believe that it provides the legislative framework that is needed to implement the Cullen recommendations in order to build on the reforms that the Crown Office has already carried out by establishing the Scottish fatalities investigation unit, which now oversees death investigations in Scotland.

The bill contains several new initiatives, including greater flexibility for the location of FAIs, which Elaine Murray and others mentioned; discretionary FAIs into deaths abroad; and the possibility of reopening or rerunning an FAI if new evidence appears, which Willie Coffey and others mentioned. The bill will underpin the new charter for bereaved families, on which the Crown Office has consulted. I will come back to that shortly.

The proposals that require parties to whom sheriff’s recommendations are addressed to respond and indicate what they have done by way of implementation will foster compliance, although I reiterate the point that I have just made to Ms Ferguson. It is worth noting, however, that we understand that the response rate in the equivalent process under the coroners system in England and Wales, which takes a similar approach, is 100 per cent, and we anticipate a high response rate in Scotland as well. Most parties to whom sheriff’s recommendations are addressed are only too keen to demonstrate compliance with them. Indeed, many such parties attend the inquiries and are able to hear the evidence as it unfolds, and they may take action to address points before the inquiry concludes.

Nigel Don (Angus North and Mearns) (SNP): I have long been concerned about an extension of that point. A recommendation to a particular employer that it does something will obviously be worked on, but I see no mechanism whereby the industry in general is told about it. That will not be in the statute, but I wonder whether the Scottish Government can do something administratively to ensure that, where appropriate, recommendations are circulated more widely.

Paul Wheelhouse: I thank the member for that point, which is a valid one. The party is required to report back to the Scottish Courts and Tribunals Service. If we deploy a reporting mechanism as discussed, it would flag up any anomalies where an industry or individual companies or representatives had not responded. However, I
take the point. I also note that, under our proposals, it is within the sheriff's powers to contact the appropriate regulator for the industry to make it aware of the concerns that have been raised in the inquiry and draw its attention to the recommendations that have been made.

As I said earlier, Lord Cullen, a former Lord President of the Court of Session, is an acknowledged expert on public inquiries. I say to those who believe that his recommendations did not go far enough that I hope that we will be able to set out how we can address any issues. It is clear that the Scottish Government's legislative proposals, which closely follow Lord Cullen's recommendations, were widely welcomed in the Scottish Government's consultation last year.

I turn to address, as much as I can, the points that colleagues throughout the chamber raised during the debate. Christine Grahame set the scene very well in her speech on behalf of the Justice Committee. I thank the committee again for its deliberations, and also the clerks. On delays, the Scottish Government recognises the need for bereaved families to be kept informed of progress with death investigations and we firmly believe that the Crown Office's charter—the "milestone charter", as it has been dubbed—will provide reassurance and enhance public confidence in the system. Putting it on a statutory footing obviously gives it more clout.

I want to reassure members on the charter, as I know that some have not seen the detail of it yet. The Crown Office has circulated it to appropriate stakeholders who represent families. The feedback that we have received has broadly been positive, but we are taking on board some points, particularly on communication between the Crown and families and the need for different approaches. Rather than a one-size-fits-all approach, we should have an approach that is sensitive to individuals' requirements so that communication is done in appropriate ways. For example, face-to-face meetings should not be required if they would be inappropriate.

I reiterate that it is proposed that the Crown Office will offer to meet bereaved families within three months of the date on which the death is reported to it, in order to give them an update on the progress of the death investigation and, we hope, an explanation if there is consideration of a criminal inquiry or some other hold-up in the process. That will make families aware of why that is the case and what to expect in terms of the potential duration of inquiries.

A number of members mentioned the Air Accidents Investigation Branch. As we know from certain recent inquiries, lengthy and technical considerations are required, so some degree of delay is inevitable, but that must not prevent us from communicating better with families. I take that point on board, and the milestone charter seeks to ensure that there is a better flow of information to families.

The Government is minded to support an amendment to the bill that will put the charter on a statutory basis, as Patricia Ferguson suggested. I acknowledge her work in raising the issue.

Patricia Ferguson: Does the minister accept that the issue is not just how quickly families are communicated with but how quickly the decision is made and then communicated to them?

Paul Wheelhouse: I take the point that it is desirable that information should be given to families as early as possible. As I am sure Patricia Ferguson is aware, some things are outwith the control of the Crown Office or Police Scotland in that regard. However, we are keen that families should be kept as well informed as possible.

Johann Lamont referred to the public interest, as did other members. The Solicitor General for Scotland, in evidence to the Justice Committee, said:

"The family interest is part of the public interest."—[Official Report, Justice Committee, 26 May 2015; c 17.]

I very much take the point and I reassure Johann Lamont that the family's interest is included in the definition of "public interest". The point has been well made and noted.

John Finnie: Will the minister give way?

Paul Wheelhouse: I must ask the member to be brief.

John Finnie: Does the minister accept that sometimes there is a tension when the family does not want something to be pursued that would be in the public interest?

Paul Wheelhouse: I can see that there is the potential for the situation that John Finnie describes—I am not aware of specific cases, but I understand the theoretical possibility.

I welcome the support from all parties for our proposals on military personnel, and I thank UK ministers for giving their consent to the process.

Christine Grahame: Is there any timescale for movement on that issue?

Paul Wheelhouse: That is not in the gift of the Scottish Government, but I understand that the UK Government is willing to move quickly and I anticipate that if the bill is enacted there will be a swift process to bring forward a section 104 order in the Parliament in London.

I have addressed Patricia Ferguson's point about an annual return.
Elaine Murray made valid points about areas of agreement between us, although she was concerned that we had not made progress in relation to looked-after children and children in care. During evidence to the committee, Glasgow City Council said:

“the current measures are sufficient.”—[Official Report, Justice Committee, 12 May 2015; c 43.]

The witness from Glasgow City Council went on to support the Government’s contention that a mandatory FAI is not needed in every case of a death of a child in care. However, the bill, like Patricia Ferguson’s Inquiries into Deaths (Scotland) Bill, provides for a mandatory FAI into the death of child in secure accommodation.

I reassure members that the Scottish Government set up a child death review working group to explore current practice in reviewing child deaths in Scotland and to consider whether Scotland should introduce a national, collaborative, multi-agency system. The group is due to report in autumn, so we will not have long to wait for something definitive from the exercise.

I welcome the support from many members on the provisions in relation to deaths abroad. I think that there is broad agreement on the issue, so I will not say more. However, I acknowledge the point that Bob Doris made about the tragic circumstances of Julie Love’s son’s death. I acknowledge the strong contribution that Julie Love and her organisation have made to the debate. I also acknowledge Mr Doris’s input on the issue.

In response to a point that Margaret Mitchell made, I clarify that the provisions in the proposed section 104 order will cover the deaths of service personnel in Scotland and will not deal with the deaths of service personnel overseas, which are dealt with in the Coroners and Justice Act 2009.

Patricia Ferguson stressed the radical nature of her proposals. I hope that the milestone charter will be a strong step towards dealing with her main concerns, which are driven by her experience of helping families. I appreciate that we still have to have some discussion on that front.

There was considerable debate about the potentially adversarial nature of FAIs, and I acknowledge that inquiries can be more adversarial than we would like them to be. That is not to say that we should not do more to make them less adversarial, so that we can get to the truth without stoking up adversarial debate.

That also relates to the issue of legal aid, which a number of members raised. The provisions in the bill have been designed to ensure that legal aid might be provided in such circumstances, perhaps when the Crown does not propose to raise questions about something that is of interest to the family. As long as the eligibility criteria are met, legal aid can be used to provide support for family members in those circumstances.

Johann Lamont mentioned NHS deaths. Public interest covers the family’s interest but the Crown must consider the circumstances of death on a case-by-case basis, and the Lord Advocate may exercise discretion if there is public concern.

I am conscious of the time, Presiding Officer—

The Presiding Officer (Tricia Marwick): Yes. You need to wind up.

Paul Wheelhouse: The debate has been fascinating and I welcome the broad support of members from across the chamber for the general principles of the bill. I acknowledge the work that Patricia Ferguson put into her member’s bill; I also acknowledge that she is willing to work with me, and I look forward to that. We wish to work constructively with Patricia Ferguson and other members, but we agree with the Justice Committee that the Government’s bill is the best vehicle for reform of fatal accident inquiries.

I commend the motion.
Inquiries into Fatal Accidents and Sudden Deaths etc.  
(Scotland) Bill

Marshalled List of Amendments for Stage 2

The Bill will be considered in the following order—

- Sections 1 to 34 Schedule 1
- Sections 35 to 37 Schedule 2
- Sections 38 to 41 Long Title

Amendments marked * are new (including manuscript amendments) or have been altered.

Section 2

Margaret Mitchell

1 In section 2, page 1, line 23, after <(3)> insert <, (3A)>

Alison McInnes

52 In section 2, page 1, line 23, after <(3)> insert <, (3B)>

Alison McInnes

56 In section 2, page 1, line 23, after <(3)> insert <, (3D)>

Margaret Mitchell

2 In section 2, page 2, line 6, at end insert—

<(3A) The death of a person is within this subsection if, at the time of death, the person was—

(a) detained in hospital by virtue of—

(i) the Mental Health (Care and Treatment) (Scotland) Act 2003, or

(ii) the Criminal Procedure (Scotland) Act 1995, or

(b) admitted voluntarily to hospital for the purpose of receiving treatment for a mental disorder.>

Alison McInnes

2A As an amendment to amendment 2, line 5, leave out from <or> to end of line 7

Alison McInnes

53 In section 2, page 2, line 6, at end insert—

<(3B) The death of a person is within this subsection if, at the time of death, the person was a child being looked after by a local authority.

(3C) For the purposes of subsection (3B), references to a child being “looked after” by a local authority are to be construed in accordance with section 17(6) of the Children (Scotland) Act 1995.>
Alison McInnes

57* In section 2, page 2, line 6, at end insert—

<(3D) The death of a person is within this subsection if, at the time of death, the person was—
(a) suffering from dementia,
(b) receiving—
   (i) treatment in a hospital, or
   (ii) a care home service within the meaning given in paragraph 2 of schedule 12 to the Public Services Reform (Scotland) Act 2010, and
(c) for a period of at least 3 months immediately prior to the person’s death, being treated with psychotropic drugs.
(3E) The Scottish Ministers may by regulations define “psychotropic drugs” for the purposes of subsection (3D).
(3F) Regulations under subsection (3E) are subject to the negative procedure.>

Margaret Mitchell

3 In section 2, page 2, line 19, at end insert—

<“mental disorder” has the meaning given by section 328 of the Mental Health (Care and Treatment) (Scotland) Act 2003,>

Section 3

Margaret Mitchell

4 In section 3, page 2, line 35, after <2(3)> insert <, (3A)>

Margaret Mitchell

5 In section 3, page 3, line 4, at end insert—

<(f) an investigation under section 11 of the Mental Health (Care and Treatment) (Scotland) Act 2003,
  (g) an inquiry under section 12 of that Act.>

Alison McInnes

5A As an amendment to amendment 5, line 4, at end insert—

<( ) But subsection (1) does not apply if, at the time of death, the person was subject to a compulsory treatment order under Part 7 of the Mental Health (Care and Treatment) (Scotland) Act 2003.>

Section 4

Margaret Mitchell

6 In section 4, page 3, line 18, after <2(3)> insert <, (3A)>

Alison McInnes

54 In section 4, page 3, line 18, after <2(3)> insert <, (3B)>
Alison McInnes
58 In section 4, page 3, line 18, after <2(3)> insert <, (3D)>

Section 6

Paul Wheelhouse
8 In section 6, page 3, leave out line 34

After section 7

Patricia Ferguson
59 After section 7, insert—

<Family liaison charter

Family liaison charter

(1) The Lord Advocate must prepare a family liaison charter.

(2) A family liaison charter is a document setting out how the procurator fiscal will liaise with the family of a person in relation to whose death an inquiry may or is to be held.

(3) In particular, the charter must set out—

(a) information to be made available to the family, and

(b) timescales for the giving of the information.

(4) The Lord Advocate may from time to time revise the charter prepared under subsection (1).

(5) The Lord Advocate must—

(a) consult such persons as the Lord Advocate considers appropriate before preparing the charter under subsection (1) or revising it under subsection (4),

(b) lay the charter or revised charter before the Scottish Parliament, and

(c) publish the charter or revised charter in such manner as the Lord Advocate considers appropriate.>

Section 8

Margaret Mitchell
7 In section 8, page 4, leave out lines 34 and 35 and insert—

<(1) The Lord Advocate must give reasons in writing to the persons mentioned in subsection (2) where it is decided that an inquiry is not to be held into the death of a person (“A”)—

(a) if the death is within section 2(3A),

(b) in all other cases, if requested to do so by a person so mentioned.

(2) The persons referred to in subsection (1) are—>
Section 10

Paul Wheelhouse

In section 10, page 5, line 31, leave out <an employee> and insert <acting in the course of the person’s employment>

Elaine Murray

In section 10, page 5, line 33, at end insert—

<(  ) a representative of A’s trade union or staff association, if A was at the time of A’s death a member of a trade union or staff association in connection with the employment or occupation concerned,>

After section 10

Patricia Ferguson

After section 10, insert—

<Availability of civil legal aid

Availability of civil legal aid

(1) The Legal Aid (Scotland) Act 1986 is amended in accordance with this section.

(2) After subsection (1) of section 14 (availability of civil legal aid), insert—

“(1ZA) The Board must, when considering an application in respect of proceedings under the Inquiries into Fatal Accidents and Sudden Deaths etc. (Scotland) Act 2015 made by a person mentioned in subsection (1ZB), treat paragraphs (a) and (b) of subsection (1) as being satisfied in relation to that applicant.

(1ZB) The persons are, in respect of inquiry proceedings in relation to the death of a person (“A”)—

(a) A’s spouse or civil partner at the time of A’s death,

(b) a person living with A as if married to A at the time of A’s death,

(c) A’s nearest known relative if, at the time of A’s death, A—

(i) did not have a spouse or civil partner, and

(ii) was not living with a person as if married to the person.”.

(3) After subsection (2) of section 15 (financial conditions), insert—

“(2A) Subsections (1) and (2) do not apply to a person mentioned in section 14(1ZB) making an application in respect of proceedings under the Inquiries into Fatal Accidents and Sudden Deaths etc. (Scotland) Act 2015.

(2B) The Scottish Ministers must by regulations make provision for the financial conditions to apply to a person to whom subsection (2A) applies.

(2C) Regulations under subsection (2B) must ensure that civil legal aid is available to such extent and on such conditions as the Scottish Ministers consider will allow such persons to participate fully in the proceedings to which the application relates.”>
Section 14

Paul Wheelhouse

10 In section 14, page 7, line 17, at end insert—

<( ) A notice under subsection (1) must include—>

Paul Wheelhouse

11 In section 14, page 7, line 21, leave out <(1)(a)> and insert <(1)>

Section 26

Paul Wheelhouse

12 In section 26, page 12, line 34, leave out <the Scottish Ministers> and insert <an office-holder in the Scottish Administration>

Paul Wheelhouse

13 In section 26, page 13, line 9, leave out from first <in> to <34(1)> in line 10

Paul Wheelhouse

14 In section 26, page 13, line 11, leave out <this section> and insert <subsection (1)(b)(iii) or (iv)>

Section 27

Paul Wheelhouse

15 In section 27, page 13, line 34, after first <of> insert <all or>

Paul Wheelhouse

16 In section 27, page 13, line 35, leave out <(5)> and insert <(5A)>

Paul Wheelhouse

17 In section 27, page 13, line 36, leave out subsection (5) and insert—

<(5A) Where a response is given to the SCTS under subsection (1), the SCTS must, after considering any representations made under subsection (4)—

(a) publish the response in full,

(b) publish the response in part, together with a notice explaining that part of the response has been withheld from publication, or

(c) publish a notice explaining that the whole of the response is being withheld from publication.

(6) The SCTS may withhold the whole of a response given under subsection (1) from publication only if representations are made to that effect under subsection (4).

(7) If no response is given in accordance with subsection (1)(a) by the end of the 8 week period mentioned in subsection (3), the SCTS must publish notice of that fact.

(8) The SCTS must publish a response or notice under subsection (5A) or (7) in such manner as it considers appropriate.>
Paul Wheelhouse

18 In section 27, page 13, line 40, at end insert—

<( ) A response under subsection (1) is not admissible in evidence, and may not be founded on, in any judicial proceedings of any nature.>

After section 27

Patricia Ferguson

61 After section 27, insert—

<Reports

(1) The Scottish Ministers must, as soon as practicable after the end of each financial year, prepare a report setting out—

(a) the number of inquiries that ended during the financial year, and
(b) in relation to such inquiries—

(i) the number in which recommendations requiring a response were made,
(ii) the total number of such recommendations made,
(iii) the number of such recommendations in relation to which a response was received by the Scottish Courts and Tribunals Service under section 27(1) during that year,
(iv) the number of such recommendations in relation to which a notice was published under section 27(7) during that year.

(2) The Scottish Ministers must—

(a) lay a copy of a report under subsection (1) before the Scottish Parliament, and
(b) publish the report in such manner as they consider appropriate.

(3) In subsection (1), “recommendations requiring a response” means recommendations to which section 27(1)(a) applies.>

Section 30

Paul Wheelhouse

19 In section 30, page 15, line 9, after <held,> insert <and>

Paul Wheelhouse

20 In section 30, page 15, line 11, at end insert—

<( ) A notice under subsection (1)(a) must include—>

Paul Wheelhouse

21 In section 30, page 15, line 12, after <28(2)(a),> insert—

<( ) the Lord Advocate’s view as to whether the further proceedings should consist of—

(i) the re-opening and continuation of the inquiry, or
(ii) the holding of a fresh inquiry,>
In section 30, page 15, line 15, after <notice> insert <and a copy of the original determination>.

In section 30, page 15, line 15, leave out <(1)(a)> and insert <(1)>.

In section 30, page 15, line 15, after <order> insert <fixing a date and place for a hearing under subsection (2A).>

(2A) A hearing under this subsection is one at which the sheriff is to give the procurator fiscal and the participants in the inquiry to which the notice under subsection (1)(a) relates the opportunity to make representations about whether the further proceedings should consist of—

(a) the re-opening and continuation of the inquiry, or
(b) the holding of a fresh inquiry.

(2B) After the sheriff makes an order under subsection (2), the procurator fiscal must give notice to the participants in the inquiry to which the notice under subsection (1)(a) relates of the date and place fixed for the hearing.

(2C) After a hearing has been held under subsection (2A), the sheriff must make an order.

In section 30, page 15, line 18, after <re-opening> insert <and continuing>.

In section 30, page 15, line 19, at end insert—

<( ) The sheriff may make an order under subsection (2C)(b)(ii) only if the sheriff considers that it is in the public interest to do so.>

In section 31, page 15, line 23, leave out <30(2)> and insert <30(2C)>

In section 31, page 16, line 8, leave out <30(2)> and insert <30(2C)>

In section 32, page 16, line 11, leave out <30(2)> and insert <30(2C)>

In section 33, page 16, line 30, leave out <30(2)(a)> and insert <30(2C)(a)>.
Paul Wheelhouse
31 In section 33, page 17, line 1, leave out <27(5)(a)> and insert <27(5A)(a) or (b)>

Paul Wheelhouse
32 In section 33, page 17, line 2, leave out <27(5)(b)> and insert <27(5A)(c) or (7)>

Schedule 2

Paul Wheelhouse
33 In schedule 2, page 21, line 3, at end insert —
<Administration of Justice (Scotland) Act 1933
   Section 38 of the Administration of Justice (Scotland) Act 1933 is repealed.>

Paul Wheelhouse
34 In schedule 2, page 21, line 7, leave out <In>

Paul Wheelhouse
35 In schedule 2, page 21, line 7, after <1974> insert <is amended in accordance with this paragraph.>

Paul Wheelhouse
36 In schedule 2, page 21, line 8, at end insert —
<( ) In section 34(1) (extension of time for bringing summary proceedings), for paragraph (d) substitute —
   “(d) an inquiry into any death that may have been so caused is held under the Inquiries into Fatal Accidents and Sudden Deaths etc. (Scotland) Act 2015.”.>

Paul Wheelhouse
37 In schedule 2, page 21, line 8, at end insert —
<Oil and Gas (Enterprise) Act 1982
   In schedule 3 of the Oil and Gas (Enterprise) Act 1982, paragraph 34 is repealed.>

Paul Wheelhouse
38 In schedule 2, page 21, line 8, at end insert —
<Anatomy Act 1984
   In section 4(6) of the Anatomy Act 1984 (lawful examinations), for “Fatal Accidents and Sudden Deaths Inquiry (Scotland) Act 1976” substitute “Inquiries into Fatal Accidents and Sudden Deaths etc. (Scotland) Act 2015”.>

Paul Wheelhouse
39 In schedule 2, page 21, line 8, at end insert —
<Merchant Shipping Act 1995
   (1) The Merchant Shipping Act 1995 is amended in accordance with this paragraph.>

480
(2) In section 108(6)(a)(iii) (returns of births and deaths in ships, etc.), for “Fatal Accidents and Sudden Deaths Inquiry (Scotland) Act 1976” substitute “Inquiries into Fatal Accidents and Sudden Deaths etc. (Scotland) Act 2015”.

(3) In section 271(6)(c) (inquiries into deaths of crew members and others), for “enquiry is to be held under the Fatal Accidents and Sudden Deaths Inquiry (Scotland) Act 1976” substitute “inquiry is to be held under the Inquiries into Fatal Accidents and Sudden Deaths etc. (Scotland) Act 2015”.

Paul Wheelhouse

40 In schedule 2, page 21, line 8, at end insert—

*Criminal Procedure (Consequential Provisions) (Scotland) Act 1995*

   In schedule 4 of the Criminal Procedure (Consequential Provisions) (Scotland) Act 1995, paragraph 10 is repealed.

Paul Wheelhouse

41 In schedule 2, page 21, line 8, at end insert—

*Petroleum Act 1998*

   In schedule 4 of the Petroleum Act 1998, paragraph 9 is repealed.

Paul Wheelhouse

42 In schedule 2, page 21, line 8, at end insert—

*Freedom of Information Act 2000*

   In section 31(1)(i) of the Freedom of Information Act 2000 (law enforcement), for “Fatal Accidents and Sudden Deaths Inquiry (Scotland) Act 1976” substitute “Inquiries into Fatal Accidents and Sudden Deaths etc. (Scotland) Act 2015”.

Paul Wheelhouse

43 In schedule 2, page 21, line 8, at end insert—

*Scottish Public Services Ombudsman Act 2002*

   In schedule 4 of the Scottish Public Services Ombudsman Act 2002, in paragraph 2(2), for “Fatal Accidents and Sudden Deaths Inquiry (Scotland) Act 1976 (c.14)” substitute “Inquiries into Fatal Accidents and Sudden Deaths etc. (Scotland) Act 2015”.

Paul Wheelhouse

44 In schedule 2, page 21, line 8, at end insert—

*Freedom of Information (Scotland) Act 2002*

   (1) The Freedom of Information (Scotland) Act 2002 is amended in accordance with this paragraph.

   (2) In section 34(2)(a) (investigations by Scottish public authorities and proceedings arising out of such investigations), for “Fatal Accidents and Sudden Deaths Inquiry (Scotland) Act 1976 (c.14)” substitute “Inquiries into Fatal Accidents and Sudden Deaths etc. (Scotland) Act 2015”.

9
(3) In section 37(3) (court records, etc.), for “Fatal Accidents and Sudden Deaths Inquiry (Scotland) Act 1976 (c.14)” substitute “Inquiries into Fatal Accidents and Sudden Deaths etc. (Scotland) Act 2015”.

Paul Wheelhouse

45 In schedule 2, page 21, line 8, at end insert—

<Police, Public Order and Criminal Justice (Scotland) Act 2006

(1) The Police, Public Order and Criminal Justice (Scotland) Act 2006 is amended in accordance with this paragraph.

(2) In section 33A(b)(ii) (general functions of the Police and Investigations Review Commissioner), for “Fatal Accidents and Sudden Deaths Inquiry (Scotland) Act 1976 (c.14)” substitute “Inquiries into Fatal Accidents and Sudden Deaths etc. (Scotland) Act 2015”.

(3) In section 41B(2)(b)(ii) (serious incidents involving the police), for “Fatal Accidents and Sudden Deaths Inquiry (Scotland) Act 1976 (c.14)” substitute “Inquiries into Fatal Accidents and Sudden Deaths etc. (Scotland) Act 2015”.

(4) In section 41C(2)(b)(ii) (investigation of matters in the public interest), for “Fatal Accidents and Sudden Deaths Inquiry (Scotland) Act 1976 (c.14)” substitute “Inquiries into Fatal Accidents and Sudden Deaths etc. (Scotland) Act 2015”.

Paul Wheelhouse

46 In schedule 2, page 21, line 8, at end insert—

<Scottish Commission for Human Rights Act 2006

In section 14(9) of the Scottish Commission for Human Rights Act 2006 (power to intervene), for “Fatal Accidents and Sudden Deaths Inquiry (Scotland) Act 1976 (c.14)” substitute “Inquiries into Fatal Accidents and Sudden Deaths etc. (Scotland) Act 2015”.

Paul Wheelhouse

47 In schedule 2, page 21, line 8, at end insert—

<Armed Forces Act 2006

In schedule 16 of the Armed Forces Act 2006, paragraph 72 is repealed.

Paul Wheelhouse

48 In schedule 2, page 21, line 8, at end insert—

<Coroners and Justice Act 2009

In the Coroners and Justice Act 2009, section 50 (amendments to the Fatal Accidents and Sudden Deaths Inquiry (Scotland) Act 1976) is repealed.

Paul Wheelhouse

49 In schedule 2, page 21, line 9, at end insert—

<( ) The Energy Act 2013 is amended in accordance with this paragraph.
Paul Wheelhouse

50 In schedule 2, page 21, line 10, leave out <of the Energy Act 2013>

Paul Wheelhouse

51 In schedule 2, page 21, line 10, at end insert—

<( ) In schedule 10 (provisions relating to offences), in paragraph 3(1)(d), for “a public inquiry under the Fatal Accidents and Sudden Deaths Inquiry (Scotland) Act 1976” substitute “an inquiry under the Inquiries into Fatal Accidents and Sudden Deaths etc. (Scotland) Act 2015”>
Groupings of Amendments for Stage 2

This document provides procedural information which will assist in preparing for and following proceedings on the above Bill. The information provided is as follows:

- the list of groupings (that is, the order in which amendments will be debated). Any procedural points relevant to each group are noted;
- the text of amendments to be debated on the day of Stage 2 consideration, set out in the order in which they will be debated. **THIS LIST DOES NOT REPLACE THE MARSHALLED LIST, WHICH SETS OUT THE AMENDMENTS IN THE ORDER IN WHICH THEY WILL BE DISPOSED OF.**

Groupings of amendments

**Mandatory inquiries: people treated for a mental disorder**

1, 56, 2, 2A, 57, 3, 4, 5, 5A, 6, 58, 7

**Mandatory inquiries: looked after children**

52, 53, 54

**Inquiries into deaths occurring abroad**

8

**Family liaison charter**

59

**Persons who may participate in inquiries into work-related deaths**

9, 55

**Availability of civil legal aid**

60

**Notice of inquiry proceedings**

10, 11, 19, 20, 22, 23

**Dissemination of sheriff’s determination**

12, 13, 14

**Responses to sheriff’s recommendations: publication**

15, 16, 17, 31, 32

**Responses to sheriff’s recommendations: admissibility in judicial proceedings**

18
Responses to sheriff’s recommendations: annual report
61

Form of further inquiry proceedings
21, 24, 25, 26, 27, 28, 29, 30

Modification of enactments
33, 34, 35, 36, 37, 38, 39, 40, 41, 42, 43, 44, 45, 46, 47, 48, 49, 50, 51
JUSTICE COMMITTEE

EXTRACT FROM THE MINUTES

30th Meeting, 2015 (Session 4)

Tuesday 3 November 2015

Present:

Christian Allard
John Finnie
Margaret McDougall
Margaret Mitchell
Gil Paterson
Roderick Campbell
Christine Grahame (Convener)
Alison McInnes
Elaine Murray (Deputy Convener)

Also present: Patricia Ferguson (item 2).

Inquiries into Fatal Accidents and Sudden Deaths etc. (Scotland) Bill: The Committee considered the Bill at Stage 2.

The following amendments were agreed to (without division): 8, 59, 9, 55, 10, 11, 12, 13, 14, 15, 16, 17, 18, 61, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 34, 35, 36, 37, 38, 39, 40, 41, 42, 43, 44, 45, 46, 47, 48, 49, 50 and 51.

The following amendments were agreed to (by division)—

1 (For 5, Against 4, Abstentions 0)
2A (For 5, Against 4, Abstentions 0)
2 (For 5, Against 4, Abstentions 0)
3 (For 5, Against 4, Abstentions 0)
4 (For 5, Against 4, Abstentions 0)
5 (For 5, Against 4, Abstentions 0)
6 (For 5, Against 4, Abstentions 0)
7 (For 5, Against 4, Abstentions 0)
60 (For 5, Against 3, Abstentions 1).

The following amendments were moved and, no member having objected, withdrawn: 52 and 33.

The following amendments were not moved: 56, 53, 57, 5A, 54 and 58.

The following provisions were agreed to without amendment: sections 1, 5, 7, 9, 11, 12, 13, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 28, 29, 34, schedule 1 and sections 35, 36, 37, 38, 39, 40 and 41 and the Long Title.

The following provisions were agreed to as amended: sections 2, 3, 4, 6, 8, 10, 14, 26, 27, 30, 31, 32, 33 and schedule 2.

The Committee completed Stage 2 consideration of the Bill.
The Convener: Item 2 is stage 2 proceedings on the Inquiries into Fatal Accidents and Sudden Deaths etc (Scotland) Bill. I remind members that our aim is to complete stage 2 today. Members should have their copies of the bill, the marshalled list and the groupings of amendments for today's consideration. I welcome Paul Wheelhouse, the Minister for Community Safety and Legal Affairs, and his officials.

I will move straight on. Amendment 1, in the name of Margaret Mitchell, is grouped with amendments 56, 2, 2A, 57, 3 to 5, 5A, 6, 58 and 7.

Margaret Mitchell (Central Scotland) (Con):
During stage 1 consideration, the committee came to the conclusion that there was no need for mandatory fatal accident inquiries into the deaths of those who are detained under mental health legislation, because some deaths of such people are straightforward. The decision was influenced by the Mental Welfare Commission for Scotland’s comments about the number of deaths of detained patients that are a result of natural causes.

However, in preparation for the stage 1 debate, I revisited Lord Cullen’s review and note that he stated:

“even investigations into deaths by natural causes may reveal unsafe conditions.”

He continued:

“it is in the public interest that an FAI should be held into the deaths of those detained by the state, especially those who are most vulnerable.”

I am therefore not convinced that the monitoring and investigation of cases by the Mental Welfare Commission are adequate safeguards for protecting some of the most vulnerable people in society, particularly when such individuals have no family members to advocate for them. It is that scenario that prompted amendment 2, which would provide for mandatory FAIs into deaths of those who are in mental health detention or those...
who are receiving treatment voluntarily, although there would be an opt-out provision.

The Mental Welfare Commission and the Royal College of Psychiatrists expressed concern that having mandatory FAIs for the approximately 73 deaths a year of patients who are detained under mental health legislation would vastly increase the number of FAIs. However, that fails to take account of the effect of my amendment 5, which would put in place an opt-out provision for the Lord Advocate, provided that he gave the reasons why he considered that no FAI was necessary. As the authorities are confident that the vast majority of such deaths are easily explained, the provisions should not be onerous.

Crucially, the opt-out and the compulsory explanation that would be required would ensure that, where patients who were detained by the state had no family members to advocate on their behalf, the conditions and circumstances of their death were properly scrutinised. That would ensure complete accountability and transparency regarding such deaths.

Furthermore, in England and Wales, all deaths of patients in compulsory mental health detention are subject to an inquest by the coroner, unless it has been ascertained that the death was from natural causes.

To put the necessity for my amendments in perspective, in 2013-14, there were 60 deaths of patients in formal detention under mental health legislation in Scotland, but there were six times as many deaths—364—of informal or voluntary patients.

Given that, my amendments not only provide important safeguards but ensure compliance with article 2 of the European convention on human rights, on the right to life. The state has a general duty to protect life, and it is therefore only right that deaths of those detained by the state are thoroughly scrutinised.

However, I have taken on board the comments about the number of cases that that approach may involve, and although that is not a reason in itself to exclude the deaths of individuals who have voluntarily received treatment for a mental disorder, I consider that the amendments in the name of Alison McInnes, which complement the amendments in my name, strike the right balance at this time.

I move amendment 1.

Alison McInnes (North East Scotland) (LD): I welcome the chance to speak on the amendments to section 2.

Section 2 sets out the circumstances under which mandatory public inquiries into certain deaths are to be held. The bill as it stands fails to include a number of Lord Cullen’s recommendations, as Margaret Mitchell said. I believe that when the state has the responsibility for someone’s health, safety and, ultimately, life, there should be an inquiry into what went wrong, should they die. We are talking about the most vulnerable in society, such as older people and patients with mental health problems.

The Scottish Human Rights Commission has said that steps need to be taken “to ensure that systems of investigation meet the Article 2 requirements outlined above and to remedy the current gaps and confusion” in the system.

I know that Richard Simpson did some sterling work on the Mental Health (Scotland) Bill. I also note that a review into how the deaths of those detained under mental health legislation are investigated will take place, but I understand that the timescale for that is up to three years. It is good to have the review, but I think that we need to deal with the issue in the interim. I will therefore support Margaret Mitchell’s amendments.

Ms Mitchell’s amendment 2 is her main amendment in the group. I am concerned that it goes too far by including mental health patients who have been admitted to hospital voluntarily; my amendment 2A removes that requirement. My amendment 5A removes the Lord Advocate’s discretion not to hold an FAI if the patient who has been detained is receiving compulsory treatment.

Similarly, my amendment 57 introduces a requirement to hold a mandatory FAI for patients with dementia who immediately before their death received prolonged treatment using psychotropic medication. That type of medication causes sedation, confusion and movement difficulty. Overuse of those drugs in such situations has been implicated in an increased risk of stroke. A number of organisations, including the Mental Welfare Commission, have raised concerns about the widespread use of those drugs in care home settings. The most vulnerable people in our society deserve our attention.

There have been a number of high-profile cases in which families have raised concerns about the circumstances of what appears to be death from natural causes. It should be the responsibility of the state to investigate and learn, in an open and transparent way, from any mistakes made.

My amendments 56 and 58 are consequential.

Roderick Campbell (North East Fife) (SNP): I have listened carefully to what both members have said.

Margaret Mitchell referred to Lord Cullen’s report, but I think that it is fair to point out that the
report did not deal with the question of voluntary admissions. Alison McInnes accepts that by proposing to delete that bit from Margaret Mitchell’s amendment.

We should also remember that, at present, the Lord Advocate has discretion to hold a fatal accident inquiry in any event if he has concerns. It is not quite a black-and-white situation.

Reference has also been made to section 37 of the Mental Health (Scotland) Act 2015, which imposes a duty on the Government to review, within three years, the arrangements for investigating the deaths of patients. It would perhaps be helpful if the Government could expedite that review, but I do not think that it is appropriate to use the bill to review and change the current position.

I am very sympathetic to the issue of deaths of people who have been treated with psychotropic drugs. I think that there is an issue about the use of psychotropic drugs and whether the guidelines for their use, which are now nine years old, are still appropriate. However, I think that that is a wider issue and not something that we should seek to encapsulate in the debate on these amendments.

John Finnie (Highlands and Islands) (Ind): For me, the issue is about the relationship between the state and the individual. It is also about perception, and I think that any member of the public who is listening in would find the comments of Margaret Mitchell and Alison McInnes very measured. I will certainly lend my support to the amendments.

Christian Allard (North East Scotland) (SNP): Mr Campbell is absolutely right: the Lord Advocate has the discretion to have an inquiry. More to the point, I do not think that the Lord Advocate would make any judgment to hold an inquiry because of pressure from families; the Lord Advocate would decide to have an inquiry regardless of whether the victim had family around them.

Elaine Murray (Dumfriesshire) (Lab): I, too, have a lot of sympathy for the amendments in the names of Margaret Mitchell and Alison McInnes. On what Roddy Campbell said, having the discretion to hold an FAI and not using it is not the same as being required to have an FAI and being able to opt out because, under the amendments, if the Lord Advocate decided not to hold an FAI, some sort of explanation would be given. Given the vulnerability of the people whom we are discussing—particularly in relation to those who are compulsorily detained—people would welcome the reassurance of knowing why an inquiry was not to be held.

Alison McInnes’s amendment 57, on people who have been treated with psychotropic drugs, addresses an important issue. I am not sure whether such a provision needs to be in the bill, but it would be helpful if the minister were able to give us some sort of assurance that the issue is being considered seriously.

The Convener: I am sympathetic to the arguments but I take a fairly plain view of things: something is either mandatory or not mandatory. As has been explained, there is discretion about whether one holds an inquiry in certain circumstances. What sustains me in keeping that position is section 8, on “Reasons for decision not to hold an inquiry”. I think that we made progress on that, because family members will not need to request reasons; reasons will be issued in any event. There are, quite rightly, pressures on the Crown Office, given that quite a lot of people—including not only the Mental Welfare Commission or the Care Inspectorate but the press—would police the Lord Advocate if there was a decision not to hold an FAI in any of the circumstances that my colleagues described. In addition, the giving of reasons will be embedded in the bill.

Although I accept the arguments that have been put forward, I come back to the point about an FAI being either mandatory or not mandatory. Where there is discretion and one feels that that discretion has not been exercised properly, the Crown Office must give reasons for its decision, which would be subject to a wide range of scrutiny. I am satisfied, as long as section 8 is amended in line with our request.

The Minister for Community Safety and Legal Affairs (Paul Wheelhouse): The group includes amendments in the name of Margaret Mitchell that would require mandatory FAIs into the deaths in hospitals of patients receiving compulsory or voluntary mental health treatment. Mental health patients who die while receiving treatment in hospital for something that is unrelated to their mental health condition, such as a heart attack or cancer, would be affected by the proposal. It is difficult to see how the public interest would be served by holding an FAI in such circumstances.

Currently, the Mental Welfare Commission is automatically informed of the deaths of detained patients and has the discretionary power to carry out its own independent investigation and inquiry, and it already liaises with the Crown Office on cases that it feels may merit an FAI. Therefore, if there was any suspicion or suggestion that a death was the result of inadequate or inappropriate treatment, a death would already be investigated by the Mental Welfare Commission and/or the Crown Office.

The Crown Office is also updating its guidance to medical practitioners to ensure that all deaths that occur while the person is subject to compulsory treatment under mental health
legislation are reported to the procurator fiscal and are, therefore, investigated as appropriate, in common with all other sudden, suspicious or unexplained deaths, of which only 50 to 60 finally result in an FAI.

It is highly significant that neither the Mental Welfare Commission nor the Royal College of Psychiatrists supports mandatory FAIs for detained mental health patients. They believe—and we agree—that the provision would be disproportionate and could, as I have said previously, lead to unnecessary distress for the family of the deceased person. In response to the proposal, the Royal College of Psychiatrists said:

“It is stigmatising to suggest mental health care and treatment should be subject to special scrutiny in relation to patient deaths, bearing in mind the commonality of mental health problems and physical illness prevalence. We would oppose any amendment seeking to change this at Stage 2 and we urge the Committee to reject any such amendments.”

The committee will be aware of a new provision under section 37 of the Mental Health (Scotland) Act 2015 that requires ministers to carry out within three years a review of the arrangements for investigating the deaths of patients who at the time of death were detained under either the Mental Health (Care and Treatment) (Scotland) Act 2003 or the Criminal Procedures (Scotland) Act 1995, or who admitted themselves voluntarily for treatment for a mental disorder.

10:15

The Mental Welfare Commission for Scotland has said that it

“believes that this review is an important opportunity to create a system of investigation of deaths of psychiatric patients which is proportionate, streamlined and effective” and that

“the priority should be for the review to be established and for its work to begin”.

I reassure committee members and other members who are present today that the review of the arrangements for the investigation of deaths of mental health patients will commence as soon as possible, and that initial discussions are already taking place with stakeholders.

The Scottish Government will consider with stakeholders the scope of the review and whether it is possible to ensure that there are safeguards to protect against alleged deaths of patients as a result of covert treatment, compulsory electroconvulsive therapy or other treatment, which I know is of concern to Alison McInnes. I do not believe that it would be appropriate or sensible to legislate to extend the mandatory category in relation to deaths of mental health patients in advance of the work of the review that is required under section 37 of the 2015 act.

Amendment 5, in the name of Margaret Mitchell, would provide discretion for the Lord Advocate not to hold a mandatory FAI where there has been an investigation or inquiry by the Mental Welfare Commission. Such investigations are, however, carried out by the commission only where there has been apparent ill treatment, neglect or deficiency in care. The amendment would therefore require that FAIs be held for deaths from natural causes and expected deaths.

Amendment 7, in the name of Margaret Mitchell, would amend section 8 of the bill, which will place a duty on the Lord Advocate to provide written reasons when it is decided that an FAI is not to be held, but has been requested by the nearest relative. As the convener said, amendment 7 would require the Lord Advocate to give written reasons in all cases in which it has been decided that there will be no FAI for a death in hospital of a patient who has been receiving mental health treatment. In such cases, written reasons would have to be given without, crucially, a request having been made by the nearest relative, as the convener indicated. For all other types of cases, a request is needed before the Lord Advocate’s duty takes effect. There is simply no good reason to make the rule for mental health cases different from that for all other cases. What is important is that the Crown Office maintains with the bereaved family the level of contact that they have indicated they want; we believe that there are better ways of achieving that than amendment 7.

The need for support and guidance that is tailored to individual family circumstances is exactly the sort of thing that will be provided for in the Crown Office’s proposed family liaison charter. I agree with the committee’s observation in its stage 1 report on Patricia Ferguson’s Inquiries into Deaths (Scotland) Bill that, if the scope of mandatory FAIs were to be extended to include the deaths of those who are detained under mental health legislation, the numbers of inquiries would rise significantly and the financial impact would be significant. It would, of course, be even more significant if voluntary patients were included.

Although I take the point that Alison McInnes’s amendment 2A would remove voluntary patients from amendment 2, the Scottish Government still cannot support mandatory FAIs into mental health-related detention or compulsory treatment. Data from the Scottish Government and the Mental Welfare Commission suggest that there are each year approximately 78 deaths of patients who are subject to detention or to compulsory mental health treatment. If mandatory FAIs were to be held into all of those deaths, that would at a stroke
more than double the number of FAIs in Scotland per annum. At least 39 of those 78 patients died from natural causes, in cases where death was expected; those deaths would trigger mandatory FAIs under the proposed arrangements.

There were in 2013-14 424 deaths of psychiatric in-patients, including voluntary patients. Amendment 2 could therefore increase the number of FAIs sevenfold. It is important to consider that the proposals may not be welcomed by bereaved families of mental health patients, who may not wish to have the death in psychiatric care of a loved one become the focus of a fatal accident inquiry in public.

We have similar concerns with regard to the amendments in the name of Alison McInnes, which would require a mandatory FAI into the death of any patient suffering from dementia who was receiving treatment in a hospital or care home service, or who was being treated with psychotropic medication for the three months leading up to their death.

As is stated in the recent letter from the Mental Welfare Commission, patients suffering from dementia often die while receiving treatment in hospital for, for example, heart attack or cancer, which are unrelated to mental health conditions, including dementia. I note the point that Alison McInnes made about strokes and take it on board; I hope that the review will be able to look at that issue. Similar to what would happen under Margaret Mitchell’s amendments, deaths from natural causes would be affected by Alison McInnes’s amendments. It is, in my opinion, difficult to see how the public interest would be served by holding an FAI in such circumstances.

The amendments incorrectly imply that use of psychotropic medication for people with dementia is a bad thing and requires extra scrutiny. I take the point that Alison McInnes has made, however. It is my understanding that patients with dementia often experience aggression, agitation, loss of inhibitions, delusions and hallucinations, which can, regrettably, require psychotropic medication. I further understand that clinical guidelines and safeguards are in place on the appropriate use of antipsychotics to help to manage those distressing symptoms.

The committee will be aware of the upcoming review of treatment of learning disability, autism spectrum disorder and dementia under the Mental Health (Care and Treatment) (Scotland) Act 2003. Scottish ministers committed to that review during the passage of the Mental Health (Scotland) Act 2015. The Mental Welfare Commission will consult key stakeholders in early 2016 to scope the content and detail of the review. In view of the fact that there will be that review and the statutory review of the arrangements for investigating the deaths of mental health patients under section 37 of the 2015 act, I firmly believe that it would be premature and inappropriate in advance of the reviews’ work and recommendations to legislate to extend the mandatory category to deaths of dementia patients.

Amendment 5A in the name of Alison McInnes would amend amendment 5 by ensuring that the deaths of mental health patients who are subject to compulsory treatment under part 7 of the Mental Health (Care and Treatment) (Scotland) Act 2003 would not be an exception under section 3 of the bill, which would mean that an FAI would be mandatory in every such case. We do not have exact figures for the number of deaths that could be captured by the amendment; however, we have been assured that the impact would be so fundamental that it would overload the system of fatal accident inquiries as well as leading to unnecessary distress for families and, potentially, staff.

Although we, as the committee’s members do, understand and sympathise with Alison McInnes’s concerns regarding that group of vulnerable people, the Scottish Government does not, for the reasons that I and both the Mental Welfare Commission and the Royal College of Psychiatrists have set out, support the amendments, but believes instead that there being discretionary FAIs for such cases strikes the right balance.

For all those reasons, I ask the members to not press their amendments.

The Convener: It is really for Margaret Mitchell to wind up, but Alison McInnes is writing something, so I wonder whether she wants to respond to any of that, first.

Alison McInnes: I am grateful for the opportunity to do that. I am also grateful to the minister for the assurances that he has put on the record today, particularly in relation to my amendment 57, about the concerns that even Roderick Campbell acknowledged are live issues at the moment. I am grateful that the review is already in the process of being commissioned. On that basis—

The Convener: You do not need to say anything about that at the moment.

Alison McInnes: Okay.

The Convener: Hold us in suspense on that. Margaret Mitchell will now wind up and press or seek to withdraw amendment 1.

Margaret Mitchell: I will address the stigma that the minister suggested will somehow occur if there were mandatory FAIs for detained mental health patients. I refer the minister to comments from Enable Scotland in response to the Cullen review:
“We think that the deaths of people detained under the Mental Health (Care and Treatment) (Scotland) Act 2003 should be included in the mandatory category. Those individuals who have been deprived of their liberty should have the same protection as those detained in prison or police cells.”

That quite conclusively explains that there would be no stigma, but that there are definitely issues of fairness and justice.

The convener’s comment that an FAI is either mandatory or not fails to take account of the fact that under my amendment 1 an FAI would be mandatory, but with an opt-out: the change of emphasis gives added protection to the group of vulnerable individuals. I also argue that it would ensure compliance with article 2 of the ECHR—the right to life. The minister has made much in his comments—which I have taken on board—about the concerns that have been expressed by the Royal College of Psychiatrists about the number of cases that could be added to the FAI workload if amendment 1 were agreed. However, it is for that very reason that I have provided for the Lord Advocate an opt-out from a mandatory FAI, if he considers that such a course of action is not necessary and also gives his reasons for that decision, which is important for transparency and accountability. If the death is from natural causes, that will be so obvious that the Lord Advocate will not find it onerous to give his reasons, and the measure will not add substantially to the number of deaths that fall into that category.

On the review of the arrangements for investigating the deaths of patients who have been receiving treatment for a mental disorder, which Alison McInnes and the minister referred to, the timetable seems to have been moved forward, although it is still due to report within three years of the Mental Health (Scotland) Act 2015 coming into force. However, I also note that last year there were 424 such deaths, 60 of which were in the compulsory detention category and a concerning 364 of which related to voluntary admissions. As a result, that issue must be revisited in the future.

In the meantime, I will press amendment 1. I urge committee members to support my amendments which, in conjunction with Alison McInnes’s amendments, strike the right balance and provide the right protection for mental health patients who are, by any standards, a very vulnerable group of people.

The Convener: The question is, that amendment 1 be agreed to. Are we agreed?

Members: No.

The Convener: There will be a division.

For
Finnie, John (Highlands and Islands) (Ind)
McDougall, Margaret (Central Scotland) (Lab)

McInnes, Alison (North East Scotland) (LD)
Mitchell, Margaret (Central Scotland) (Con)
Murray, Elaine (Dumfriesshire) (Lab)

Against
Allard, Christian (North East Scotland) (SNP)
Campbell, Roderick (North East Fife) (SNP)
Grahame, Christine (Midlothian South, Tweeddale and Lauderdale) (SNP)
Paterson, Gil (Clydebank and Milngavie) (SNP)

The Convener: The result of the division is: For 5, Against 4, Abstentions 0.

Amendment 1 agreed to.

The Convener: Amendment 52, in the name of Alison McInnes, is grouped with amendments 53 and 54.

Alison McInnes: This group of amendments also refers to section 2. The main amendment is amendment 53, which introduces the requirement to hold a mandatory FAI as a result of the death of a child who was looked after by the state, even if they lived with their parents or guardians at the time of their death.

When social services are involved, there is usually a good reason for that involvement, and it becomes our responsibility to keep these children safe. Although we acknowledge that there is a limit to what a social worker can do, we must also recognise that lessons need to be learned from any mistakes that might have been found to have been made in these tragic situations.

Although not a great many cases are covered by what is described in amendment 52, I hope that we all agree that even one child who dies while being looked after by the state is too many. I believe that it is important to have a mechanism in place that would require any such cases to be considered in the open and transparent way offered by an FAI. Indeed, in its written submission to the committee, Together, otherwise known as the Scottish Alliance for Children’s Rights, argued this position and said that the proposal for mandatory FAI’s for “children in secure accommodation ... is welcomed ... but should be widened to include all looked-after children. The Scottish Government has a direct responsibility for all looked-after children—regardless of whether they are in secure care, residential care or foster care—and as such any death of a looked-after child must be investigated, regardless of placement type.”

I move amendment 52.

Roderick Campbell: I have listened to what Alison McInnes has said, but we need to bear in mind that we already have the Looked After Children (Scotland) Regulations 2009, which provide that in the event of any death local authorities are required to report to Scottish ministers and, indeed, the Care Inspectorate within one day. One assumes that once the Care
Inspectorate gets that report it will carry out an inquiry and that, if it has any concerns, it will in turn report to the Crown Office, which at that point could decide to launch a discretionary inquiry.

Moreover, we did not take much oral evidence on this point. We had some written submissions on the matter, and I note that, in a recent letter to the committee, the centre of excellence for looked-after children in Scotland argued reasonably strongly against the idea of having mandatory inquiries. There is by no means a uniform view among the professionals in this area.

10:30

Paul Wheelhouse: This group of amendments in the name of Alison McInnes seeks to require mandatory FAIs into the deaths of children who were looked after by a local authority. Given that the provision would affect all natural-cause and expected deaths of looked-after children, many of which happen as a result of life-limiting conditions, it is difficult to see how the public interest, including that of the families, would be served by holding an FAI in such circumstances.

The amendments also fail to recognise that a judicially led inquiry is not the only means of investigating the deaths of children in the care of the state. As Glasgow City Council confirmed during stage 1, the deaths of looked-after children are already provided for in the reporting requirements of the Looked After Children (Scotland) Regulations 2009, which require local authorities to notify Scottish ministers and the Care Inspectorate of a death within one working day. That reporting responsibility has been further extended by the Children and Young People (Scotland) Act 2014 to include the reporting of deaths of any care leaver up to the age of 26 and any young person in a continuing care placement.

Deaths of children in residential establishments, half of which happen as a result of life-limiting conditions and other health issues, are investigated and reviewed by the Care Inspectorate, which identifies any lessons to be learned and makes recommendations on the review of legislation, policy or guidance. Such deaths are already the subject of investigation by the procurator fiscal, and the Lord Advocate has discretionary power to hold an FAI into such deaths when that is considered to be in the public interest. The Crown Office liaises with the Care Inspectorate and refers to its reports in order to inform decisions on whether to hold a discretionary FAI.

The committee will also be aware of the child death review. Ministers agreed that Scotland should set up a national child death review system to review the deaths of all children and young people, not just those in care. Between January and June, a steering group met to develop a model for the system, and its report and recommendations will be submitted to ministers very shortly. I do not believe that it would be appropriate or sensible to legislate to extend the mandatory category to include deaths of looked-after children in advance of the review’s work.

The Care Inspectorate reported that, in the three-year period from 2009 to 2011, there were 30 deaths of looked-after children in Scotland, which means that, as a result of this provision, there could be an additional 10 FAIs per year. Of course, the resource impact is not the only consideration. At stage 1, both Glasgow City Council and CELCIS did not support extending the mandatory category in this way. Glasgow City Council considers the current arrangements that I have just described for the reporting and review of deaths of looked-after children to be suitable and sufficient, and CELCIS did not recommend making this a mandatory category, because it felt that there was no certainty that it would lead to improvements in services for looked-after children and those leaving care. In its letter of 19 October to the committee, it reiterated its view that it was not necessary to extend the provision for mandatory FAIs to all accidental or sudden deaths of looked-after children in residential care.

On that basis, the Government does not support these amendments, and it agrees that the combination of the provisions in the 2009 regulations and the Children and Young People (Scotland) Act 2014 and the proposal to have discretionary FAIs in such cases strikes the right balance. We believe that the proposals in these amendments would not be welcomed by bereaved families of looked-after children. Some looked-after children continue to live in the family home following involvement with the children’s hearings system, and 11 of the deaths from 2009 to 2011 were of children who were living at home or with relatives. Others live away from their family home—for example, with a foster carer or in residential accommodation—and 12 of the deaths reported were in residential care, while four were in foster care. Children usually become looked after to promote their care—for example, respite care for children with complex difficulties or disabilities—and to protect them from neglect and abuse. Families and those known to the child might not wish to have the death become the focus of a public inquiry. I also remind the committee that, under the bill as it stands, the death of a child in secure accommodation would trigger a mandatory FAI.

For all those reasons, I ask the member to withdraw her amendments.
Alison McInnes: I caution the minister against making a case on the basis of the resource impact, because I think that that is the weakest argument that can be made. If a number of cases need to be investigated, they need to be investigated.

The Convener: I agree with you. I do not like to hear resources being brought in—the argument should be based on the principle.

Alison McInnes: That aside, the minister has set out a detailed reason for not supporting amendments 52, 53 and 54. I considered them to be probing amendments to test the Government’s position, and I am grateful to have heard more about the review.

In the circumstances, I will not press amendment 52.

Amendment 52, by agreement, withdrawn.

Amendment 56 not moved.

Amendment 2 moved—[Margaret Mitchell].

Amendment 2A moved—[Alison McInnes].

The Convener: The question is, that amendment 2A be agreed to. Are we agreed?

Members: No.

The Convener: There will be a division.

For
Finnie, John (Highlands and Islands) (Ind)
McDougall, Margaret (Central Scotland) (Lab)
McInnes, Alison (North East Scotland) (LD)
Mitchell, Margaret (Central Scotland) (Con)
Murray, Elaine (Dumfriesshire) (Lab)

Against
Allard, Christian (North East Scotland) (SNP)
Campbell, Roderick (North East Fife) (SNP)
Grahame, Christine (Midlothian South, Tweeddale and Lauderdale) (SNP)
Paterson, Gil (Clydebank and Milngavie) (SNP)

The Convener: The result of the division is: For 5, Against 4, Abstentions 0.

Amendment 2, as amended, agreed to.

Amendments 53 and 57 not moved.

Amendment 3 moved—[Margaret Mitchell].

The Convener: The question is, that amendment 3 be agreed to. Are we agreed?

Members: No.

The Convener: There will be a division.

For
Finnie, John (Highlands and Islands) (Ind)
McDougall, Margaret (Central Scotland) (Lab)
McInnes, Alison (North East Scotland) (LD)
Mitchell, Margaret (Central Scotland) (Con)
Murray, Elaine (Dumfriesshire) (Lab)

Against
Allard, Christian (North East Scotland) (SNP)
Campbell, Roderick (North East Fife) (SNP)
Grahame, Christine (Midlothian South, Tweeddale and Lauderdale) (SNP)
Paterson, Gil (Clydebank and Milngavie) (SNP)

The Convener: The result of the division is: For 5, Against 4, Abstentions 0.

Amendment 3 agreed to.

Section 2, as amended, agreed to.

Amendment 4 moved—[Margaret Mitchell].

The Convener: The question is, that amendment 4 be agreed to. Are we agreed?

Members: No.

The Convener: There will be a division.

For
Finnie, John (Highlands and Islands) (Ind)
McDougall, Margaret (Central Scotland) (Lab)
McInnes, Alison (North East Scotland) (LD)
Mitchell, Margaret (Central Scotland) (Con)
Murray, Elaine (Dumfriesshire) (Lab)

Against
Allard, Christian (North East Scotland) (SNP)
Campbell, Roderick (North East Fife) (SNP)
Grahame, Christine (Midlothian South, Tweeddale and Lauderdale) (SNP)
Paterson, Gil (Clydebank and Milngavie) (SNP)

The Convener: The result of the division is: For 5, Against 4, Abstentions 0.

Amendment 4 agreed to.
Amendment 5 moved—[Margaret Mitchell].
Amendment 5A not moved.

The Convener: The question is, that amendment 5 be agreed to. Are we agreed?
Members: No.
The Convener: There will be a division.

For
Finnie, John (Highlands and Islands) (Ind)
McDouggall, Margaret (Central Scotland) (Lab)
McInnes, Alison (North East Scotland) (LD)
Mitchell, Margaret (Central Scotland) (Con)
Murray, Elaine (Dumfriesshire) (Lab)

Against
Allard, Christian (North East Scotland) (SNP)
Campbell, Roderick (North East Fife) (SNP)
Grahame, Christine (Midlothian South, Tweeddale and Lauderdale) (SNP)
Paterson, Gil (Clydebank and Milngavie) (SNP)

The Convener: The result of the division is: For 5, Against 4, Abstentions 0.
Amendment 5 agreed to.
Section 3, as amended, agreed to.

Section 4—Discretionary inquiries

Amendment 6 moved—[Margaret Mitchell].

The Convener: The question is, that amendment 6 be agreed to. Are we agreed?
Members: No.
The Convener: There will be a division.

For
Finnie, John (Highlands and Islands) (Ind)
McDouggall, Margaret (Central Scotland) (Lab)
McInnes, Alison (North East Scotland) (LD)
Mitchell, Margaret (Central Scotland) (Con)
Murray, Elaine (Dumfriesshire) (Lab)

Against
Allard, Christian (North East Scotland) (SNP)
Campbell, Roderick (North East Fife) (SNP)
Grahame, Christine (Midlothian South, Tweeddale and Lauderdale) (SNP)
Paterson, Gil (Clydebank and Milngavie) (SNP)

The Convener: The result of the division is: For 5, Against 4, Abstentions 0.
Amendment 6 agreed to.
Section 4, as amended, agreed to.

Section 6—Inquiries into deaths occurring abroad: general

The Convener: Amendment 8, in the name of the minister, is in a group on its own.

Paul Wheelhouse: Amendment 8 seeks to remove the requirement for a body to be repatriated to Scotland before a fatal accident inquiry may be held into the death of a Scot abroad. The bill as introduced included that requirement mainly because Lord Cullen recommended as much in his review of the FAI legislation but also because it mirrors the practice in England and Wales. The coroner’s duty to investigate a death abroad arises only if the body is returned to the coroner’s district and the circumstances are such that an inquest would have been held if the death had occurred in England and Wales.

When she gave evidence to the committee at stage 1, the Solicitor General for Scotland indicated that repatriation of the body might provide crucial evidence of the cause of death. Repatriation obviously opens up the possibility of a post mortem being held in Scotland. When a body is repatriated from abroad, it might be accompanied by a death certificate from the foreign authority that might also provide useful evidence. Depending on the standard of the examination that was carried out abroad, that might or might not confirm the results of examination of the body.

However, it is accepted that, in certain instances, it might simply not be possible for a body to be repatriated. The body might not be available because it might have been destroyed in the accident that caused the death, or the body might have been lost at sea, for example. It might simply not be possible to repatriate a body on grounds of cost. The advice from the Foreign and Commonwealth Office is that bereaved families might wish to consider cremation of a body in the country where the death occurred. That is partly because of the significant expense of repatriating a body, but it means that a family might have a body cremated before they became aware of the possibility of a death investigation and FAI in Scotland. The Scottish Government is liaising with the Foreign and Commonwealth Office with a view to its guidance being updated with these new arrangements, which will come into operation as smoothly as possible for families.

I know that the committee raised the issue of repatriation of the body as an area of concern very early in its consideration of the bill and has consistently pressed the point, including in the stage 1 report. I am happy that the Government and the Crown Office have been able to take on board those concerns and are now able to agree that repatriation should not be required.

The important discretion that is afforded to the Lord Advocate in paragraphs (b), (c) and (d) of section 6(3) will remain in place. That means that the Lord Advocate would have to consider that
“the circumstances of the death have not been sufficiently established in the course of an investigation in relation to the death” and “there is a real prospect that those circumstances would be sufficiently established in an inquiry” and decide that “it is in the public interest for an inquiry be held”.

We should also be careful not to raise unreasonable expectations among the bereaved family that an inquiry will definitely be held and of what an inquiry in Scotland might be able to achieve. The Crown Office will have to rely on the Government and legal authorities of the country in which the death occurred and standards of investigation and co-operation vary across the world.

It is expected that only in exceptional circumstances would the Lord Advocate decide that a death investigation and possible FAI were merited in the absence of repatriation of the body, but it is a very important advance that that possibility should exist, particularly as that is not the case in England and Wales.

I move amendment 8.

The Convener: Are you saying that repatriation of the body is not required in England and Wales?

Paul Wheelhouse: It is required in England and Wales. We have gone beyond the practice in England and Wales.

The Convener: So the committee has done a good deed.

Christian Allard: I want to show my appreciation for the fact that the Government has listened to the committee, particularly on behalf of many families in the north-east of Scotland who have members working abroad, many of them offshore. They will be delighted to hear the news that, in exceptional circumstances, there is the possibility of having an FAI without the body being recovered.

Paul Wheelhouse: I thank Mr Allard for those comments.

The Convener: It is a commonsense amendment.

Amendment 8 agreed to.

Section 6, as amended, agreed to.

Section 7 agreed to.

After section 7

The Convener: Amendment 59, in the name of Patricia Ferguson, is in a group on its own.

Patricia Ferguson (Glasgow Maryhill and Springburn) (Lab): A sudden death in a family is a traumatic experience and the sudden death of a family member in circumstances that might require a fatal accident inquiry is likely to be particularly traumatic. We have all heard of instances when that experience is exacerbated by the time lag between the death and the decision about whether an FAI is to be held. Many families have felt uncomfortable about the way in which information is communicated to them.

My member’s bill, the Inquiries into Deaths (Scotland) Bill, sought to introduce time limits within which that decision should be made and provisions on communication with families affected by that decision. However, those ideas did not meet with universal approval. In the meantime, the Crown Office and Procurator Fiscal Service had begun to draw up a charter detailing how communication with bereaved families will take place and when it will take place. I believe that the charter is an improvement on the current situation, so I am content to support the idea. However, it seemed to me that the provision of such a charter should be underpinned in this legislation and that, although the Lord Advocate should retain the right to revise the document from time to time, he or she must lay before Parliament the charter and any revision that might be made.

I am grateful to the minister for facilitating this amendment and I hope that the committee will support it.

I move amendment 59.

Roderick Campbell: I support amendment 59. Anything that increases the families’ understanding of the system and how it is supposed to operate is to be welcomed.

The Convener: I congratulate Patricia Ferguson on pursuing the issue. It is a bewildering process for families; any court process can be bewildering, but in an FAI, people can be coping with the loss of a close family member and the process is carried out in the public interest, which means that families sometimes feel as though they are on the sidelines. Patricia Ferguson has made important progress on that. I do not mean that to sound patronising—members’ bills are useful in facilitating such steps.

Paul Wheelhouse: At stage 1, I welcomed the commitment by the Solicitor General to consult on, and produce, a charter of investigation milestones, which will address concerns over keeping bereaved families informed about death investigations and complement the provisions in the bill to make the FAI system more efficient. I acknowledge Patricia Ferguson’s role in raising that agenda.
I welcome the committee’s comment in its stage 1 report that “the publication of a milestone charter should help address the delays in the FAI process”.

Bereaved families must be kept better informed of progress throughout death investigations and, although the Crown Office has made great strides in this area in recent years, particularly since the establishment of the Scottish fatalities investigation unit, the charter will provide a clear and easily understandable guide for families of what to expect from the investigative authorities at the Crown Office at a time of great strain and stress for those families.  

10:45

The charter aims to provide guidance on what the bereaved family should expect from the Crown Office by way of the provision of information about death investigations and the timescales within which that information will be provided. The Crown Office will communicate with families in the manner that the family prefers, such as in face-to-face meetings or by letter or phone call.

It is proposed that, in cases requiring further investigation with a view to deciding whether criminal proceedings should be instigated and/or whether an FAI should be held, the Crown Office will make contact with bereaved families three months after the date that the death has been reported to the COPFS. The Crown Office will offer the family a personal meeting within 14 days to give them an update on the progress of the death investigation, as well as an idea of the likelihood of criminal proceedings and the possibility of an FAI.

It is also proposed that the charter will explain the different stages of a death investigation and set out the commitments of the Crown Office in terms of keeping in touch with relatives. It is proposed that it will contact the families every six weeks after the initial contact. The charter will also include a frequently asked questions section and links to further information.

I am therefore delighted to welcome this proposal by Patricia Ferguson to give the charter statutory underpinning. The amendment places a duty on the Lord Advocate to prepare and publish the charter and specifies what should be included in it, though it will be subject to occasional review. The charter must be laid before the Scottish Parliament.

I take this opportunity to thank Patricia Ferguson again for all her work on FAIs and for agreeing to discuss areas of potential common ground, as recommended by the committee in its report. We had an open and constructive discussion on areas where there was common ground for collaboration to improve the FAI system by strengthening the Government’s bill, and amendment 59 is one of two that we have agreed with the member.

The Government is happy to support amendment 59, in the name of Patricia Ferguson, and I ask the committee to do the same.

Amendment 59 agreed to.

Section 8—Reasons where inquiry not held

Amendment 7 moved—[Margaret Mitchell].

The Convener: The question is, that amendment 7 be agreed to. Are we agreed?

Members: No.

The Convener: There will be a division.

For
Finnie, John (Highlands and Islands) (Ind)
McDougall, Margaret (Central Scotland) (Lab)
McInnes, Alison (North East Scotland) (LD)
Mitchell, Margaret (Central Scotland) (Con)
Murray, Elaine (Dumfriesshire) (Lab)

Against
Allard, Christian (North East Scotland) (SNP)
Campbell, Roderick (North East Fife) (SNP)
Grahame, Christine (Midlothian South, Tweeddale and Lauderdale) (SNP)
Paterson, Gil (Clydebank and Milngavie) (SNP)

The Convener: The result of the division is: For 5, Against 4, Abstentions 0.

Amendment 7 agreed to.

The Convener: Section 8, as amended, agreed to.

Section 9 agreed to.

The Convener: Amendment 9, in the name of the minister, is grouped with amendment 55.

Paul Wheelhouse: Amendment 9 is a technical drafting amendment that is intended to bring a reference in section 10, which relates to persons who are entitled to participate in a fatal accident inquiry, into line with that in section 2(3), for reasons of consistency and clarity. The provision in section 10 ensures that the employer of someone who is killed in the course of their employment is entitled to participate in the mandatory FAI, as was the case under the Fatal Accidents and Sudden Deaths Inquiry (Scotland) Act 1976.

Amendment 55, in the name of Elaine Murray, would give a statutory right of participation in a fatal accident inquiry to a trade union or staff association representative if the deceased was a member of that trade union or staff association at the time of death and if they died in Scotland as the result of an accident in the course of their
employment or occupation. The committee’s stage 1 report stated:

“We believe it is imperative that families, trade unions and staff associations are able to participate in a meaningful way in an FAI and that families are represented appropriately and are kept informed throughout the process.”

The Scottish Government agrees with that statement.

As the convener has noted,

“Section 10(1)(e) says that

‘any other person who the sheriff is satisfied has an interest in the inquiry’


The Scottish Government considers that section 10(1)(e) would permit the sheriff to allow a trade union or staff association representative to participate in an accident at work fatal accident inquiry, if he or she thought it appropriate. Nonetheless, in light of the committee’s stage 1 report, the Government is content to support amendment 55 in principle, subject to exploring with Dr Murray whether any adjustments to the wording should be made at stage 3 to ensure that the bill gives full effect to the policy intention.

I move amendment 9.

The Convener: I think that that is a semi-victory.

Elaine Murray: I thank the minister for making most of my case for me. Many of the things that I was going to say no longer require to be said.

The Convener: It is not mandatory to contribute.

Elaine Murray: I am happy to consider the wording. It was a bit difficult to phrase amendment 55 so that it referred to someone being at the time of their death a member of a trade union that is relevant to the occupation—for example, they might have been a trade union member with some other employment or because of some previous occupation.

The way in which the amendment is written is maybe slightly clumsy, but I am pleased that the minister will accept it. It is important that trade union and staff association representatives have a right to be there, not only because they might have information that could be of assistance but because they could provide significant support to victims’ families.

The Convener: I feel a tweak coming on. Tweaks are very fashionable. Does the minister wish to wind up?

Paul Wheelhouse: I am happy to leave it at that, convener.

Amendment 9 agreed to.

Amendment 55 moved—[Elaine Murray]—and agreed to.

Section 10, as amended, agreed to.

After section 10

The Convener: Amendment 60, in the name of Patricia Ferguson, is in a group on its own.

Patricia Ferguson: As the committee is aware, the bill had its genesis in the review of fatal accident inquiries that Lord Cullen undertook at the Scottish Government’s request. One of his recommendations, which has not so far found its way into the bill, relates to the availability of legal aid.

My Inquiries into Deaths (Scotland) Bill explored that area, but I acknowledge that it went considerably further than Lord Cullen suggested. He made two particularly important points about legal aid. The first relates to the fact that relatives often believe that the procurator fiscal attends an FAI to look after their interests, particularly if they are unrepresented. The Crown Office and Procurator Fiscal Service’s guidance makes it clear that that is not the case and says that the procurator fiscal’s role is to represent to the court any matter that affects the public interest.

Lord Cullen’s second point was that an FAI can take place whether or not relatives consent to it. If relatives want to participate, their ability to do so without representation is limited, and they can be at a considerable disadvantage in comparison with other interested parties. The Faculty of Advocates stated in evidence to Lord Cullen that

“It is impossible for relatives to participate effectively in important inquiries without legal representation.”

Sheriff JP Murphy observed that relatives

“should not be expected to be capable of self-representation in the traumatic situation of an FAI. I have never seen a lay person do it adequately”.

Amendment 60, in my name, seeks to disapply the normal test of reasonableness and the normal financial conditions and thresholds and to require ministers to produce a special scheme of conditions for relatives who are involved in FAls. I have deliberately not been prescriptive about those regulations and I have instead left that decision to ministers. However, I do so in the context of a presumption that legal aid will be available and that families will be able to be represented throughout the process—that has been an issue—and will not find that cash runs out part of the way through an FAI. That is a basic
principle and I hope that the committee will support it.

I move amendment 60.

Margaret Mitchell: I support what Patricia Ferguson said, which is backed by the evidence that the committee heard when we considered the issue. As she rightly said, the COPFS represents the public interest, and the interests of relatives are not represented. It is therefore only right and fair that legal aid should be available to ensure that those interests are represented. I am very much in favour of amendment 60.

Roderick Campbell: I am interested to hear what the minister has to say. I accept that Lord Cullen reported in those terms in 2009, but I do not think that the committee quizzed him further on that in taking evidence, so I do not know whether that has remained his view given the circumstances in which we now stand. Comments have been made about resource implications, and we should have regard to the amendment’s resource implications. I am interested to hear from the minister on that point.

The Convener: I am in a similar position. I am sympathetic to the arguments. I do not think that I will support the amendment at this stage but, if it fails, I would like to hear further reasons for such a provision at stage 3.

There is an issue for FAIs, which are very different from criminal proceedings, in that in certain circumstances the deceased’s family and relatives have no legal support of any kind. I have concerns about a special case being made, were there to be no financial test, but I note that the amendment says that

“The Scottish Ministers must by regulations make provision for the financial conditions to apply to a person to whom subsection (2A) applies.”

I would like that to be developed. I will not at this stage support the amendment, but I would like further inquiry and investigation by the Government into whether there might be something in regulations, perhaps subject to financial tests of a certain kind, to provide support for relatives.

There is an issue. FAIs are a very grey area. Although FAIs are held in the public interest, bereaved families—for whom an FAI will open everything up again—are sitting there.

We have previously made changes to the communications that the Crown has to make so that people are involved in the process more and get some support, which might just be in the form of explaining the legal process to them. There is an issue that I would like the Government to explore further. I will not at this stage support the amendment, but I would like it to be considered.

Paul Wheelhouse: I note the comments that the convener has made.

I am aware that a number of groups support Lord Cullen’s recommendations that the reasonableness test should be removed and that financial eligibility levels should be increased when relatives seek civil legal aid for FAI proceedings. Amendment 60 aims to implement that.

I fully acknowledge that relatives are in a terrible situation when they experience the death of a family member. It is important that they should be able to participate appropriately in an FAI when there is one. However, that does not automatically require legal representation in every case.

The purpose of a fatal accident inquiry is to investigate in the public interest the circumstances of a death, to try to avoid any future incident of the same kind. The procurator fiscal leads evidence to establish the cause of death.

Procurators fiscal therefore have a public duty to fulfil at the inquiry. They meet the family to discuss the witnesses and evidence that they intend to produce at the inquiry and the questions that they intend to ask. Often the fiscal asks the family whether there are any particular questions that they wish to have answered. Sometimes, families have questions that the fiscal does not feel that it would be appropriate to ask, since they are representing the public interest. Families might wish to ask questions that are intended to establish whether there are grounds for civil proceedings following the FAI. In such cases, they might consider that they require their own legal representative to do that.

If the family cannot afford to pay for such legal representation, they might be eligible to receive legal aid. The Scottish Legal Aid Board can make legal aid available when a person who is entitled to be represented at a fatal accident inquiry can show that they have concerns that the procurator fiscal is not going to raise at the inquiry. I hope that the charter process will improve openness about what the procurator fiscal is going to do, which will help to inform the family’s actions. The reasonableness test will be satisfied if the family can show that they have legitimate concerns and questions that the procurator fiscal cannot ask in the public interest.

If the amendment was agreed to, legal aid would become available more or less on demand for fatal accident inquiries. I note the point that the convener made. I understand that point fully and sympathise with much of what was said. Many FAIs result in purely formal findings from the sheriff on the basis of the evidence that is led by the procurator fiscal. It is difficult to see the case for a guarantee of legal representation in all such cases.
If legal representation became universal, the likelihood is that FAls would become more adversarial, longer and, potentially, more costly. I understood that that was one of the key points that Patricia Ferguson wished to avoid.

In the current financial climate, during which the Scottish Government’s budget has remained broadly unchanged in cash terms, controlling legal aid expenditure is necessary. Statutory tests of probable cause and reasonableness apply to any application for civil legal aid, although anyone who is eligible for legal aid will be granted it, and the Government has prioritised maintaining the wide scope of matters for which legal aid is available in order to protect access to justice.

11:00

Removing the reasonableness test for relatives in FAI cases would have a price tag. Legal aid expenditure on such cases varies widely from year to year, but we could expect an additional cost of at least £500,000 per year. I appreciate the earlier comments about not wishing to reduce the debate to a discussion about resources, but resources have a significant bearing on the Government’s position, and that money would have to come from somewhere.

In England and Wales, there have been serious and swingeing cuts to civil legal aid to save money. People there can no longer access legal aid to help with certain types of family, medical, housing and welfare benefits problems. In certain cases, people have to provide evidence that they or their children have been victims of domestic abuse or violence in order to access legal aid. I put it on the record that I do not want to go down that route in Scotland.

As I have explained, if a family have concerns that the procurator fiscal cannot address in the public interest—again, I stress that the charter will help to improve transparency on that and engagement with the family—the likelihood is that the reasonableness test for legal aid will be satisfied. When a death has occurred in prison, it will also be likely that the reasonableness test will be satisfied.

Legal aid will be focused on the cases that deserve it, so that access to justice can be maintained. The extension of entitlement to legal aid at fatal accident inquiries that the amendment proposes would be not only unaffordable but unnecessary. A balance has to be struck; I regret saying that, because I appreciate the points that have been made about resources, but I hope that the committee will appreciate that we are not in an easy position. Therefore, although I have a great deal of sympathy with the intention to make legal aid eligibility more certain, unfortunately I cannot support the amendment.

Patricia Ferguson: I say in response to Mr Campbell that I am not aware that Lord Cullen has repudiated his view. I would have thought that, if he had changed his mind, he would have said so when he gave evidence to the committee. In my view, this is a matter of principle and we should not focus at all on the amount of money that the proposal might cost, but I will return to that in a second.

To take that point of principle, relatives are also capable of being pragmatic. I point to the example that I know best, which was not a fatal accident inquiry, although it was in some ways similar—the Stockline inquiry, where there were 10 bereaved families but only three representatives, because eight of the families came together and agreed to have one representative for all the people in that group, while two of the families decided that that was not the way that they wanted to go. That example shows that families can be pragmatic.

With regard to the role of the procurator fiscal, the guidance that the Crown Office and Procurator Fiscal Service is giving families indicates

“that it is unlikely that [he or she] will be able adequately to represent their interest and concerns at the Inquiry and that separate representation is considered appropriate”.

It seems strange that the state makes that suggestion to people but does not provide them with a methodology that allows them to access the representation.

I have deliberately said that the Scottish ministers should come forward with a financial contributions scheme. I have not left that as an open-ended blank cheque, but I have left it open for ministers to work out a formula that would be acceptable. As matters stand, the Scottish Legal Aid Board automatically treats the condition of reasonableness as met without question in the case of deaths in prison, for example. What I propose is a provision that in the interests of fairness—and, more important, in the interests of justice—has to be taken forward. I hope that the committee will see fit to support the amendment.

The Convener: The question is, that amendment 60 be agreed to. Are we agreed?

Members: No.

The Convener: There will be a division.

For

Finnie, John (Highlands and Islands) (Ind)
McDougall, Margaret (Central Scotland) (Lab)
McInnes, Alison (North East Scotland) (LD)
Mitchell, Margaret (Central Scotland) (Con)
Murray, Elaine (Dumfriesshire) (Lab)
Against
Allard, Christian (North East Scotland) (SNP)
Campbell, Roderick (North East Fife) (SNP)
Paterson, Gil (Clydebank and Milngavie) (SNP)

Abstentions
Grahame, Christine (Midlothian South, Tweeddale and Lauderdale) (SNP)

The Convener: The result of the division is: For 5, Against 3, Abstentions 1.

Amendment 60 agreed to.
Sections 11 to 13 agreed to.

Section 14—Initiating the inquiry

The Convener: Amendment 10, in the name of the minister, is grouped with amendments 11, 19, 20, 22 and 23.

Paul Wheelhouse: Amendment 10 is a technical amendment that clarifies what information the procurator fiscal must provide to the sheriff when giving the sheriff notice that a fatal accident inquiry is to be held. Under section 14(1), the fiscal must provide the sheriff with “notice that the inquiry is to be held ... a brief account of the circumstances of the death so far as known to the procurator fiscal, and ... any other information required by an act of sederunt” made under the bill. Section 14(2) requires the sheriff to make an order to fix the date and place of a preliminary hearing, if one is to be held, and the date and place of the inquiry. At present, it refers to the sheriff doing so only on receipt of notice that the inquiry is to be held under section 14(1)(a). It does not refer to the requirements of paragraphs (b) and (c) of section 14(1) and the question arises as to what the sheriff should do if he or she does not receive that information.

Amendment 10 removes that uncertainty by making it clear that the sheriff should receive all the material that is set out in section 14(1). If the sheriff does not receive that material, he or she will not be required to order the inquiry. Amendment 11 is consequential on amendment 10.

Amendments 20 and 22 are concerned with what material the procurator fiscal must provide to the sheriff if further inquiry proceedings are to be held under section 28 in light of new evidence in relation to the circumstances of the death. Amendment 22 requires the fiscal to provide the sheriff with a copy of the determination from the original inquiry into the death or deaths, as well as notice that further proceedings are to be held. Amendment 20 requires the notice of the further inquiry proceedings to include the material that is mentioned in paragraphs (c) and (d) of section 30(1).

Amendments 19 and 23 are consequential. I move amendment 10.

Amendment 10 agreed to.

Amendment 11 moved—[Paul Wheelhouse]—and agreed to.

Section 14, as amended, agreed to.

Sections 15 to 25 agreed to.

Section 26—Dissemination of the sheriff’s determination

The Convener: Amendment 12, in the name of the minister, is grouped with amendments 13 and 14.

Paul Wheelhouse: The amendments in this group are technical amendments to section 26, under which the sheriff can redact or withhold all or part of their determination from publication.

Amendment 12 amends section 26(2), which sets out the Government bodies that should be given a copy of the determination and related documents on request. The intention is to put devolved non-ministerial departments in the same position as United Kingdom departments. The amendment therefore changes “the Scottish Ministers” to “an office-holder in the Scottish Administration”.

The Scottish Administration includes the Scottish Government, so there is no longer a need for separate reference to the Scottish ministers. The Scottish Housing Regulator and Food Standards Scotland are within the Scottish Administration.

The purpose of the amendment is also to ensure that future devolved departments, such as a Scottish health and safety department, are covered by the provision, so I commend amendment 12 to the committee.

Amendment 13 removes the reference in section 26(5) to a sheriff having to look to provision made in an act of sederunt made under the bill when considering redacting sensitive or other material in a determination at the conclusion of a fatal accident inquiry.

The Lord President has recently issued guidance on redaction of judicial decisions generally, including FAI determinations, and the amendment is consistent with the principle that redaction is a matter for judicial discretion and guidance. Sheriffs will therefore continue to use their discretion in relation to redacting determinations, guided by the framework provided by the Lord President.

Amendment 14 ensures that the Lord Advocate and participants in the inquiry will receive full unredacted copies of the sheriff’s determination at
the conclusion of an inquiry. The reason for drawing a distinction in terms of different recipients is that the persons who may receive unredacted copies of determinations are either participants in the inquiry or public authorities, including Governments and the Health and Safety Executive. By contrast, the sheriff will be able to exercise discretion, using the guidance from the Lord President, when sending to a person to whom a recommendation has been addressed, to ensure that their copy contains all the material relevant to them while omitting sensitive material that they do not need to see, such as material affecting children or national security.

I move amendment 12.

**Margaret Mitchell:** Will you clarify the purpose of the amendment to ensure that future devolved departments, such as a health and safety department, are covered by the provision? How are such issues normally dealt with, in advance of that happening?

**Paul Wheelhouse:** Amendment 12 provides the ability for any future devolved departments, such as a Scottish health and safety department, to be covered by the provision. The amendment is meant to avoid the necessity of coming back to the legislation to amend it. It is purely a practical measure and there is no particular agenda underlying it, if that is Margaret Mitchell’s concern. It is just meant to allow flexibility and avoid the need to come back to and amend legislation.

**Margaret Mitchell:** I was just trying to clarify whether, at present, such cases are dealt with and when the eventuality arises.

**Paul Wheelhouse:** I believe that that is normal. The amendment is a practical measure to avoid us having to come back to amend legislation retrospectively.

**The Convener:** Margaret Mitchell has her suspicious face on.

**Paul Wheelhouse:** I do not have any suspicious agenda here—that is all that I can stress.

**The Convener:** Was that was your winding up, minister?

**Paul Wheelhouse:** It was indeed.

_Amendment 12 agreed to._

**The Convener:** Are you agreed, Margaret?

**Margaret Mitchell:** I may as well.

**The Convener:** That is a semi-victory.

_Amendments 13 and 14 moved—[Paul Wheelhouse]—and agreed to._

_Section 26, as amended, agreed to._

Section 27—Compliance with sheriff's recommendations

**The Convener:** Amendment 15, in the name of the minister, is grouped with amendments 16, 17, 31 and 32.

**Paul Wheelhouse:** This group of amendments is intended to clarify how the process of dealing with responses to sheriffs' recommendations will be dealt with by the Scottish Courts and Tribunals Service.

In its stage 1 report, the committee welcomed the bill’s proposals to require sheriffs’ determinations to be published and to require parties that were involved in the inquiry and to whom a recommendation is addressed to respond to the recommendations. The committee considered that those proposals struck the correct balance in seeking compliance with recommendations. The Scottish Government believes that the proposals will have the effect of ensuring that sheriffs’ recommendations are respected and that the whole process becomes more transparent.

However, there may sometimes be good and justified reasons why part or all of a response should not be published. Amendment 15 makes it clear that it will be possible to withhold from publication the whole of a response to a sheriff’s recommendation and not just part. It is expected that requests for the withholding of the whole of responses will be very rare, but a party may have good reasons for doing so, such as commercial confidentiality or the protection of vulnerable persons.

Amendment 17 will ensure that the SCTS website will make it clear whether all or part of a response has been published. If part has been withheld, a note will explain that fact and if, unusually, the whole of a response has been withheld, an appropriate note will signify that fact. Under the new subsection (7), notice will be given if no response is received.

Although the SCTS may withhold part of a response for data protection or other reasons without a request being made to that effect, it will withhold all of a response only if a request to that effect is received. The final decision will, of course, always be with the SCTS, which has experience of redacting judicial opinions under formal guidance that is issued by the Lord President.

The experience of the equivalent procedure in England and Wales is that responses have been received in 100 per cent of cases, and thus far there have been no representations for part or all of a response to be withheld. Parties seem anxious to demonstrate compliance with any recommendation that is directed towards them. There is no reason to suppose that the response
rates and reaction in Scotland will be different from that experience in England and Wales.

The Crown Office has previously indicated that there is no evidence that parties fail to implement sheriffs’ recommendations, and in many cases remedial action has been taken by the time an FAI is held.

I move amendment 15.

Amendment 15 agreed to.

Amendments 16 and 17 moved—[Paul Wheelhouse]—and agreed to.

The Convener: Amendment 18, in the name of the minister, is in a group on its own.

Paul Wheelhouse: It is an essential aspect of the Scottish Government’s policy that fatal accident inquiries should remain inquisitorial and not adversarial in nature. By endorsing the general principles of the bill, the Justice Committee has endorsed that particular principle.

Section 6(3) of the Fatal Accidents and Sudden Deaths Inquiry (Scotland) Act 1976 protects the inquisitorial principle by providing that the determination of the sheriff is not admissible in evidence and cannot be founded on in any future judicial proceedings, of whatever nature, that arise out of the death or any accident from which the death resulted. That provision will be re-enacted in section 25(6) of the bill.

The rationale for that provision is that the sheriff should not be inhibited from explicitly or implicitly criticising a party that was involved in the death, since the function of the determination is to record the result of the examination of all the circumstances of the death and to permit the sheriff to make recommendations as to how deaths in similar circumstances may be avoided in the future.

11:15

Equally, it is reiterated that the FAI process is not designed to be a foundation for subsequent civil litigation. The bill contains express provision for sheriffs to make recommendations in their determinations at the conclusion of FAIs; a new requirement for participants to whom recommendations are addressed to respond; and a statutory regime for the collation and publication of responses to recommendations. An interested person will in future be able to find on the SCTS website both the sheriff’s determination and responses to the recommendations. The question then arises as to the admissibility status of the recommendations.

The Government is concerned that, if a recipient of recommendations were to engage with recommendations directed to them in good faith and offer a full and open response, explicitly or implicitly accepting criticism, a pursuer’s agents might seek to found on the response as the basis for civil action. That could have the effect of inhibiting recipients of recommendations from responding fully and openly—or at all. They may feel, having taken legal or communications advice, that a note on the SCTS website stating that they have not responded is preferable to, and a lesser risk than, a response that could invite civil proceedings, or at least hamper prospects of a defence.

Responses to sheriffs’ recommendations should therefore be inadmissible in other judicial proceedings. We strongly believe that that will help to foster a culture of respondents making a virtue of having constructively addressed sheriffs’ recommendations.

I move amendment 18.

Amendment 18 agreed to.

Section 27, as amended, agreed to.

After section 27

The Convener: Amendment 61, in the name of Patricia Ferguson, is in a group on its own.

Patricia Ferguson: Amendment 61 requires ministers to prepare annually a report of recommendations that are made by sheriffs in relation to FAls. The report would contain information regarding the number of recommendations made, the number requiring a response and the number of responses received. The amendment also requires such a report to be laid before Parliament.

As members know, my bill went further than is now proposed, but I am conscious that my preferred way of working might have resulted in such recommendations becoming the subject of appeals that were designed to delay the introduction of a recommendation, which was not my intention. It is to be hoped that the alternative will reinforce the importance of such recommendations by making them the subject of such a report and that that importance is emphasised by ensuring that they are laid before Parliament and published. I am again grateful to the minister and his team for their co-operation in making that element of the proposed new section possible.

I move amendment 61.

The Convener: No one else wishes to comment, except for me, and I just want to say, “Well done again, Ms Ferguson.” There is hope for us all on the back benches.

Paul Wheelhouse: I am aware of the concerns that have been expressed by the committee and
others about ensuring that recommendations that are made by sheriffs at the conclusion of FAIs are respected. I thank Patricia Ferguson for working so hard on that.

The view of the Crown Office and Procurator Fiscal Service and the Health and Safety Executive is that, where sheriffs make recommendations as to how deaths in circumstances similar to those of the death that is the subject of an inquiry can be prevented, they are passed on to the relevant parties and regulatory and other authorities and they are taken very seriously. The COPFS and the HSE have commented that remedial action has often been taken by the time that an FAI is held. That should not, however, be taken as a reason for complacency.

The bill now formally obliges the SCTS to give a copy of a determination to each person to whom a recommendation is addressed and to any other person whom the sheriff considers has an interest in a recommendation. That will obviously include any regulatory or Government body at Scottish or UK level.

In its stage 1 report, the committee stated that it welcomed the proposal in the bill to require sheriffs’ determinations to be published and to require parties that were involved in the inquiry and to which a recommendation is addressed to respond to the recommendations. The report also said that the committee considered that the proposals struck the correct balance on improving compliance with the recommendations. The committee noted the view of witnesses that there could be difficulties in placing a duty on a particular body to monitor the implementation of sheriffs’ recommendations, and it considered the proposals in the bill to be sufficient.

I believe that the proposals in the bill for requiring responses to sheriffs’ recommendations will foster compliance. That is based on the evidence that I have outlined from England and Wales, where there has been a high degree of compliance. Publication of the response or notice that no response has been received will make the system more transparent. That mirrors the procedure that is used under the system of coroners’ inquests in the south. However, as I have said, we should not be complacent in this regard.

Amendment 61 in the name of Patricia Ferguson places a duty on the Scottish ministers to publish and lay before the Parliament an annual report of responses to recommendations that are made in sheriffs’ determinations. The report will indicate the number of such responses received alongside the number of inquiries and the number of recommendations requiring a response that were made during a reporting year. It will also indicate the number of failures to respond. The Ministry of Justice reports that there has been a 100 per cent response rate for the similar rules that are in effect for coroners’ inquiries in England and Wales, and there is no reason to believe that a similar rate of response would not be achieved under FAI legislation in Scotland. Persons to whom recommendations are addressed are usually only too anxious to demonstrate their compliance, and recommendations are made in only a third of FAI determinations—an average of 20 per year—so reporting the number of responses and non-responses should not be onerous or expensive, and having a record of non-responses in an annual report will allow trends to be identified over time by interested bodies.

I agree with the principle of Patricia Ferguson’s proposal and I again thank her for her work on that area of the bill. I hope that the committee will support the amendment.

Amendment 61 agreed to.

Sections 28 and 29 agreed to.

Section 30—Initiating further proceedings

Amendments 19 and 20 moved—[Paul Wheelhouse]—and agreed to.

The Convener: Amendment 21, in the name of the minister, is grouped with amendments 24 to 30.

Paul Wheelhouse: This group of amendments is intended to clarify the procedure for reopened and fresh fatal accident inquiries when there is a need for further proceedings following new evidence in relation to the circumstances of a death.

Lord Cullen recommended in his review that it should be possible for further inquiry proceedings to be instigated if new evidence came to light that would, in the opinion of the Lord Advocate, mean that a finding or recommendation from the original inquiry would have been materially different. However, Lord Cullen expressed the view that it would be rare for new evidence to render so much of the original determination unsafe that a completely fresh inquiry would be necessary.

The Scottish Government agrees that it will be rare for a new inquiry to be necessary and that, if new evidence is brought forward, which may be rare in itself, the norm will be that the original inquiry will be reopened and continued. I would like to clarify that the proposed provisions are not meant to assist parties who are dissatisfied with the handling or outcome of the original FAI. The appropriate remedy in such a case would be a
judicial review, were there any legal flaw in decision making.

Amendment 21 requires the Lord Advocate’s opinion on whether the form of further proceedings should be a reopened or fresh inquiry to be included on the notice to the sheriff under section 30(1) that further inquiry proceedings are to be held. It is entirely appropriate that the view of the Lord Advocate should be known to the sheriff who is to take the final decision on whether an inquiry is to be reopened or a fresh inquiry held. It is also appropriate that the Lord Advocate should express such a view, since he or she has taken the original decision that the new evidence merits further judicial consideration.

Amendment 24 requires the sheriff to hold a hearing when a notice is given under section 30(1) that further inquiry proceedings are to be held. That hearing will allow the sheriff to hear representations of the procurator fiscal and the participants in the inquiry in order to permit the sheriff to reach an informed decision about the form that the inquiry is to take. The purpose of the amendment is to meet the rationale behind Lord Cullen’s recommendation to allow further proceedings.

In his review, Lord Cullen said:

“It should be for the sheriff to whom the application is presented, after hearing the procurator fiscal and the interested parties, to decide which form of proceedings is appropriate in the particular case.”

However, Lord Cullen went on to say that in general he favoured having reopened inquiries, since a rehearing of the whole evidence may be unnecessary, although he conceded that there may be cases where a fresh inquiry is necessary.

Amendment 26 will oblige the sheriff to consider whether there is a public interest in a fresh inquiry being held rather than reopening the original inquiry. That will be assessed on the basis of the circumstances of the particular case. There are clearly potentially substantial resource and cost issues to holding an entirely fresh inquiry and it is right that the sheriff should have regard to the public interest in deciding whether the original inquiry should be continued or a new inquiry held.

Amendment 25 is a drafting amendment that provides consistency in the provisions of the bill, and amendments 27 to 30 are consequential on amendment 24.

I move amendment 21.

Amendment 21 agreed to.

Amendments 22 to 26 moved—[Paul Wheelhouse]—and agreed to.

Section 30, as amended, agreed to.
Where related amendments require to be made to UK-extent statutes in the law of England, Wales and Northern Ireland, they will be taken forward in an order under section 104 of the Scotland Act 1998.

If it is okay with the convener, I do not move amendment 33—

The Convener: We are inventing a new procedure here. [Laughter.]

Paul Wheelhouse: Amendment 33 would repeal section 38 of the Administration of Justice (Scotland) Act 1933. After further researches by the bill team, it transpired that the redundant section has already been repealed and there is therefore no need for amendment 33.

I move amendment 34.

The Convener: We are not at that yet. I will go through this again. You are not moving amendment 33, which we are all quite happy about. [Interruption.] What? Bear with me a second.

Amendment 33 moved—[Paul Wheelhouse].

The Convener: Because I made you move it, you have to seek to withdraw it.

Paul Wheelhouse: I seek to withdraw amendment 33.

The Convener: We are all feeling charming today, so we say yes.

Amendment 33, by agreement, withdrawn.

Amendments 34 to 51 moved—[Paul Wheelhouse]—and agreed to.

The Convener: We are coming to the end. You will be glad to know that the finishing post is in sight.

Schedule 2, as amended, agreed to.

Sections 38 to 41 agreed to.

Long title agreed to.

The Convener: That ends stage 2 consideration of the bill. I thank the minister and his officials. An amended reprint of the bill will be published overnight. I know that committee members will be glad about that, as they will be able to get busy with lodging any stage 3 amendments with the legislation team.

I am going to give us a seven-minute break, because the minister is coming back again for the next item.

11:29

Meeting suspended.
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Schedule 1—Procedure rules
Schedule 2—Modification of enactments
Inquiries into Fatal Accidents and Sudden Deaths etc. Scotland Bill

[AS AMENDED AT STAGE 2]

An Act of the Scottish Parliament to make provision for the holding of public inquiries in respect of certain deaths.

**Inquiries into certain deaths**

1 Inquiries under this Act

5 (1) Where an inquiry is to be held into the death of a person in accordance with sections 2 to 7, the procurator fiscal must—

(a) investigate the circumstances of the death, and

(b) arrange for the inquiry to be held.

(2) An inquiry is to be conducted by a sheriff.

10 (3) The purpose of an inquiry is to—

(a) establish the circumstances of the death, and

(b) consider what steps (if any) might be taken to prevent other deaths in similar circumstances.

(4) But it is not the purpose of an inquiry to establish civil or criminal liability.

15 (5) In this Act, unless the context requires otherwise—

(a) “inquiry” means an inquiry held, or to be held, under this Act,

(b) references to a “sheriff” in relation to an inquiry are to a sheriff of the sheriffdom in which the inquiry is, or is to be, held.

**Inquiries into deaths occurring in Scotland**

2 Mandatory inquiries

20 (1) An inquiry is to be held into the death of a person which—

(a) occurred in Scotland, and

(b) is within subsection (3), (3A) or (4).
(2) Subsection (1) is subject to section 3.

(3) The death of a person is within this subsection if the death was the result of an accident which occurred—
   (a) in Scotland, and
   (b) while the person was acting in the course of the person’s employment or occupation.

(3A) The death of a person is within this subsection if, at the time of death, the person was—
   (a) detained in hospital by virtue of—
       (i) the Mental Health (Care and Treatment) (Scotland) Act 2003, or
       (ii) the Criminal Procedure (Scotland) Act 1995,

(4) The death of a person is within this subsection if, at the time of death, the person was—
   (a) in legal custody, or
   (b) a child required to be kept or detained in secure accommodation.

(5) For the purposes of subsection (4)(a), a person is in legal custody if the person is—
   (a) required to be imprisoned or detained in a penal institution,
   (b) in police custody, within the meaning of section 56 of the Criminal Justice (Scotland) Act 2015,
   (c) otherwise held in custody on court premises,
   (d) required to be detained in service custody premises.

(6) For the purposes of subsections (4)(b) and (5)(a) and (d), it does not matter whether the death occurred in secure accommodation, a penal institution or, as the case may be, service custody premises.

(7) In this section—
   “mental disorder” has the meaning given by section 328 of the Mental Health (Care and Treatment) (Scotland) Act 2003,
   “penal institution” means any—
       (a) prison (including a legalised police cell within the meaning of section 14(1) of the Prisons (Scotland) Act 1989), other than a naval, military or air force prison,
       (b) remand centre, within the meaning of section 19(1)(a) of that Act,
       (c) young offenders institution, within the meaning of section 19(1)(b) of that Act,
   “secure accommodation” means accommodation provided in a residential establishment, approved in accordance with regulations made under section 78(2) of the Public Services Reform (Scotland) Act 2010, for the purpose of restricting the liberty of children,
   “service custody premises” has the meaning given by section 300(7) of the Armed Forces Act 2006.
3  **Mandatory inquiries: exceptions**

(1) The Lord Advocate may decide that an inquiry is not to be held into the death of a person within section 2(3), (3A) or (4) if satisfied that the circumstances of the death have been sufficiently established during the course of proceedings of a kind mentioned in subsection (2).

(2) The proceedings referred to in subsection (1) are—

(a) criminal proceedings,

(b) an inquiry under section 17(2) of the Gas Act 1965 (accidents),

(c) an inquiry under section 14(2A) of the Health and Safety at Work etc. Act 1974 (power of the Health and Safety Executive to direct investigations and inquiries),

(d) an inquiry under section 1 of the Inquiries Act 2005 (power to establish inquiry),

(e) an inquiry under section 85(1) of the Energy Act 2013 (inquiries),

(f) an investigation under section 11 of the Mental Health (Care and Treatment) (Scotland) Act 2003,

(g) an inquiry under section 12 of that Act.

(3) But subsection (1) does not apply if—

(a) at the time of death, the person was required to be detained in service custody premises, and

(b) the proceedings referred to in that subsection are an inquiry under section 1 of the Inquiries Act 2005.

4  **Discretionary inquiries**

(1) An inquiry is to be held into the death of a person which occurred in Scotland if the Lord Advocate—

(a) considers that the death—

(i) was sudden, suspicious or unexplained, or

(ii) occurred in circumstances giving rise to serious public concern, and

(b) decides that it is in the public interest for an inquiry to be held into the circumstances of the death.

(2) Subsection (1) does not apply to a death within section 2(3), (3A) or (4).

5  **Certain deaths and accidents to be treated as occurring in Scotland**

(1) For the purposes of sections 2 and 4, the death of a person, or an accident, is to be treated as having occurred in Scotland if it occurred—

(a) in connection with an activity falling within section 11(2) of the Petroleum Act 1998 (application of civil law to offshore activities), and

(b) in a relevant area.

(2) In subsection (1)(b), “relevant area” means an area in respect of which it is provided by Order in Council under section 11(1) of the Petroleum Act 1998 that questions arising out of acts or omissions taking place in the area are to be determined in accordance with the law in force in Scotland.
6 Inquiries into deaths occurring abroad: general

(1) Subsection (3) applies to the death of a person if—

(a) the death occurred outwith the United Kingdom, and

(b) at the time of death, the person was ordinarily resident in Scotland.

(2) But that subsection does not apply to the death of a person within section 12(2) or (3) of the Coroners and Justice Act 2009 (investigation in Scotland of deaths of service personnel abroad).

(3) An inquiry is to be held into a death to which this subsection applies if the Lord Advocate—

(a) considers that the death—

(i) was sudden, suspicious or unexplained, or

(ii) occurred in circumstances giving rise to serious public concern,

(b) considers that the circumstances of the death have not been sufficiently established in the course of an investigation in relation to the death,

(c) considers that there is a real prospect that those circumstances would be sufficiently established in an inquiry, and

(d) decides that it is in the public interest for an inquiry to be held into the circumstances of the death.

7 Inquiries into deaths occurring abroad: service personnel

(1) An inquiry is to be held into the death of a person if—

(a) the Lord Advocate is notified in relation to the death under section 12(4) or (5) of the Coroners and Justice Act 2009 (investigation in Scotland of deaths of service personnel abroad),

(b) the death is within subsection (2) or (3), and

(c) the Lord Advocate—

(i) decides that it is in the public interest for an inquiry to be held into the circumstances of the death, and

(ii) does not reverse that decision.

(2) The death of a person is within this subsection if the person was, at the time of death, in custody in circumstances analogous to legal custody (as construed by reference to section 2(5)).

(3) The death of a person is within this subsection if the Lord Advocate considers that the death—

(a) was sudden, suspicious or unexplained, or

(b) occurred in circumstances giving rise to serious public concern.

(4) But this section does not apply to a death within subsection (2) if the Lord Advocate is satisfied that the circumstances of the death have been sufficiently established in the course of any criminal proceedings against any person in respect of the death.
Family liaison charter

(1) The Lord Advocate must prepare a family liaison charter.

(2) A family liaison charter is a document setting out how the procurator fiscal will liaise with the family of a person in relation to whose death an inquiry may or is to be held.

(3) In particular, the charter must set out—
   (a) information to be made available to the family, and
   (b) timescales for the giving of the information.

(4) The Lord Advocate may from time to time revise the charter prepared under subsection (1).

(5) The Lord Advocate must—
   (a) consult such persons as the Lord Advocate considers appropriate before preparing the charter under subsection (1) or revising it under subsection (4),
   (b) lay the charter or revised charter before the Scottish Parliament, and
   (c) publish the charter or revised charter in such manner as the Lord Advocate considers appropriate.

Reasons where inquiry not held

(1) The Lord Advocate must give reasons in writing to the persons mentioned in subsection (2) where it is decided that an inquiry is not to be held into the death of a person (“A”)—
   (a) if the death is within section 2(3A),
   (b) in all other cases, if requested to do so by a person so mentioned.

(2) The persons referred to in subsection (1) are—
   (a) A’s spouse or civil partner at the time of A’s death,
   (b) a person living with A as if married to A at the time of A’s death, or
   (c) A’s nearest known relative if, at the time of A’s death, A—
      (i) did not have a spouse or civil partner, and
      (ii) was not living with a person as if married to the person.

Procurator fiscal’s investigation

(1) The procurator fiscal may cite a person to attend for precognition in connection with an investigation under section 1(1)(a).

(2) This section is sufficient warrant for such citation.

(3) Subsection (4) applies where a person cited under subsection (1)—
(a) having been given reasonable notice in the citation, and without reasonable excuse, fails to attend for precognition at the time and place mentioned in the citation, or

(b) does so attend but refuses to give information which is—

(i) within the person’s knowledge, and

(ii) relevant to the investigation.

(4) The sheriff may, on the application of the procurator fiscal, make an order requiring the person to attend for precognition or, as the case may be, give the information at a time and place specified in the order.

(5) A person who fails to comply with an order under subsection (4) commits an offence.

(6) A person who commits an offence under subsection (5) is liable on summary conviction to imprisonment for a term not exceeding 21 days or a fine not exceeding level 3 on the standard scale (or both).

Participants

10 Persons who may participate in the inquiry

(1) The following persons may participate in inquiry proceedings in relation to the death of a person (“A”)—

(a) A’s spouse or civil partner at the time of A’s death,

(b) a person living with A as if married to A at the time of A’s death,

(c) A’s nearest known relative if, at the time of A’s death, A—

(i) did not have a spouse or civil partner, and

(ii) was not living with a person as if married to the person,

(d) where the death is within section 2(3)—

(i) A’s employer, if A was acting in the course of the person’s employment,

(ii) an inspector appointed under section 19 of the Health and Safety at Work etc. Act 1974 (appointment of inspectors),

(iii) a representative of A’s trade union or staff association, if A was at the time of A’s death a member of a trade union or staff association in connection with the employment or occupation concerned,

(e) any other person who the sheriff is satisfied has an interest in the inquiry.

(2) In this Act—

(a) “inquiry proceedings” means any proceedings under this Act in relation to an inquiry,

(b) references to a participant in an inquiry are references to a person who participates in the inquiry proceedings by virtue of subsection (1).

Availability of civil legal aid

10A Availability of civil legal aid

(1) The Legal Aid (Scotland) Act 1986 is amended in accordance with this section.
(2) After subsection (1) of section 14 (availability of civil legal aid), insert—

“(1ZA) The Board must, when considering an application in respect of proceedings under the Inquiries into Fatal Accidents and Sudden Deaths etc. (Scotland) Act 2015 made by a person mentioned in subsection (1ZB), treat paragraphs (a) and (b) of subsection (1) as being satisfied in relation to that applicant.

(1ZB) The persons are, in respect of inquiry proceedings in relation to the death of a person (“A”)—

(a) A’s spouse or civil partner at the time of A’s death,
(b) a person living with A as if married to A at the time of A’s death,
(c) A’s nearest known relative if, at the time of A’s death, A—

(i) did not have a spouse or civil partner, and

(ii) was not living with a person as if married to the person.”.

(3) After subsection (2) of section 15 (financial conditions), insert—

“(2A) Subsections (1) and (2) do not apply to a person mentioned in section 14(1ZB) making an application in respect of proceedings under the Inquiries into Fatal Accidents and Sudden Deaths etc. (Scotland) Act 2015.

(2B) The Scottish Ministers must by regulations make provision for the financial conditions to apply to a person to whom subsection (2A) applies.

(2C) Regulations under subsection (2B) must ensure that civil legal aid is available to such extent and on such conditions as the Scottish Ministers consider will allow such persons to participate fully in the proceedings to which the application relates.”.

Location

11 Places at which inquiries may be held

(1) The Scottish Ministers may by regulations designate places at which a sheriff court may be held for the purposes of this Act (in addition to the places designated by virtue of the Courts Reform (Scotland) Act 2014 for the holding of sheriff courts).

(2) The Scottish Ministers may make regulations under subsection (1) only following the submission of a proposal under subsection (3).

(3) The Scottish Courts and Tribunals Service (“the SCTS”) may, with the agreement of the Lord President of the Court of Session, submit a proposal to the Scottish Ministers for the making of regulations under subsection (1).

(4) Before submitting a proposal to the Scottish Ministers, the SCTS must consult such persons as it considers appropriate.

(5) If, following the submission of a proposal, the Scottish Ministers decide to make regulations, they must have regard to the proposal in deciding what provision to make in the regulations.

(6) The Scottish Ministers may make regulations under subsection (1) only with the consent of—

(a) the Lord President, and

(b) the SCTS.
(7) Regulations under subsection (1)—
   (a) may make transitional, transitory or saving provision,
   (b) are subject to the affirmative procedure.

12 Jurisdiction in relation to inquiries

5 (1) Inquiry proceedings may be held in a sheriffdom whether or not there is a connection between the death, or any accident resulting in the death, to which the inquiry relates and the sheriffdom, and a sheriff of the sheriffdom accordingly has jurisdiction in relation to the proceedings.

10 (2) The Lord Advocate is, after consulting the Scottish Courts and Tribunals Service, to choose the sheriffdom in which proceedings are to be held.

15 (3) But the sheriff may make an order transferring the proceedings to a sheriff of another sheriffdom.

20 (4) The sheriff may make an order under subsection (3) only—
   (a) after giving the procurator fiscal and the participants in the inquiry an opportunity to make representations about the proposed transfer, and
   (b) with the consent of—
      (i) the sheriff principal of the sheriffdom of which the sheriff is a sheriff, and
      (ii) the sheriff principal of the sheriffdom to which the sheriff proposes to transfer the proceedings.

25 (5) The sheriff may make such an order—
   (a) on the sheriff’s own initiative, or
   (b) on the application of the procurator fiscal or a participant in the inquiry.

Inquiries into multiple deaths

13 Inquiry into more than one death

25 (1) A single inquiry may be held into the deaths of more than one person if it appears to the Lord Advocate that the deaths occurred—
   (a) as a result of the same accident, or
   (b) otherwise in the same or similar circumstances.

30 (2) Where an inquiry is held in relation to the deaths of more than one person, references in this Act to the death to which, or person to whom, the inquiry relates are references to each death to which, or person to whom, the inquiry relates.

Pre-inquiry procedure

14 Initiating the inquiry

35 (1) Where an inquiry is to be held into the death of a person, the procurator fiscal must give the sheriff notice that the inquiry is to be held.

35 (1A) A notice under subsection (1) must include—
   (b) a brief account of the circumstances of the death so far as known to the procurator fiscal, and
(c) any other information required by an act of sederunt under section 34(1).

(2) On receiving notice under subsection (1), the sheriff must make an order—
(a) fixing—
   (i) a date and place for the holding of a preliminary hearing in accordance with section 15 (if one is to be held), and
   (ii) a date for the start of the inquiry and the place at which it is to be held, and
(b) granting warrant for the procurator fiscal and the participants in the inquiry to cite persons to attend and give evidence at the inquiry.

(3) But the sheriff need not fix a date for the start of the inquiry (and the place at which it is to be held) in the order if—
(a) a preliminary hearing is to be held, and
(b) the sheriff considers that it is not appropriate to fix the date before that hearing.

(4) The sheriff may make an order varying a date or place fixed in an order under subsection (2).

(5) The sheriff must, when fixing a date for the start of the inquiry, have regard to the desirability of holding the inquiry as soon as is reasonably practicable.

15 Preliminary hearings

(1) At least one preliminary hearing is to be held before the start of an inquiry unless the sheriff dispenses with that requirement in accordance with provision made in an act of sederunt under section 34(1).

(2) Subsection (3) applies where the sheriff dispenses with the requirement to hold a preliminary hearing.

(3) The sheriff may subsequently make an order—
(a) for the holding of such a hearing, and
(b) fixing the date and place for it to be held.

(4) Provision is to be made in an act of sederunt under section 34(1) about—
(a) matters to be dealt with at a preliminary hearing under this Act,
(b) things that the procurator fiscal and the participants in the inquiry must do before such a hearing.

16 Notice of the inquiry

(1) After the sheriff makes an order under section 14(2) in relation to an inquiry, the procurator fiscal must give notice to the persons mentioned in subsection (2) of the following matters—
(a) the fact that the inquiry is to be held, and
(b) if fixed in the order—
   (i) the date and place for the holding of the preliminary hearing,
   (ii) the date for the start of the inquiry and the place at which it is to be held.

(2) The persons referred to in subsection (1) are—
(a) a person appearing to the procurator fiscal to be entitled to participate in the inquiry under section 10(1)(a) to (d), and

(b) any other person specified, or in a category of persons specified, in an act of sederunt under section 34(1).

The procurator fiscal must also give public notice of the matters specified in subsection (1)(a) and (b).

Subsection (5) applies where the sheriff makes an order under section 14(4).

The procurator fiscal must—

(a) give notice to the persons mentioned in subsection (2) of the new date or, as the case may be, place fixed in the order, and

(b) give public notice of that fact.

Subsection (7) applies where the sheriff makes an order under section 15(3).

The procurator fiscal must—

(a) give notice to the persons mentioned in subsection (2) of the following matters—

(i) the fact that a preliminary hearing is to be held, and

(ii) the date and place fixed for the holding of the hearing, and

(b) give public notice of those matters.

**Agreement of facts before an inquiry**

(1) Provision is to be made in an act of sederunt under section 34(1) about the agreement, by the procurator fiscal and the participants in an inquiry, of any facts of a kind mentioned in subsection (2) before the start of the inquiry.

(2) The facts referred to in subsection (1) are facts—

(a) in relation to which the procurator fiscal or a participant intends to bring forward evidence at the inquiry, and

(b) which the procurator fiscal or, as the case may be, participant considers are unlikely to be disputed at the inquiry.

**The inquiry**

(1) The sheriff has all such powers in relation to inquiry proceedings as a sheriff, under the law of Scotland, inherently possesses for the purposes of the discharge of the sheriff’s jurisdiction and competence and giving full effect to the sheriff’s decisions in civil proceedings.

(2) Subsection (1) is subject to—

(a) the other provisions of this Act,

(b) provision made in an act of sederunt under section 34(1).

**Evidence and witnesses**

(1) At an inquiry—
(a) the procurator fiscal must bring forward evidence relating to the circumstances of
the death to which the inquiry relates,

(b) a participant in the inquiry may bring forward such evidence.

(2) Without limiting subsection (1), the sheriff may require the procurator fiscal or a
participant in the inquiry to bring forward evidence about any matter relating to the
circumstances of the death.

(3) The rules of evidence which apply in relation to civil proceedings in the sheriff court
(other than a simple procedure case) apply in relation to an inquiry.

(4) Subsection (3) is subject to provision made in an act of sederunt under section 34(1).

(5) The examination of a person at an inquiry does not prevent criminal proceedings being
taken against the person.

(6) A person is not required at an inquiry to answer a question tending to show that the
person is guilty of an offence.

(7) In subsection (3), “simple procedure case” has the same meaning as in section 72(9) of
the Courts Reform (Scotland) Act 2014.

20 Inquiry to be conducted in public

(1) Inquiry proceedings are to be conducted in public.

(2) But the sheriff may order that such proceedings (or any part of them) are to be
conducted in private.

(3) The sheriff may make an order under subsection (2)—

(a) on the sheriff’s own initiative, or

(b) on the application of the procurator fiscal or a participant in the inquiry.

21 Publishing restrictions in relation to children

(1) Subsection (2) applies where a child is involved in an inquiry.

(2) The sheriff may order that no person may publish any material by which the child may
be identified in connection with the inquiry.

(3) Such material includes (but is not limited to)—

(a) the child’s name or address,

(b) the name of a school attended by the child,

(c) a picture of the child.

(4) The sheriff may make an order under subsection (2)—

(a) on the sheriff’s own initiative, or

(b) on the application of the procurator fiscal or a participant in the inquiry.

(5) A person who fails to comply with an order under subsection (2) commits an offence.

(6) A person who commits an offence under subsection (5) is liable on summary conviction
to a fine not exceeding level 4 on the standard scale.
(7) It is a defence for a person charged with an offence under subsection (5) to show that the person did not know or have reason to believe that the publication of the material would identify the child in connection with the inquiry.

(8) In this section—

“material” means anything that is capable of being read, looked at, watched or listened to, either directly or after conversion from data stored in another form, “publish” includes in particular—

(a) to publish in a programme service, as defined by section 201 of the Broadcasting Act 1990,

(b) to cause to be published.

22 Offences by bodies corporate etc.

(1) Subsection (2) applies where—

(a) an offence under section 21(5) has been committed by—

(i) a body corporate,

(ii) a Scottish partnership, or

(iii) an unincorporated association other than a Scottish partnership, and

(b) it is proved that the offence was committed with the consent or connivance of, or was attributable to neglect on the part of—

(i) a relevant individual, or

(ii) an individual purporting to act in the capacity of a relevant individual.

(2) The individual (as well as the body corporate, partnership or, as the case may be, association) commits the offence and is liable to be proceeded against and punished accordingly.

(3) In subsection (1)(b), “relevant individual” means—

(a) in relation to a body corporate (other than a limited liability partnership)—

(i) a director, manager, secretary or similar officer of the body,

(ii) where the affairs of the body are managed by its members, a member,

(b) in relation to a limited liability partnership, a member,

(c) in relation to a Scottish partnership, a partner,

(d) in relation to an unincorporated association other than a Scottish partnership, an individual who is concerned in the management or control of the association.

23 Assessors

(1) The sheriff may appoint a person (an “assessor”) to assist the sheriff in an inquiry.

(2) The sheriff may appoint a person as an assessor if the sheriff considers that the person has knowledge and expertise in matters that are relevant to the inquiry.

(3) The sheriff may make an appointment under subsection (1)—

(a) on the sheriff’s own initiative, or

(b) on the application of the procurator fiscal or a participant in the inquiry.
24 Expenses
The sheriff may not make any award of expenses in relation to inquiry proceedings.

Findings and recommendations

25 The sheriff’s determination

(1) As soon as possible after the conclusion of the evidence and submissions in an inquiry, the sheriff must make a determination setting out—
(a) in relation to the death to which the inquiry relates, the sheriff’s findings as to the circumstances mentioned in subsection (2), and
(b) such recommendations (if any) as to any of the matters mentioned in subsection (4) as the sheriff considers appropriate.

(2) The circumstances referred to in subsection (1)(a) are—
(a) when and where the death occurred,
(b) when and where any accident resulting in the death occurred,
(c) the cause or causes of the death,
(d) the cause or causes of any accident resulting in the death,
(e) any precautions which—
   (i) could reasonably have been taken, and
   (ii) had they been taken, might realistically have resulted in the death, or any accident resulting in the death, being avoided,
(f) any defects in any system of working which contributed to the death or any accident resulting in the death,
(g) any other facts which are relevant to the circumstances of the death.

(3) For the purposes of subsection (2)(e) and (f), it does not matter whether it was foreseeable before the death or accident that the death or accident might occur—
(a) if the precautions were not taken, or
(b) as the case may be, as a result of the defects.

(4) The matters referred to in subsection (1)(b) are—
(a) the taking of reasonable precautions,
(b) the making of improvements to any system of working,
(c) the introduction of a system of working,
(d) the taking of any other steps,
which might realistically prevent other deaths in similar circumstances.

(5) A recommendation under subsection (1)(b) may (but need not) be addressed to—
(a) a participant in the inquiry,
(b) a body or office-holder appearing to the sheriff to have an interest in the prevention of deaths in similar circumstances.

(6) A determination is not admissible in evidence, and may not be founded on, in any judicial proceedings of any nature.
26 Dissemination of the sheriff’s determination

(1) The Scottish Courts and Tribunals Service (“the SCTS”) must—

(a) publish, in such manner as it considers appropriate, each determination made under section 25(1),

(b) give a copy of each such determination to—

(i) the Lord Advocate,

(ii) each participant in the inquiry,

(iii) each person to whom a recommendation made in the determination is addressed, and

(iv) any other person who the sheriff considers has an interest in a recommendation made in the determination.

(2) The SCTS must, on request, give an office-holder in the Scottish administration, a Minister of the Crown, a department of the Government of the United Kingdom or the Health and Safety Executive a copy of—

(a) a determination made under section 25(1),

(b) the notice given under section 14(1) in relation to the inquiry to which the determination relates,

(c) any transcript of the evidence at the inquiry,

(d) any report or documentary production used in the inquiry.

(3) The SCTS must, on payment of the specified fee, give any other person a copy of—

(a) a determination made under section 25(1),

(b) any transcript of the evidence at an inquiry, if the person—

(i) makes a request for it within the specified period, and

(ii) has an interest in the inquiry.


(5) The sheriff may decide that part of a determination—

(a) is not to be given to a person under subsection (1)(b)(iii) or (iv),

(b) is to be withheld from publication under this section.

(6) After the sheriff has made a determination under section 25(1), the procurator fiscal must give the following information to the Registrar General of Births, Deaths and Marriages for Scotland—

(a) the name and last known address of the person to whose death the determination relates, and

(b) the date, place and cause of the death.

27 Compliance with sheriff’s recommendations

(1) A person to whom a recommendation under section 25(1)(b) is addressed—

(a) must, if the person was a participant in the inquiry to which the recommendation relates, give the Scottish Courts and Tribunals Service (“the SCTS”) a response in writing,
(b) may do so in any other case.

(2) A response under subsection (1) must set out—

(a) details of what the respondent has done or proposes to do in response to the recommendation, or

(b) if the respondent has not done, and does not intend to do, anything in response to the recommendation, the reasons for that.

(3) A response under subsection (1)(a) must be given to the SCTS within the period of 8 weeks beginning with the day on which the respondent receives a copy of the determination in which the recommendation is made.

(4) A person who gives a response to the SCTS under subsection (1) may, at the same time, make representations to the SCTS as to the withholding of all or part of the response from publication under subsection (5A).

(5A) Where a response is given to the SCTS under subsection (1), the SCTS must, after considering any representations made under subsection (4)—

(a) publish the response in full,

(b) publish the response in part, together with a notice explaining that part of the response has been withheld from publication, or

(c) publish a notice explaining that the whole of the response is being withheld from publication.

(6) The SCTS may withhold the whole of a response given under subsection (1) from publication only if representations are made to that effect under subsection (4).

(7) If no response is given in accordance with subsection (1)(a) by the end of the 8 week period mentioned in subsection (3), the SCTS must publish notice of that fact.

(8) The SCTS must publish a response or notice under subsection (5A) or (7) in such manner as it considers appropriate.

(9) A response under subsection (1) is not admissible in evidence, and may not be founded on, in any judicial proceedings of any nature.

27A Reports

(1) The Scottish Ministers must, as soon as practicable after the end of each financial year, prepare a report setting out—

(a) the number of inquiries that ended during the financial year, and

(b) in relation to such inquiries—

(i) the number in which recommendations requiring a response were made,

(ii) the total number of such recommendations made,

(iii) the number of such recommendations in relation to which a response was received by the Scottish Courts and Tribunals Service under section 27(1) during that year,

(iv) the number of such recommendations in relation to which a notice was published under section 27(7) during that year.

(2) The Scottish Ministers must—

(a) lay a copy of a report under subsection (1) before the Scottish Parliament, and
(b) publish the report in such manner as they consider appropriate.

(3) In subsection (1), “recommendations requiring a response” means recommendations to which section 27(1)(a) applies.

**Further inquiry proceedings**

28 **Circumstances in which there may be further proceedings**

(1) Where an inquiry into the death of a person has ended, further inquiry proceedings may be held in relation to the death only in accordance with subsection (2).

(2) Further inquiry proceedings are to be held in relation to the death if—

(a) there is new evidence in relation to the circumstances of the death, and

(b) the Lord Advocate—

(i) considers that it is highly likely that a finding or recommendation set out in the determination would have been materially different if the evidence had been brought forward at the inquiry, and

(ii) decides that it is in the public interest for further inquiry proceedings to be held in relation to the circumstances of the death.

(3) For the purposes of subsection (2)(a), “new evidence” is evidence which was not available, and could not with the exercise of reasonable diligence have been made available, at the inquiry.

(4) For the purposes of subsection (1), an inquiry ends when the sheriff makes a determination in the inquiry.

(5) In this section and sections 29 and 30, references to the holding of further inquiry proceedings in relation to a death are references to—

(a) the re-opening and continuation of an inquiry into the death, or

(b) the holding of a fresh inquiry into the death.

29 **Precognition of witnesses**

(1) Subsection (2) applies where the Lord Advocate is considering whether further inquiry proceedings should be held in relation to the death of a person.

(2) The procurator fiscal may cite a person to attend for precognition in connection with that consideration.

(3) This section is sufficient warrant for such citation.

(4) Subsection (5) applies where a person cited under subsection (2)—

(a) having been given reasonable notice in the citation, and without reasonable excuse, fails to attend for precognition at the time and place mentioned in the citation, or

(b) does so attend but refuses to give information which is—

(i) within the person’s knowledge, and

(ii) relevant to the Lord Advocate’s consideration.
(5) The sheriff may, on the application of the procurator fiscal, make an order requiring the person to attend for precognition or, as the case may be, give the information at a time and place specified in the order.

(6) A person who fails to comply with an order under subsection (5) commits an offence.

(7) A person who commits an offence under subsection (6) is liable on summary conviction to imprisonment for a term not exceeding 21 days or a fine not exceeding level 3 on the standard scale or both.

(8) In this section and section 30, references to the sheriff are references to a sheriff of the sheriffdom in which the inquiry into the person’s death was held.

30 Initiating further proceedings

(1) Where further inquiry proceedings are to be held in relation to the death of a person in accordance with section 28(2), the procurator fiscal must give the sheriff—

(a) notice that such proceedings are to be held, and

(b) a copy of the determination made in relation to the death (“the original determination”).

(1A) A notice under subsection (1)(a) must include—

(c) a brief account of the nature of the new evidence mentioned in section 28(2)(a),

(ca) the Lord Advocate’s view as to whether the further proceedings should consist of—

(i) the re-opening and continuation of the inquiry, or

(ii) the holding of a fresh inquiry, and

(d) any other information required by an act of sederunt under section 34(1).

(2) On receiving notice and a copy of the original determination under subsection (1), the sheriff must make an order fixing a date and place for a hearing under subsection (2A).

(2A) A hearing under this subsection is one at which the sheriff is to give the procurator fiscal and the participants in the inquiry to which the notice under subsection (1)(a) relates the opportunity to make representations about whether the further proceedings should consist of—

(a) the re-opening and continuation of the inquiry, or

(b) the holding of a fresh inquiry.

(2B) After the sheriff makes an order under subsection (2), the procurator fiscal must give notice to the participants in the inquiry to which the notice under subsection (1)(a) relates of the date and place fixed for the hearing.

(2C) After a hearing has been held under subsection (2A), the sheriff must make an order—

(a) setting aside the original determination, and

(b) either—

(i) re-opening and continuing the inquiry into the death, or

(ii) requiring a fresh inquiry to be held into the death.

(3) The sheriff may make an order under subsection (2C)(b)(ii) only if the sheriff considers that it is in the public interest to do so.
31 Re-opened inquiries

(1) Sections 14 to 17 apply in relation to a re-opened inquiry into the death of a person as they apply in relation to any other inquiry, subject to subsections (2) to (4).

(2) The sheriff must, when making the order under section 30(2C) re-opening the inquiry, also make an order under section 14(2) in relation to the re-opened inquiry (and section 14(1) (which requires the procurator fiscal to notify the sheriff that an inquiry is to be held) does not apply).

(3) The procurator fiscal must give notice of the re-opened inquiry under section 16(1), in addition to the persons mentioned in section 16(2), to any person not mentioned in that section—

(a) who was a participant in the original inquiry proceedings, or

(b) to whom a recommendation in the determination in those proceedings was addressed by virtue of section 25(5)(b).

(4) The notice required by section 16(1) and (3) must include notice of—

(a) the fact that the inquiry has been re-opened (and section 16(1)(a) does not apply), and

(b) the matters to which the new evidence relates.

(5) Evidence may be brought forward at a re-opened inquiry only if it relates to a matter to which the new evidence relates.

(6) But the sheriff may—

(a) require evidence to be brought forward about any other matter relating to the circumstances of the death, or

(b) on the application of the procurator fiscal or a participant in the inquiry, allow such evidence to be brought forward.

(7) In this section—

“new evidence” means the new evidence mentioned in section 28(2)(a),

“original inquiry proceedings” means the part of an inquiry held before it is re-opened under section 30(2C),

“re-opened inquiry” means the part of an inquiry held after it is so re-opened.

32 Fresh inquiries

(1) This section applies where the sheriff makes an order under section 30(2C) setting aside the determination in an inquiry (“the original inquiry”) and requiring a fresh inquiry to be held.

(2) The sheriff must, when making the order, also make an order under section 14(2) in relation to the fresh inquiry (and section 14(1) (which requires the procurator fiscal to notify the sheriff that an inquiry is to be held) does not apply).

(3) The procurator fiscal must give notice of the fresh inquiry under section 16(1), in addition to the persons mentioned in section 16(2), to any person not mentioned in that section—

(a) who was a participant in the original inquiry, or
(b) to whom a recommendation in the determination in that inquiry was addressed by virtue of section 25(5)(b).

(4) The fresh inquiry is to be held in the sheriffdom in which the original inquiry was held (and section 12(2) (which requires the Lord Advocate to choose where the inquiry is to be held) does not apply).

(5) Subsection (4) is subject to section 12(3).

33 Further inquiry proceedings: compliance with recommendations

(1) This section applies where—

(a) a determination (“the original determination”) made in an inquiry into the death of a person has been set aside under section 30(2C)(a), and

(b) the sheriff makes a determination (“the new determination”) in the re-opened inquiry or, as the case may be, the fresh inquiry into the death.

(2) Section 27(1) does not apply in relation to a person to whom a recommendation is addressed in the new determination if a recommendation in the same terms was addressed to the person in the original determination.

(3) Subsection (4) applies where—

(a) a recommendation was addressed to a person in the original determination, but

(b) a recommendation in the same terms is not addressed to the person in the new determination.

(4) The Scottish Courts and Tribunals Service must withdraw from publication—

(a) a response to the recommendation published under section 27(5A)(a) or (b), or

(b) a notice published under section 27(5A)(c) or (7) in relation to the recommendation.

Inquiry procedure rules

34 Power to regulate procedure etc.

(1) The Court of Session may by act of sederunt make provision for or about—

(a) the practice and procedure to be followed in inquiry proceedings,

(b) any matter incidental or ancillary to an inquiry.

(2) Without limiting the generality of subsection (1), the power in that subsection includes power to make provision for or about—

(a) the giving of notice under section 16,

(b) the conduct and management of inquiry proceedings, including the use of technology,

(c) the form of any document to be used in, or in connection with, inquiry proceedings,

(d) the process by which a person becomes a participant in an inquiry,

(e) the representation of the procurator fiscal and participants in inquiry proceedings, including representation of participants by persons who—

(i) are neither solicitors nor advocates, or
(ii) do not have the right to conduct litigation, or a right of audience, by virtue of section 27 of the Law Reform (Miscellaneous Provisions) (Scotland) Act 1990,

(f) witnesses and evidence, including modifying the rules of evidence as they apply to an inquiry,

(g) action to be taken by the procurator fiscal and the participants before the start of an inquiry or a re-opened inquiry,

(h) the fees payable to solicitors and advocates in relation to inquiry proceedings,

(i) the expenses payable to persons attending inquiry proceedings,

(j) the appointment of assessors under section 23(1) (including their functions and the terms on which they may be appointed),

(k) the giving and publication of responses under section 27,

(l) such other matters as the Court thinks necessary or appropriate for the purposes of carrying out or giving effect to the provisions of any enactment (including this Act) relating to inquiry proceedings or matters incidental or ancillary to such proceedings.

(3) An act of sederunt under subsection (1) may make—

(a) incidental, supplemental, consequential, transitional, transitory or saving provision,

(b) provision amending, repealing or revoking any enactment (including any provision of this Act) relating to matters with respect to which an act of sederunt may be made,

(c) different provision for different purposes.

(4) Before making an act of sederunt under subsection (1) with respect to any matter, the Court of Session must—

(a) consult the Scottish Civil Justice Council, and

(b) take into consideration any views expressed by the Council with respect to that matter.

(5) Subsection (4) does not apply in relation to an act of sederunt that embodies, with or without modifications, draft rules submitted by the Scottish Civil Justice Council to the Court of Session.

(6) Schedule 1 makes further provision (including transitional provision) in relation to the regulation of the practice and procedure to be followed in inquiry proceedings.

**Specialist sheriffs and summary sheriffs**

**Judicial specialisation in inquiries**

(1) The sheriff principal of a sheriffdom may designate one or more sheriffs or summary sheriffs of that sheriffdom as specialists in inquiries for the purposes of this Act.

(2) The sheriff principal may at any time withdraw a designation made under subsection (1).

(3) The Lord President of the Court of Session may designate one or more part-time sheriffs or part-time summary sheriffs as specialists in inquiries for the purposes of this Act.

(4) The Lord President may at any time withdraw a designation made under subsection (3).
(5) The designation of a sheriff, summary sheriff, part-time sheriff or part-time summary
sheriff (a “designated judicial officer”) under subsection (1) or (3) does not affect the
competence of any other member of the judiciary of the sheriffdom to conduct inquiry
proceedings.

(6) Subsection (7) applies where the sheriff principal is exercising any function relating to
the allocation of inquiry proceedings.

(7) The sheriff principal must have regard to the desirability of ensuring that inquiry
proceedings are conducted by a designated judicial officer.

(8) In subsection (5), the reference to a member of the judiciary of the sheriffdom is to be
construed in accordance with section 136(2) of the Courts Reform (Scotland) Act 2014.

36 Summary sheriff: competence to conduct inquiries
A summary sheriff may, in relation to inquiry proceedings, exercise the jurisdiction and
powers that attach to the office of sheriff.

General

37 Repeal and modification of enactments
(1) The Fatal Accidents and Sudden Deaths Inquiry (Scotland) Act 1976 is repealed.
(2) Schedule 2 modifies other enactments.

38 Interpretation
In this Act, unless the context requires otherwise—

“advocate” means a member of the Faculty of Advocates,
“child” means a person who has not yet reached the age of 18 years,
“inquiry” has the meaning given by section 1(5),
“inquiry proceedings” has the meaning given by section 10(2)(a),
“participant” is to be construed in accordance with section 10(2)(b),
“procurator fiscal” means any procurator fiscal, assistant procurator fiscal,
procurator fiscal depute or person duly authorised to execute the duties of a
procurator fiscal,
“re-opened inquiry” has the meaning given by section 31(7),
“solicitor” means a solicitor enrolled in the roll of solicitors kept under section 7
of the Solicitors (Scotland) Act 1980.

39 Ancillary provision
(1) The Scottish Ministers may by regulations make such incidental, supplemental,
consequential, transitional, transitory or saving provision as they consider necessary or
expedient for the purposes of, in consequence of, or for giving full effect to, any
provision of this Act.
(2) Regulations under subsection (1)—
(a) may—
(i) make different provision for different purposes,
(ii) modify any enactment (including this Act),
(b) are subject to—
(i) the affirmative procedure if they add to, replace or omit any part of the text of an Act,
(ii) otherwise, the negative procedure.

40 Commencement
(1) This section and sections 38, 39 and 41 come into force on the day after Royal Assent.
(2) The remaining provisions of this Act come into force on such day as the Scottish Ministers may by regulations appoint.
(3) Regulations under subsection (2) may—
(a) include transitional, transitory or saving provision,
(b) make different provision for different purposes.

41 Short title
The short title of this Act is the Inquiries into Fatal Accidents and Sudden Deaths etc. (Scotland) Act 2015.
SCHEDULE 1

(introduced by section 34(6))

PROCEDURE RULES

Role of the Scottish Civil Justice Council

1 (1) The Scottish Civil Justice Council and Criminal Legal Assistance Act 2013 is amended in accordance with this paragraph.

(2) In subsection (1) of section 2 (functions of the Council)—

(a) after paragraph (ba) insert—

“(bb) to review the practice and procedure followed in inquiry proceedings under the Inquiries into Fatal Accidents and Sudden Deaths etc. (Scotland) Act 2015,”,

(b) after paragraph (c)(ii) insert—

“(iii) draft inquiry procedure rules,”.

(3) After subsection (7) of that section insert—

“(8) For the purposes of this Part, “draft inquiry procedure rules” are draft rules prepared with a view to the making by the Court of Session of an act of sederunt under section 34(1) of the Inquiries into Fatal Accidents and Sudden Deaths etc. (Scotland) Act 2015.”.

(4) In section 4 (Court of Session to consider rules)—

(a) in subsection (1), for “or draft tribunal procedure rules” substitute “, draft tribunal procedure rules or draft inquiry procedure rules”,

(b) in subsection (2), for “or draft tribunal procedure rules” substitute “, draft tribunal procedure rules or draft inquiry procedure rules”.

(5) In subsection (1) of section 16 (interpretation of Part 1), after the entry relating to draft civil procedure rules insert—

““draft inquiry procedure rules” has the meaning given in section 2(8),”.

Transitional arrangements

2 (1) Until paragraph 1 comes into force, section 34 applies as if, instead of conferring power on the Court of Session to make provision by act of sederunt for or about the matters mentioned in paragraphs (a) and (b) of subsection (1), that subsection conferred power on the Scottish Ministers to make such provision by regulations (and subsection (3) of that section is to be read accordingly).

(2) Section 34(4) does not apply in relation to regulations made by virtue of sub-paragraph (1).

(3) Before making regulations by virtue of sub-paragraph (1), the Scottish Ministers must consult—

(a) the Lord President of the Court of Session,

(b) such other persons as they consider appropriate.

(4) Regulations by virtue of sub-paragraph (1) are subject to the negative procedure.
SCHEDULE 2
(introduced by section 37(2))

MODIFICATION OF ENACTMENTS

Gas Act 1965

1 In the Gas Act 1965, section 17(4) (accidents) is repealed.

Health and Safety at Work etc. Act 1974

2 (1) The Health and Safety at Work etc. Act 1974 is amended in accordance with this paragraph.

(2) Section 14(7) (power of the Health and Safety Executive to direct investigations and inquiries) is repealed.

(3) In section 34(1) (extension of time for bringing summary proceedings), for paragraph (d) substitute—

“(d) an inquiry into any death that may have been so caused is held under the Inquiries into Fatal Accidents and Sudden Deaths etc. (Scotland) Act 2015,”.

Oil and Gas (Enterprise) Act 1982

2A In schedule 3 of the Oil and Gas (Enterprise) Act 1982, paragraph 34 is repealed.

Anatomy Act 1984

2B In section 4(6) of the Anatomy Act 1984 (lawful examinations), for “Fatal Accidents and Sudden Deaths Inquiry (Scotland) Act 1976” substitute “Inquiries into Fatal Accidents and Sudden Deaths etc. (Scotland) Act 2015”.

Merchant Shipping Act 1995

2C(1) The Merchant Shipping Act 1995 is amended in accordance with this paragraph.

(2) In section 108(6)(a)(iii) (returns of births and deaths in ships, etc.), for “Fatal Accidents and Sudden Deaths Inquiry (Scotland) Act 1976” substitute “Inquiries into Fatal Accidents and Sudden Deaths etc. (Scotland) Act 2015”.

(3) In section 271(6)(c) (inquiries into deaths of crew members and others), for “enquiry is to be held under the Fatal Accidents and Sudden Deaths Inquiry (Scotland) Act 1976” substitute “inquiry is to be held under the Inquiries into Fatal Accidents and Sudden Deaths etc. (Scotland) Act 2015”.

Criminal Procedure (Consequential Provisions) (Scotland) Act 1995

2D In schedule 4 of the Criminal Procedure (Consequential Provisions) (Scotland) Act 1995, paragraph 10 is repealed.

Petroleum Act 1998

2E In schedule 4 of the Petroleum Act 1998, paragraph 9 is repealed.
Inquiries into Fatal Accidents and Sudden Deaths etc. Scotland Bill
Schedule 2—Modification of enactments

Freedom of Information Act 2000

2F In section 31(1)(i) of the Freedom of Information Act 2000 (law enforcement), for “Fatal Accidents and Sudden Deaths Inquiry (Scotland) Act 1976” substitute “Inquiries into Fatal Accidents and Sudden Deaths etc. (Scotland) Act 2015”.

Scottish Public Services Ombudsman Act 2002

2G In schedule 4 of the Scottish Public Services Ombudsman Act 2002, in paragraph 2(2), for “Fatal Accidents and Sudden Deaths Inquiry (Scotland) Act 1976 (c.14)” substitute “Inquiries into Fatal Accidents and Sudden Deaths etc. (Scotland) Act 2015”.

Freedom of Information (Scotland) Act 2002

2H (1) The Freedom of Information (Scotland) Act 2002 is amended in accordance with this paragraph.

(2) In section 34(2)(a) (investigations by Scottish public authorities and proceedings arising out of such investigations), for “Fatal Accidents and Sudden Deaths Inquiry (Scotland) Act 1976 (c.14)” substitute “Inquiries into Fatal Accidents and Sudden Deaths etc. (Scotland) Act 2015”.

(3) In section 37(3) (court records, etc.), for “Fatal Accidents and Sudden Deaths Inquiry (Scotland) Act 1976 (c.14)” substitute “Inquiries into Fatal Accidents and Sudden Deaths etc. (Scotland) Act 2015”.

Police, Public Order and Criminal Justice (Scotland) Act 2006

2I (1) The Police, Public Order and Criminal Justice (Scotland) Act 2006 is amended in accordance with this paragraph.

(2) In section 33A(b)(ii) (general functions of the Police and Investigations Review Commissioner), for “Fatal Accidents and Sudden Deaths Inquiry (Scotland) Act 1976 (c.14)” substitute “Inquiries into Fatal Accidents and Sudden Deaths etc. (Scotland) Act 2015”.

(3) In section 41B(2)(b)(ii) (serious incidents involving the police), for “Fatal Accidents and Sudden Deaths Inquiry (Scotland) Act 1976 (c.14)” substitute “Inquiries into Fatal Accidents and Sudden Deaths etc. (Scotland) Act 2015”.

(4) In section 41C(2)(b)(ii) (investigation of matters in the public interest), for “Fatal Accidents and Sudden Deaths Inquiry (Scotland) Act 1976 (c.14)” substitute “Inquiries into Fatal Accidents and Sudden Deaths etc. (Scotland) Act 2015”.

Scottish Commission for Human Rights Act 2006

2J In section 14(9) of the Scottish Commission for Human Rights Act 2006 (power to intervene), for “Fatal Accidents and Sudden Deaths Inquiry (Scotland) Act 1976 (c.14)” substitute “Inquiries into Fatal Accidents and Sudden Deaths etc. (Scotland) Act 2015”.

Armed Forces Act 2006

2K In schedule 16 of the Armed Forces Act 2006, paragraph 72 is repealed.
Coroners and Justice Act 2009

2L In the Coroners and Justice Act 2009, section 50 (amendments to the Fatal Accidents and Sudden Deaths Inquiry (Scotland) Act 1976) is repealed.

Energy Act 2013

3 (1) The Energy Act 2013 is amended in accordance with this paragraph.

(2) In section 85 (inquiries), subsections (7) and (8) are repealed.

(3) In schedule 10 (provisions relating to offences), in paragraph 3(1)(d), for “a public inquiry under the Fatal Accidents and Sudden Deaths Inquiry (Scotland) Act 1976” substitute “an inquiry under the Inquiries into Fatal Accidents and Sudden Deaths etc. (Scotland) Act 2015”.

10
Inquiries into Fatal Accidents and Sudden Deaths etc. 
(Scotland) Bill
[AS AMENDED AT STAGE 2]

An Act of the Scottish Parliament to make provision for the holding of public inquiries in respect of certain deaths.

Introduced by:  Michael Matheson
Supported by:   Paul Wheelhouse
On:           19 March 2015
Bill type:     Government Bill
INTRODUCTION

1. As required under Rule 9.7.8A of the Parliament’s Standing Orders, these revised Explanatory Notes are published to accompany the Inquiries into Fatal Accidents and Sudden Deaths etc. (Scotland) Bill (introduced in the Scottish Parliament on 19 March 2015) as amended at Stage 2. Text has been added or amended as necessary to reflect amendments made to the Bill at Stage 2 and these changes are indicated by sidelining in the right margin.

2. These revised Explanatory Notes have been prepared by the Scottish Government in order to assist the reader of the Bill and to help inform debate on it. They do not form part of the Bill and have not been endorsed by the Parliament.

3. The Notes should be read in conjunction with the Bill. They are not, and are not meant to be, a comprehensive description of the Bill. So where a section or schedule, or a part of a section or schedule, does not seem to require any explanation or comment, none is given.

THE BILL

4. The Bill seeks to modernise the legislative framework for Fatal Accident Inquiries (FAIs) in Scotland. The provisions in the Bill take forward many of the recommendations requiring primary legislation from Lord Cullen’s Review of the operation of the Fatal Accidents and Sudden Deaths Inquiry (Scotland) Act 1976 (“the 1976 Act”), which reported in 2009\(^1\). The Scottish Government issued its response to the review in 2011\(^2\), accepting the majority of Lord Cullen’s 36 recommendations.

5. The recommendations from Lord Cullen which were addressed to the Crown Office and Procurator Fiscal Service (COPFS) have already been taken forward by the establishment of the Scottish Fatalities Investigation Unit (SFIU).


6. The Bill will implement the remaining recommendations that the Government accepted in its response in 2011. A public consultation³ on the proposals of the Bill was carried out from 1 July to 9 September 2014 and responses published⁴ on 15 October 2014.

7. The Bill will repeal the 1976 Act and enact new provisions to govern the system of FAIs in Scotland. The Bill does not attempt to legislate for all of the recommendations made by Lord Cullen that were accepted by the Government. Some of the changes recommended will be implemented by the Lord President and the Scottish Courts and Tribunal Service (SCTS). Other changes will be implemented through FAI Rules to govern the procedure. The Bill seeks to set out the framework within which the rules will add the necessary detail.

8. For the purposes of this document, the term ‘FAI’ will be used to describe an inquiry under the 1976 Act and this Bill. Inquiry or FAI proceedings mean the whole FAI court process and inquiry or FAI refers to the actual inquiry hearing.

9. The Bill is in 44 sections and 2 schedules.

10. Section 1 sets out the nature and purpose of an inquiry under the Bill, with sections 2 to 7 describing the situations where an inquiry must or may be held.

11. Section 7A provides for a family liaison charter to be published by the Lord Advocate and section 8 provides for the Lord Advocate to explain to close relatives and partners why an inquiry is not to be held.

12. Sections 9 to 13 make general provision, firstly, relative to the procurator fiscal’s investigation (section 9), then for who may participate in an inquiry (section 10), for the availability of civil legal aid to certain family members (section 10A), for the location of the inquiry and the jurisdiction of the sheriff (sections 11 and 12), and lastly for inquiries into multiple deaths (section 13).

13. Sections 14 to 17 provide for the procedure that precedes the inquiry proper. This includes the procedure for initiating the inquiry (section 14) and for giving notice of it (section 16), provision for preliminary hearings (section 15), and provision for the agreement of undisputed facts between the procurator fiscal and the participants (section 17).

14. Sections 18 to 24 provide for the inquiry itself. This includes provision relating to the powers of the sheriff (section 18), provision about evidence and witnesses (section 19), a requirement that the inquiry be held in public (section 20), and publishing restrictions and offences relating to those restrictions in relation to the identification of children (sections 21 and 22). Section 23 permits a sheriff to appoint a person (known as an assessor) to assist him/her. Finally, section 24 prohibits the sheriff from awarding expenses in relation to the proceedings.

³ Consultation on proposals to reform Fatal Accident Inquiries legislation: http://www.scotland.gov.uk/Publications/2014/07/6772
⁴ Responses to the consultation on proposals to reform Fatal Accident Inquiries legislation: http://www.scotland.gov.uk/Publications/2014/10/8764
15. Sections 25 to 27A provide for the sheriff’s findings, dissemination of his/her determination, compliance with any recommendations, and annual reporting on compliance.

16. Sections 28 to 33 make provision for the circumstances in which there might be further proceedings and the procedures for those. Section 31 makes provision where these further proceedings are to be a re-opening of the original inquiry and section 32 where they are to be a fresh inquiry.

17. Section 34 provides for the Court of Session to make rules relating to procedure, schedule 1 (which is introduced by subsection (6)) makes provision in relation to the functions of the Scottish Civil Justice Council and sets out transitional provisions relating to the making of rules. Section 35 makes provision for the designation of specialist judicial officers in relation to FAIs.

18. Finally, sections 37 to 41 make general provision in relation to the Bill and schedule 2 lists modifications of existing legislation.

COMMENTARY ON SECTIONS

Inquiries into certain deaths

Section 1 - Inquiries under this Act

19. Subsection (1) provides that where an FAI is to be held into a death, it is the duty of the procurator fiscal to investigate the death, and arrange for an FAI to be held into it. Subsection (2) provides that the FAI is to be conducted by a sheriff (this may include a sheriff principal) as defined in subsection (5)(b). Subsection (3) makes it clear that the purpose of an FAI is to establish the circumstances of the death and to consider whether any precautions could be taken which may prevent other deaths in similar circumstances. Subsection (4) makes it clear that it is not the purpose of FAIs to establish civil or criminal liability. They are not adversarial hearings and are not designed to be like civil litigation. Nor have they any connection to criminal proceedings. The definition of sheriff in subsection (5)(b) means that when the Bill refers to sheriff it is referring to a sheriff of the sheriffdom in which the FAI is, or is to be, held. Section 12 makes provision about where the FAI is to be held. The powers of the sheriff can also be exercised by a summary sheriff, given the effect of section 36 of the Bill, and the reference to sheriff also includes the sheriff principal given the effect of section 134(2) of the Courts Reform (Scotland) Act 2014.

Inquiries into deaths occurring in Scotland

Section 2 - Mandatory inquiries

20. Section 2 sets out the circumstances in which an FAI is mandatory. Under subsection (3) an FAI is mandatory if a person died in Scotland as a result of an accident in Scotland, in the course of the person’s employment or occupation. This replicates the effect of section 1(1)(a)(i) of the 1976 Act.
21. Under subsection (3A) a FAI is mandatory if a person has died in Scotland and was detained in hospital by virtue of the Mental Health (Care and Treatment) (Scotland) Act 2003 or the Criminal Procedure (Scotland) Act 1995. This is a new provision not found in the 1976 Act.

22. Under subsection (4) an FAI is mandatory if a person has died in Scotland and was in legal custody, or was a child required to be kept or detained in secure accommodation. A person being in legal custody or secure accommodation is defined by the status of that person regardless of the person’s physical location at the time of the death. Accordingly if a person dies in hospital who is at the time of death still serving a custodial sentence, an FAI must be carried out. The effect is the same as that in section 1(1)(a)(ii) and (4) of the 1976 Act.

23. Subsection (5) defines “legal custody”. This includes being imprisoned or detained in a penal institution, being in police custody, being held in custody on court premises or being detained in service custody premises. The definition of police custody takes its meaning from the Criminal Justice (Scotland) Bill which has completed stage 2 before the Parliament. The reference to court custody includes the death of any person in the court cells or the court building, which may be separate from police custody or occur after the end of police custody. A death of a person required to be detained in premises used by the armed forces as service custody premises continues to be included as before restating reserved law in this regard.

24. The inclusion of a death of a child required to be kept or detained in secure accommodation is an addition to the mandatory categories in the 1976 Act. “Child” is defined in section 38 as a person who has not yet reached the age of 18 and secure accommodation takes its definition from regulations made under the Public Services Reform (Scotland) Act 2010, thus keeping pace with any change to the meaning of such accommodation which may occur from time to time.

25. By providing that an FAI is to be held in these circumstances, the effect of this section is to require the procurator fiscal to investigate the circumstances of the death and arrange for a FAI to be held.

26. It is expected that a further category of mandatory FAI will be provided in an Order under section 104 of the Scotland Act 1998, namely deaths of service personnel in the course of armed service in Scotland. Deaths of service personnel abroad are within section 7 of the Bill.

Section 3 – Mandatory inquiries: exceptions

27. This section allows the Lord Advocate to decide that an FAI is not to be held into a death which falls within the categories of death set out in section 2 (mandatory inquiries). The Lord Advocate can exercise this discretion only if satisfied that the circumstances of the death have been sufficiently established in the course of certain other proceedings.

28. The other proceedings which the Lord Advocate is permitted to rely upon are criminal proceedings, an inquiry under section 17(2) of the Gas Act 1965, an inquiry under section 14(2A) of the Health and Safety at Work etc. Act 1974, an inquiry under section 85(1) of the

3 The relevant regulations are the Secure Accommodation (Scotland) Regulations 2013, as amended.
Energy Act 2013 and, except in the case of a death of a person required to be detained in service custody premises, an inquiry under section 1 of the Inquiries Act 2005. Inquiries under the 2005 Act are public inquiries into events that have caused or have potential to cause public concern. Examples include inquiries into a particular event (e.g., Dunblane inquiry 1996) or a series of events (e.g., BSE inquiry 1997). They are held at the instigation of UK or Scottish Government Ministers with the aim of helping to restore public confidence in systems or services by investigating the facts, which may include why matters may have been dealt with in a particular way over the course of many years and making recommendations to prevent recurrence, not to establish liability or to punish anyone. By comparison, FAIs provide a local inquiry into the circumstances of a death and consider what steps might be taken to prevent deaths in similar circumstances.

29. Currently, section 1(2) of the 1976 Act makes provision for the interaction between deaths that are subject to a mandatory inquiry and criminal proceedings. In relation to other inquiries, currently separate provision is made in section 17(4) of the Gas Act 1965, section 14(7) of the Health and Safety at Work etc. Act 1974 and section 85(7) and (8) of the Energy Act 2013, which state that an FAI is not held where a death has already been investigated in an inquiry under those Acts, unless the Lord Advocate directs otherwise. In relation to the Inquiries Act 2005, there is currently no provision which allows the Lord Advocate to take into account that the circumstances of the death requiring a mandatory FAI have been established during the course of a mandatory FAI. For inquiries under the various statutory provisions noted above, the Bill therefore shifts the emphasis from there being no FAI unless the Lord Advocate directs otherwise. In relation to the Inquiries Act 2005, there is currently no provision which allows the Lord Advocate to take into account that the circumstances of the death requiring a mandatory FAI have been established during the course of an inquiry under the 2005 Act. For inquiries under the various statutory provisions noted above, the Bill therefore shifts the emphasis from there being no FAI unless the Lord Advocate directs otherwise. So if the discretion is not exercised the result under the Bill is that (if the circumstances are within section 2(3), (3A) or (4)) there will be an FAI. The Bill also brings the relevant interactions with mandatory inquiries and other inquiries within fatal accident legislation, making it easier to access. Insofar as these provisions modify the law on reserved matters they effect a restatement (see also the Explanatory Note to schedule 2).

30. Section 3(2)(f) and (g) allows the Lord Advocate to decide that an inquiry is not to be held where the circumstances of the death have been sufficiently established in an investigation or inquiry by the Mental Welfare Commission for Scotland under sections 11 or 12 of the Mental Health (Care and Treatment) (Scotland) Act 2003. Such an investigation or inquiry may be held into a death falling within section 2(3A) (death of a mental health patient detained in hospital). These exceptions are not found in the 1976 Act.

31. In summary, this section permits the Lord Advocate to decide that the circumstances of the death have been sufficiently established in certain specified proceedings and therefore no FAI is necessary. If the circumstances have not been established then an inquiry must be held. But the Bill also permits the Lord Advocate to decide that even where the circumstances have been established, an inquiry could still be held. There may be deaths where the Lord Advocate may conclude that even though the circumstances have been established, the public interest demands that a sheriff should consider whether recommendations should be made in the public interest as to how deaths in similar circumstances might be avoided in the future.
Section 4 – Discretionary inquiries

32. Section 4 reproduces the effect of section 1(1)(b) of the 1976 Act to give the Lord Advocate discretion to require an inquiry to be held into a death in Scotland if they consider that the death was sudden, suspicious or unexplained or occurred in circumstances which give rise to serious public concern, and that it is in the public interest to do so. Subsection (2) provides that the power to hold discretionary inquiries does not apply to a death where a mandatory inquiry is required.

Section 5 – Certain deaths and accidents to be treated as occurring in Scotland

33. Section 5 reproduces the effect of section 9 of the 1976 Act as a restatement of reserved law. Section 5 operates to ensure that a death or accident is to be treated as having occurred in Scotland if it was connected to certain activities related to the offshore oil and gas industry and took place within the area of sea adjacent to Scotland which is treated as being subject to Scottish civil law. The Bill does this by defining the activities and areas regulated by reference to section 11(2) of the Petroleum Act 1998, with the effect that those activities and that area subject to section 11(2) are also covered by the Bill.

Inquiries into deaths occurring abroad

Section 6 – Inquiries into deaths occurring abroad: general

34. Section 6 permits an FAI to be held into a death of a person ordinarily resident in Scotland, if the death occurs outwith the United Kingdom (subsection (1)). Until now it has only been possible to hold an FAI into a death which occurred in Scotland (other than the deaths of service personnel). Section 6 does not apply to deaths in England, Wales and Northern Ireland as such deaths will continue to be subject to the system of coroners’ inquests in those countries (see the use of the words “outwith the United Kingdom” in subsection (1)(a)). The effect of subsection (2) is that this section does not apply to deaths of service personnel abroad, which are dealt with in section 7.

35. Subsection (3) sets out the criteria for the Lord Advocate’s discretion to decide if an FAI should be held into such a death. As for other discretionary FAIs, the Lord Advocate will consider whether the death was either sudden, suspicious or unexplained, or occurred in circumstances giving rise to serious public concern. The Lord Advocate must also consider whether the circumstances of the death have already been established in the course of an investigation by the appropriate authorities in the country where the death occurred, and whether there is a real prospect that those circumstances would be sufficiently established in a FAI. The FAI will only be held if the Lord Advocate decides that it is in the public interest to investigate the circumstances of the death. An FAI into a death within this section will proceed in the same way as any other FAI under the Bill.

Section 7 – Inquiries into deaths occurring abroad: service personnel

36. Section 7 re-enacts section 1A of the 1976 Act which was inserted by section 12 of the Coroners and Justice Act 2009. Those provisions were inserted following a Legislative Consent

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6 See the Civil Jurisdiction (Offshore Activities) Order 1987.
Resolution passed by the Scottish Parliament on 21 May 2009\(^7\) and accordingly the Scottish Government’s position is that elements of section 7 restate reserved law. Section 12 permits the Secretary of State or the Chief Coroner to notify the Lord Advocate if it is considered that it is appropriate for the death abroad of armed forces service personnel, or of a civilian subject to service discipline who was accompanying service personnel who were engaged in active service, to be the subject of an FAI rather than a coroner’s inquest. This will normally be where the deceased was domiciled in Scotland.

37. Section 7 of the Bill makes provision for an FAI to be held into such a death if it occurs while the person is in legal custody, or is sudden, suspicious or unexplained, or occurs in circumstances giving rise to serious public concern. This includes a death abroad whilst detained abroad in premises analogous to service custody premises as defined under the Armed Forces Act 2006.

38. An FAI will be held if the Lord Advocate decides that it will be in the public interest so to do. Subsection (4) means that no inquiry can be held if the Lord Advocate is satisfied that the circumstances of the death have been sufficiently established in criminal proceedings. An FAI into a death within this section will proceed in the same way as any other FAI under the Bill.

**Family liaison charter**

*Section 7A – Family liaison charter*

39. The Solicitor General, in her evidence on the Bill at Stage 1, announced the proposal to develop a family liaison charter, drafts of which were shared with the Justice Committee in advance of Stage 2. Section 7A requires the Lord Advocate to prepare a family liaison charter, after consulting such persons as the Lord Advocate considers appropriate. Subsection (3) provides that the charter must set out information to be made available to bereaved families by procurators fiscal and timescales for the giving of such information. The charter aims to provide guidance on what the bereaved family should expect from the Crown Office by way of the provision of information about death investigations, including the possibility of criminal proceedings and the possibility of an FAI, and the timescales within which that information will be provided. The charter must be laid before the Scottish Parliament and published. The Lord Advocate may revise the charter in which case the revised charter must also be laid and published. The words “procurator fiscal” are defined widely in section 38 of the Bill so as to cover family liaison officers who may not be fiscals themselves.

**Reasons where inquiry not held**

*Section 8 – Reasons for decision not to hold an inquiry*

40. Under section 8, where it is decided that an FAI is not to be held, the Lord Advocate must give reasons (in writing) for that decision. This duty applies where the death is within section 2(3A) (death of a mental health patient detained in hospital) or, in any other case, where a request is made by the spouse or partner (civil or cohabiting) or nearest relative of the deceased. Subsection (2)(b) includes a same sex couple living together.

\(^7\) For details of the legislative consent process see [http://www.scottish.parliament.uk/parliamentarybusiness/Bills/16067.aspx](http://www.scottish.parliament.uk/parliamentarybusiness/Bills/16067.aspx).
Procurator fiscal’s investigation

Section 9 – Citation of witnesses for precognition

41. It will sometimes be necessary for the procurator fiscal to precognosce witnesses as part of a death investigation prior to determining whether there are to be further proceedings. Section 9 replicates section 2 of the 1976 Act to enable the citation of witnesses for precognition as part of that death investigation. Subsection (5) makes it an offence to fail to comply with an order made by the sheriff requiring a person to attend for precognition and subsection (6) sets out the penalty if convicted of that offence.

Participants

Section 10 – Persons who may participate in the inquiry

42. Section 10 specifies the people who may participate in an FAI in addition to the procurator fiscal. The provisions in this section have been updated to capture modern relationships as the 1976 Act does not include civil or cohabiting partners. There may be circumstances where the deceased may not have been living with a spouse or civil partner at the time of death and may instead have been cohabiting with another person. This provision gives a cohabitee in such circumstances the right to participate in the FAI. The Bill’s description in section 10(1)(b) of a living with A as if married to A at the time of A’s death will include a same sex couple living together.

43. The provisions preserve the effect of section 4(2) of the 1976 Act providing that, where the inquiry concerns a death at work, an inspector appointed under section 19 (appointment of person inspectors) of the Health and Safety at Work etc. Act 1974 may also be a participant if he or she so chooses. In that limited regard, the Bill restates reserved law.

44. Section 10(1)(d)(iii) is a new provision entitling trade union or staff association representatives to participate in mandatory FAIs held under section 2(3) (death in the course of employment or occupation) but only if the deceased was a member of the trade union or staff association.

Availability of civil legal aid

Section 10A – Availability of civil legal aid

45. Section 10A amends sections 14 and 15 of the Legal Aid (Scotland) Act 1986 (“the 1986 Act”) to modify the ordinary rules for eligibility for civil legal aid. A defined family member will be treated as having probable cause for participation in an FAI into a death, and their receipt of legal aid will be deemed to be reasonable. A defined family member is a spouse, civil partner, cohabiting partner or nearest known relative. The Scottish Ministers are required to make regulations for financial eligibility with a view to allowing defined family members to participate fully in inquiry proceedings. The regulations are subject to the negative procedure by virtue of section 37 of the 1986 Act.
Location

Section 11 – Places at which inquiries may be held

46. The Scottish Ministers will be able to make regulations under section 11 to designate places at which a sheriff court may be held for the purposes of holding an FAI. Subsection (1) makes it clear that these places will be additional to the places already designated for the holding of sheriff courts under the Courts Reform (Scotland) Act 2014. “Places” in this sense means the towns and cities where sheriff courts are held – it does not mean specific sheriff court buildings as FAIs have already been held in other buildings.

47. An FAI may be held at a sheriff court building, but it may also be held in another building in a place designated under the 2014 Act or section 11 of the Bill. This allows the current practice of holding FAIs in buildings not usually used for court purposes (e.g. locations such as the Council Chamber in, for example, Aberdeen City Chambers and the Maryhill Community Centre in Glasgow, or in places where there is no sheriff court (e.g. Motherwell)).

48. Since the SCTS has the statutory responsibility for providing property for the Scottish courts under section 61(1) of the Judiciary and Courts (Scotland) Act 2008, the Scottish Ministers will only make regulations under subsection (1) following the submission of a proposal by SCTS – with the agreement of the Lord President – for the designation of a place for the holding of FAIs under subsections (2) and (3). However, this procedure will be subject to consultation with appropriate persons under subsection (4).

49. In making the regulations, the Scottish Ministers are to have regard to the SCTS proposal under subsection (5). Given the statutory responsibility which the Lord President has for the efficient disposal of business in Scotland’s courts under section 2(2) of the 2008 Act, and the equivalent responsibility of the SCTS set out above, the Scottish Ministers must obtain the consent of both the Lord President and the SCTS under subsection (6) before making those regulations. This power is subject to affirmative procedure.

Section 12 – Jurisdiction in relation to inquiries

50. Section 12(1) provides that an FAI may be held in any sheriffdom in Scotland regardless of the place of the death or (if applicable) any accident causing the death. This removes the requirement of a close connection between the place most closely connected with the circumstances of the death and the procurator fiscal for the sheriff court district relating to that place that is provided by section 1 of the 1976 Act. This will allow greater flexibility in the system of FAIs which may allow inquiries to be held more quickly if they can be accommodated in alternative accommodation. This flexibility still permits an FAI to be heard locally in relation to the circumstances of the death, however, and indeed it is expected that the majority of FAIs will be held in the same sheriffdom as the place of death.

51. Subsection (2) allows the Lord Advocate to choose in which sheriffdom the FAI is to be held, after consulting with the SCTS. It does not allow the Lord Advocate to choose the place or building within the sheriffdom where the FAI will be held, which will be a matter for discussion between the Lord Advocate (who will have been in contact with any relatives of the deceased), the sheriff principal and the SCTS. Ultimately the decision is for the sheriff principal under his
or her powers relative to the efficient disposal of business contained in the Courts Reform (Scotland) Act 2014.

52. Subsections (3) and (5) allow the sheriff to transfer the FAI to another sheriffdom, but only after the procurator fiscal and the participants have been given an opportunity to make representations about such a transfer and only with the consent of the sheriff principal for that sheriffdom and the sheriffdom to which the FAI is to transfer. The transfer order may be made at the sheriff’s own initiative or at the instigation of the procurator fiscal or one of the participants at the FAI.

Inquiries into multiple deaths

Section 13 – Inquiry into more than one death

53. Section 13 permits a single FAI to be held into multiple deaths if they are as a result of the same accident or occur in the same or similar circumstances. The 1976 Act only allows inquiries into multiple deaths that occur in the same sheriffdom. This provision, along with section 12, means that one FAI may take place into multiple deaths regardless of the place where the deaths took place.

Pre-inquiry procedure

Section 14 – Initiating the inquiry

54. An inquiry is only to be held where the Lord Advocate makes a decision to that effect or where the Bill requires one to be held on a mandatory basis. Section 14 provides that where an inquiry is to be held, the procurator fiscal is to give notice to the sheriff of that fact. The notice must include a brief account of the circumstances of the death so far as they are then known to the procurator fiscal and any other information which may be set out as required in FAI rules made by act of sederunt under section 34(1) of the Bill. Under subsection (2), the sheriff will set out in an order the date and place for the preliminary hearing to the FAI if one is to be held, and for the FAI itself, which need not be held at the same place. The sheriff will also grant warrant for the procurator fiscal and participants to cite witnesses.

55. Subsection (3) provides flexibility for the sheriff to not fix a date and place for the hearing, but only if a preliminary hearing is to be held and the sheriff considers it appropriate not to fix such a date. It is left to the discretion of the sheriff as to the circumstances in which it is not appropriate to fix a date; it may be that at this early stage the sheriff is unsure as to the scope of the FAI and may wish to hear submissions prior to fixing the date.

56. Subsection (4) allows the sheriff to vary a date and place fixed for the holding of a preliminary hearing or inquiry.

57. Subsection (5) makes it clear that, in deciding the date for the holding of the FAI, the sheriff must have regard to the desirability of holding the inquiry as soon as is reasonably practicable. This means that the sheriff must bear in mind the need to hold the inquiry soon, and while the inquiry need not be held immediately, that only practical aspects which require a delay
be taken into account (such as available accommodation and reasonable time for participants to prepare) when choosing a date.

Section 15 – Preliminary hearings

58. Section 15 requires a preliminary hearing to be held before every FAI unless the sheriff dispenses with that requirement in accordance with rules made in an act of sederunt under section 34(1). The sheriff is given further power to reverse a decision not to hold a preliminary inquiry.

59. Further provision is to be made with regard to the content and purpose of preliminary hearings in rules made in an act of sederunt under section 34(1). The purpose of a preliminary hearing for an FAI is to consider the likely length of the proceedings, the state of preparedness of participants and the procurator fiscal, the amount of evidence and any areas for agreement of uncontroversial facts, and anything else that needs to be addressed before the inquiry proceedings can begin.

Section 16 – Notice of the inquiry

60. Once the date and location of the preliminary hearing and/or FAI hearing is fixed (in accordance with the sheriff’s powers under section 14), then section 16 places a duty on the procurator fiscal to notify those persons who the procurator fiscal considers to be persons who are entitled to participate in the FAI. Those who are entitled to be participants are set out in section 10. In addition, the procurator fiscal is also required to notify any person specified in FAI rules or in a category of person specified in FAI rules made in an act of sederunt under section 34(1). Subsection (3) provides that the procurator fiscal will also have to provide public notice of the FAI, the date and place of any preliminary hearing, and the date and place of the FAI.

61. The procurator fiscal is under a continuing duty to notify and publicise changes to the place or date of these matters, including notification of a preliminary hearing where the sheriff has reversed his or her decision not to hold one. For the avoidance of doubt, the procurator fiscal only has to notify directly those who appear to the procurator fiscal to be entitled to participate or whom he or she has to notify under FAI rules.

Section 17 – Agreement of facts before an inquiry

62. Section 17 provides that FAI rules will make provision about the agreement, before the start of the inquiry, by the procurator fiscal and the participants in an inquiry of uncontroversial facts which are unlikely to be disputed. This is to avoid the need for evidence to be led at the FAI about issues which are not in doubt and thus contribute to shortening the FAI. FAI rules are likely to set out the process by which agreement is to be reached, and include a duty to seek agreement.
The inquiry

Section 18 – The powers of the sheriff

63. Section 18 makes it clear that sheriffs have all of the inherent powers that they have as a judge in civil proceedings in relation to an FAI. This does not make an FAI a form of civil proceedings. Such inherent powers are, however, subject to the other provisions in the Bill or provision made by FAI rules by virtue of subsection (2).

Section 19 – Evidence and witnesses

64. Section 19 sets out that the procurator fiscal must bring forward evidence relating to the circumstances of the death at the inquiry and that participants may also bring forward such evidence. The Bill does not regulate the procedure to be followed or the way in which evidence is led and further details on that may be provided in rules. In addition, subsection (2) enables the sheriff to instruct a participant in the FAI or the procurator fiscal to lead evidence on any matter relating to the circumstances of the death. The sheriff is not, therefore, dependent upon the procurator fiscal nor the participants with regard to what evidence is led. An FAI is an inquisitorial judicial inquiry held in the public interest and empowering the sheriff in this way is in keeping with the aims of the process.

65. Subsection (3) applies the rules of evidence that apply in civil proceedings to FAIs. This continues the approach in section 4(7) of the 1976 Act and, accordingly, evidence that has not been corroborated and hearsay evidence are both admissible in inquiry proceedings (as set out in sections 1, 2, and 9(c) of the Civil Evidence (Scotland) Act 1988). It follows that the evidential standard for facts to be proven for FAIs is the civil standard of proof – the balance of probabilities.

66. Subsection (4) makes it clear that subsection (3) is subject to any provision made in rules in an act of sederunt under section 34(1).

67. Subsections (5) and (6) restate section 5 of the 1976 Act. These subsections make clear that, where a witness is questioned, that does not mean that subsequent criminal proceedings may not then be taken against that person. Further, if a question is put to a witness the answer to which could show the witness was guilty of an offence, that witness is not required to answer that question.

Section 20 – Inquiry to be conducted in public

68. Section 20 provides that an FAI should normally be open to the public. However subsection (2) allows the sheriff to order that an inquiry, or part of it, is to be held in private. The sheriff can make this order if the procurator fiscal or one of the participants applies for it, or may do so on his or her own initiative. The circumstances in which an FAI may be held in private have been left to the discretion of the sheriff, as the reasons may range widely from issues of national security to the need to protect children or other vulnerable persons.
Section 21 – Publishing restrictions in relation to children

69. Section 21 allows the sheriff to prohibit publication of material that could identify a child involved in an FAI. “Child” now means a person who has yet to reach the age of 18 years. The prohibited material which may lead to identification of the child includes, but is not limited to, the items listed in subsection (3). Under subsection (4), the sheriff may make such an order on his or her own initiative or on the application of the procurator fiscal or a participant in the FAI. Failure to comply with the sheriff’s order will constitute an offence under subsection (5), the penalty for which is set out in paragraph (6). The Bill recognises that some of those involved in the process of publishing, such as a newspaper distributor or retailer, may not be aware that the content of the publication is in breach of such an order and provides for a defence. The definitions of “publish” and “material” in subsection (8) are wide and include material published online. The Scottish Government proposes that the Order under section 104 of the Scotland Act 1998 referred to in the Policy Memorandum will extend the effect of publishing restrictions to England and Wales and Northern Ireland.

Section 22 – Offences by bodies corporate etc.

70. Section 22 applies where the publication offence in section 21(5) is committed by bodies such as companies, partnerships and unincorporated associations (e.g. a club). This provision allows for natural persons who have an element of control over such bodies (e.g. a director or partner (as set out in subsection (3)) also to be held criminally liable and to be fined in certain circumstances.

Section 23 – Assessors

71. Under section 23, the sheriff can appoint an assessor to provide assistance to the sheriff in relation to that FAI based on the assessor’s specialist knowledge or expertise.

Section 24 – Expenses

72. This provision expressly removes any power of the court to award legal expenses in an FAI. The effect of this section is unconnected with the payment of the expenses of witnesses etc. about which rules may be made in an act of sederunt under section 34(1).

73. The decision to hold an FAI is taken by the Lord Advocate acting in the public interest. The rule making power in the Bill will permit rules to be made to give sheriffs sufficient case management powers to be able to deal with vexatious behaviour as it arises without the need to award expenses. For example, FAI rules will greatly empower the sheriff to control proceedings through the use of minutes of agreed evidence, powers to regulate the conduct and management of proceedings and the regulation of witnesses and evidence.

Findings and recommendations

Section 25 – The sheriff’s determination

74. Section 25 provides for the determination made by the sheriff at the end of an FAI. Subsection (1) modernises what is currently set out in section 6(1) of the 1976 Act as recommended by Lord Cullen. The sheriff must make findings in relation to the circumstances of the death as set out in subsection (2), and has discretion as he or she considers appropriate,
whether to make recommendations about steps which might realistically prevent deaths in similar circumstances in the future (as set out in subsection (4)).

75. Subsection (2) specifies the circumstances of the death or facts which must be set out in the determination, i.e. it looks back at what happened in the particular case. Subsection (2)(a) to (d) replicates section 6(1)(a) and (b) of the 1976 Act.

76. Subsection (2)(e) requires the determination to set out any precautions which were not taken before the death which is the subject of the FAI, but that could reasonably have been taken and might realistically have prevented the death. The precautions that the sheriff identifies at this point relate to the death which is the subject of the FAI and might not be the same as those recommended to prevent other deaths in the future under subsection (4)(a). In subsection (2)(e)(i), “reasonably” relates to the reasonableness of taking the precautions rather than the foreseeability of the death or accident. A precaution might realistically have prevented a death if there is a real or likely possibility, rather than a remote chance, that it might have so done.

77. Subsection (2)(f) is based on section 6(1)(d) in the 1976 Act. It allows the sheriff to make findings about any defects in a system of working which contributed to the death or accident resulting in the death.

78. Subsection (2)(g) allows the sheriff to make findings about any other facts which are relevant to the circumstances of the death.

79. Subsection (3) provides that, for the purpose of identifying precautions that might have been taken, it does not matter whether it was foreseeable before the death or accident that the death or accident might occur if the precautions were not taken. Subsection (3) also provides that it does not matter, for the purpose of identifying defects in a system of working, whether or not if it was foreseeable that the death or accident might have occurred as a result of those defects. This makes it clear that the sheriff may employ hindsight when considering these findings, and further distinguishes an FAI from civil litigation.

80. Subsection (4) sets out the matters about which the sheriff may make recommendations, i.e. it looks forward to the prevention of similar deaths in the future. These matters are the taking of reasonable precautions, the making of improvements to, or introduction of, a system of working, or the taking of any other steps that might realistically prevent future deaths in similar circumstances. Again, there must be a real or likely possibility that the matters recommended may prevent other deaths in similar circumstances, rather than a remote chance that a similar death in the future might be prevented.

81. Subsection (5) allows the sheriff to address a recommendation to a participant or a body or office-holder with an interest in the prevention of deaths in similar circumstances to those in which the death occurred.

82. Subsection (6) provides that an FAI determination is inadmissible in evidence and cannot be founded on in other judicial proceedings. This reproduces the effect of section 6(3) of the 1976 Act. This is an essential element of the distinction between, on the one hand, the fact-
finding inquisitorial nature of the FAI with the sheriff empowered to make recommendations and on the other, the fault-finding, adversarial nature of civil proceedings. It is not the purpose of the FAI to establish liability. If liability arises from the death, then a civil case is the forum in which such matters are to be examined.

Section 26 – Dissemination of the sheriff’s determination

83. Section 26 confers duties on SCTS to publish and disseminate an FAI determination once it has been made by the sheriff.

84. Subsection (1)(a) requires the SCTS to publish all FAI determinations in such manner as it considers appropriate, but it is expected that this will be done by posting on the SCTS website. Subsection (1)(b) requires SCTS to issue a copy of the determination to the Lord Advocate, participants at the FAI, any person to whom a recommendation has been addressed and anyone else who may have an interest in any recommendation made.

85. Subsections (2) and (3) replicate the effect of sections 6(4)(a) and (5) of the 1976 Act respectively. Subsection (2) obliges SCTS on request to send to the people and bodies listed there: a copy of the determination, the notice given by the procurator fiscal which initiated the FAI, any transcript of the evidence which was taken and any report or documentary production used in the FAI. A new addition is that any office-holder in the Scottish Administration is to be provided with that material on request. This is intended to capture the Scottish Government and also the Scottish Housing Regulator and Food Standards Scotland, all of which are part of the devolved Scottish Administration. Subsection (3) obliges SCTS to give to any other person, if requested and on payment of a fee to be set out in the FAI rules, a copy of the determination, or, if the person has an interest in the inquiry and makes the request within a timeframe set out in rules, any transcript of the evidence at the inquiry.

86. There may, however, be cases where persons should not receive all the details (for example cases involving children where identities may be irrelevant to the recipients). Subsection (5) provides that the sheriff may decide that part of the determination should not be published or should not be given to a person within subsection (1)(b)(iii) or (iv). A full copy of the determination will always be given to the Lord Advocate and participants in the inquiry. It is expected that the determination will be treated in the same way as any other sensitive court judgement. The subsection gives the sheriff flexibility to redact where he or she thinks fit. The Lord President issued guidance to judicial office holders, under section 2 of the Judiciary and Courts (Scotland) Act 2008, about the redaction of judgments which applies in relation to FAIs as well as other judicial proceedings.\(^8\)

87. Subsection (6) provides that the procurator fiscal must, after the determination has been issued, advise the Registrar General of Births, Deaths and Marriages for Scotland of the date, place and cause death and the deceased’s name and last known address. This replicates the effect of section 6(4)(b) of the 1976 Act.

\(^8\) The guidance about reporting restrictions and anonymising judgments has been issued directly to Senators and Sheriffs as part of guidance on data protection via the Judicial Hub, which is used for judicial learning and communication.
Section 27 – Compliance with sheriff’s recommendations

88. Subsection (1) obliges a person to whom a sheriff has made a recommendation to provide SCTS with a written response to that recommendation if he or she was a participant in the inquiry. In any other case, the person may choose to respond.

89. Under subsection (2) the respondent must state—

- what the respondent has done or proposes to do in response to the sheriff’s recommendation; or
- if the respondent has not done and does not intend to do anything in response to the recommendation, their reasons for that.

90. Under subsection (3), the respondent should reply within eight weeks of receipt of a copy of the determination. If the person does not respond to the determination with that period, there will be no sanction as such – the incentive for parties to respond would be that a lack of response or lack of good reasons for not implementing the recommendation would become public knowledge, thus promoting accountability and transparency. A person responding will have the opportunity to make representations to SCTS that all or part of the response should be withheld (subsection (4)).

91. SCTS will publish the response alongside the original determination, subject to such redaction as considered appropriate taking into account any representations from the respondent and any other reason (such as data protection law). Where a response has been partly withheld from publication, SCTS must publish a notice explaining that fact (subsection (5A)(b)). Where a response has been completely withheld from publication – which may only be done if representations are made to that effect – SCTS must publish a notice explaining that fact (subsection (5A)(c)). If no response is received, SCTS will publish a note to that effect alongside the original determination (subsection (7)). Subsection (9) provides that responses to recommendations are inadmissible in evidence and cannot be founded on in other judicial proceedings.

Section 27A – Reports

92. Section 27A requires the Scottish Ministers to publish an annual report on the number of inquiries that ended in a financial year and containing details of the number of recommendations requiring a response made in such inquiries. “Recommendations requiring a response” is defined by reference to section 27(1)(a). The report will not contain details of recommendations requiring a response. It will, however, give details of the number of recommendations requiring a response, the number of responses received and the number of recommendations to which no response is received. Each annual report must be laid before the Scottish Parliament and published.
Further inquiry proceedings

Section 28 – Circumstances in which there may be further proceedings

93. Section 28 makes provision for the circumstances in which there may be further proceedings under the Bill in relation to a death. This is a new power conferred on the Lord Advocate, which was not provided for in the 1976 Act.

94. Subsection (1) provides that, after an inquiry has ended, there may only be further inquiry proceedings in accordance with subsection (2).

95. Subsection (2) sets out the test for holding further inquiry proceedings. The Lord Advocate may decide that there are to be further proceedings if there is new evidence in relation to the circumstances of the death, and the Lord Advocate considers that it is highly likely that any of the sheriff’s findings and/or recommendations would have been materially different if the new evidence had been available at the original FAI (rather than the determination as a whole being materially different), and the Lord Advocate decides that it is in the public interest for further proceedings to be held.

96. The definition of “new evidence” in subsection (3) is based on section 4(7)(b) of the Double Jeopardy (Scotland) Act 2011. It means evidence which was not available, and could not reasonably have been made available, at the original inquiry into the death.

97. Further inquiry proceedings can take one of two forms, either the re-opening and continuation of the original inquiry, or a completely new (fresh) inquiry being held into a death which was the subject of the original inquiry. The making of a determination by the sheriff is treated as the end of the original FAI in subsection (4). The sheriff will decide if further proceedings should be in the form of re-opening the original FAI or in the form of holding a fresh FAI (see section 30).

Section 29 – Precognition of witnesses

98. Section 29 allows the procurator fiscal to cite witnesses for precognition prior to any further proceedings. It is based on section 9 of the Bill and, if a person fails to comply when cited, the person is subject to the same level of sanction.

Section 30 – Initiating further proceedings

99. Section 30(1) requires the procurator fiscal to notify the sheriff that there are to be further proceedings in relation to the death and to provide a copy of the original determination. The notice must include a brief account of the new evidence which has come to light together with the Lord Advocate’s view as to whether the further proceedings should consist of re-opening and continuation of the original inquiry or a fresh inquiry, and also any other information required by FAI rules. The sheriff to be notified is a sheriff of the sheriffdom within which the original proceedings were held (section 29(8)). Under subsection (2), the sheriff must order a hearing under subsection (2A) to hear representations about the form of the further proceedings.
100. Following that hearing the sheriff must set aside the determination made at the original inquiry and order whether there is to be a fresh FAI or whether the original FAI is to be re-opened, having regard to the public interest test in subsection (3). A fresh FAI should be held only if it is in the public interest to have a new inquiry rather than re-opening the original one. The location of the fresh or re-opened FAI is not a matter for the Lord Advocate.

101. Irrespective of whether the sheriff decides to re-open or hold a fresh FAI, the whole determination in the original proceedings must be set aside. This is because, even if the only change to a determination is to record the new evidence led at a re-opened FAI, there will be another determination at the end of the further proceedings.

Section 31 – Re-opened inquiries

102. Subsection (1) applies sections 14 to 17 of the Bill (which provide for pre-inquiry procedure) to a re-opened inquiry in the same way as to the original inquiry. Subsections (2) to (4) modify the application of those sections to take into account that this is a re-opening of the original inquiry. Accordingly, as the procurator fiscal has already notified the sheriff that there are to be further proceedings, the notification procedure on the procurator fiscal in section 14(1) is disapplied by subsection (2). This subsection also provides that the sheriff is to make an order under section 14(2) at the same time as he or she makes the order under section 30(2C). An order under section 14(2) is one fixing a date and place for the holding of a preliminary hearing and the inquiry.

103. Subsection (3) requires notice of the re-opened FAI under section 16 to be given to the participants at the original FAI and persons to whom recommendations were originally addressed.

104. Subsection (4)(b) requires notice to include the nature of the new evidence which was provided to the sheriff by the procurator fiscal. The purpose of this is to focus the minds of participants as to why the FAI has been re-opened and help them to prepare the relevant submissions and evidence they may wish to lead and any relevant background evidence which was led at the original FAI and which is required in order to set the context of the new evidence.

105. Subsection (5) restricts the evidence that is to be led to evidence about the matters to which the new evidence relates. However subsection (6) permits any evidence to be led if the sheriff either requires or allows it to be led. Taken together, the intention is that there is to be strong presumption that the re-opened FAI will consider only those matters related to the new evidence. However, there is a recognition that it may not be foreseeable where that new evidence will lead, permitting the sheriff to widen the scope of the inquiry as required.

106. As a continuation of the original proceedings, the re-opened FAI is to be held in the same sheriffdom as the original proceedings (but may be transferred by the sheriff to a different sheriffdom under section 12(3)).

107. Continued inquiries will follow the procedure set out in sections 18 to 27A.
Section 32 – Fresh inquiries

108. Section 32 makes provision about fresh inquiries.

109. Subsection (2) requires the sheriff to make an order under section 14(2) (fixing the date and place for the holding of a preliminary hearing and the inquiry) at the same time as making the order requiring it to be held.

110. Subsection (3) requires the procurator fiscal to notify all participants in the original FAI about the fresh FAI.

111. Subsections (4) and (5) provide that the fresh FAI is to be held in the same sheriffdom as the original FAI, unless transferred by the sheriff to a different sheriffdom under section 12(3).

112. Fresh inquiries will follow the procedure in sections 18 to 27A.

Section 33 – Further proceedings: compliance with recommendations

113. Under section 30(2C)(a), a sheriff will set aside the original determination made after the original proceedings. The sheriff will therefore issue a new determination at the conclusion of a re-opened or fresh FAI even if the only change to the original determination is to record the new evidence led at that FAI. Section 33(2) makes provision about the application of section 27 (compliance with the sheriff’s recommendations) where there is a new determination.

114. Under subsection (2), the requirement on a participant to respond to a sheriff’s recommendation under section 27 will not apply anew if the recommendation is the same as that already made in the original determination from the original FAI. This removal of a requirement to respond again to the same point does not affect any published response or published note of a lack of response made by SCTS in relation to the original FAI.

115. Under subsections (3) and (4), if a recommendation was addressed to a person in the original determination, but that recommendation is not made again in the new determination, the SCTS will be obliged to withdraw from publication any response made to the recommendation, any notice stating that part or all of a response has been withheld from publication or any notice that no response has been given.

Inquiry procedure rules

Section 34 – Power to regulate procedure etc.

116. Section 34 gives the Court of Session a broad power to make acts of sederunt concerning the procedure and practice to be followed in FAI proceedings.

117. Subsection (1) contains a broad general power to make provision regarding practice and procedure. Subsection (2) contains some specific illustrative examples of the sort of matters about which provision may be made. For example, rules can be made in relation to witnesses and evidence (which may be used to further empower the sheriff to focus the evidence led on matters of concern to the inquiry having regard to its purpose), the conduct and management of
FAI proceedings, the forms of documents used, and action to be taken before the FAI commences. However, this does not limit the broad power in subsection (1), which is a substantial widening of the power to regulate practice and procedure in FAIs.

118. Subsections (4) and (5) require the Court of Session to consult with the Scottish Civil Justice Council when making acts of sederunt which were not prepared in draft by the Council. The power to make rules under this section will be subject to transitional provisions set out in schedule 1 to the Bill as explained below.

**Specialist sheriffs and summary sheriffs**

*Section 35 – Judicial specialisation in inquiries*

119. Section 35 makes provision for sheriffs, part-time sheriffs, summary sheriffs and part-time summary sheriffs to be designated as specialist sheriffs in FAIs. Subsection (1) allows the sheriff principal to designate sheriffs and summary sheriffs within the sheriffdom, with section (3) allowing the Lord President of the Court of Session to designate part-time sheriffs and part-time summary sheriffs, who are not assigned to any particular sheriffdom, as specialists.

120. Subsection (5) makes it clear that it is still competent for a sheriff, part-time sheriff, summary sheriff, or part-time summary sheriff who is not designated as a specialist in FAIs to conduct an FAI. This may be inevitable owing to pressure of other casework. Under subsection (7), however, the sheriff principal must have to have regard to the desirability of allocating an FAI to a specialist.

*Section 36 – Summary sheriff: competence to conduct inquiries*

121. Section 36 gives summary sheriffs the same competence as sheriffs to conduct FAIs.

*Section 37 – Repeal and modification of enactments*

122. Section 37(1) repeals the 1976 Act in consequence of its re-enactment in the form of the Bill. For the most part the 1976 Act only extends to Scots law, however section 4(4) and (5) which are the precursor provisions for section 21 (publishing restrictions) extend to the law of England and Wales and Northern Ireland. The Scottish Government proposes that the full repeal of these provisions be progressed via the Order under section 104 of the Scotland Act 1998, as a natural consequence of extending the effect of section 21 to those jurisdictions. Section 37(2) introduces schedule 2 which is more fully described below. Insofar as any of the repeal modifies the law on reserved matters this is in the context of repealing provisions which are spent as a consequence of restatement in the Bill.

**General**

*Section 38 – Interpretation*

123. Section 38 sets out the definitions that apply throughout the Bill unless the context requires otherwise.
Schedule 1 – Procedure rules

Role of the Scottish Civil Justice Council

124. Paragraph 1 of schedule 1 amends the Scottish Civil Justice Council and Criminal Legal Assistance (Scotland) Act 2013, bringing the practice and procedure of FAIs and the making of FAI rules under the ambit of the Scottish Civil Justice Council.

Transitional arrangements

125. Paragraph 2 of schedule 1 sets out the transitional arrangement affecting section 34. It will initially be the role of the Scottish Ministers, by regulations, to make FAI rules until such time as the provisions conferring responsibility on the Scottish Civil Justice Council and the Court of Session for the making of FAI rules are commenced. It is made clear that section 34(4), which requires consultation with the Scottish Civil Justice Council prior to the making of rules, will not apply during this transitional period. However, the Scottish Ministers must instead consult the Lord President and such other persons as are considered appropriate before making any such regulations.

Schedule 2 – Modification of enactments

126. Paragraphs 1, 2(2) and 3(2) of schedule 2 repeal certain provisions in the Acts of Parliament referred to in section 3(2)(b), (c) and (e). The provisions being repealed have the same effect as the replacement provisions. As mentioned, this also effects a restatement of reserved law.

127. Paragraphs 2A, 2D, 2E, 2K and 2L repeal redundant provisions.

128. Paragraphs 2(3), 2B, 2C, 2F, 2G, 2H, 2I, 2J and 3(3) make purely consequential amendments to update references to the 1976 Act to become references to the Bill.

129. Wherever the provisions amended or repealed by schedule 2 extend to the law of England and Wales and Northern Ireland the Scottish Government proposes that equivalent amendment or repeal be achieved in the Order under section 104 of the Scotland Act 1998.
INQUIRIES INTO FATAL ACCIDENTS AND SUDDEN DEATHS ETC. (SCOTLAND) BILL

SUPPLEMENTARY DELEGATED POWERS MEMORANDUM

INTRODUCTION

1. This memorandum has been prepared by the Scottish Government to assist the Delegated Powers and Law Reform Committee in its consideration of the Inquiries into Fatal Accidents and Sudden Deaths etc. (Scotland) Bill. This memorandum describes provisions in the Bill conferring power to make subordinate legislation which were introduced, amended or removed from the Bill at Stage 2. The memorandum supplements the Delegated Powers Memorandum on the Bill as introduced.

2. The contents of this Memorandum are entirely the responsibility of the Scottish Government and have not been endorsed by the Scottish Parliament.

DELEGATED POWERS

Section 10A(3) – Availability of civil legal aid

Power conferred on: the Scottish Ministers
Power exercisable by: regulations made by Scottish statutory instrument
Parliamentary procedure: negative
Change at Stage 2: new power

Provision

3. Section 10A(3) inserts new subsections (2A) to (2C) into section 15 of the Legal Aid (Scotland) Act 1986 (financial conditions). Subsection (2B) places a duty on the Scottish Ministers to make regulations providing for special financial conditions to be applied to specified types of family member applying for civil legal aid in order to participate in a fatal accident inquiry (“FAI”) into the circumstances of the death of their relative. The family members (for example spouses or civil partners) are those referred to in new section 14 (1ZB) of the Legal Aid (Scotland) Act 1986 (availability of civil legal aid), inserted by section 10A(2) of the Bill. New section 15(2C) requires the Scottish Ministers to ensure that civil legal aid is made available under regulations to allow persons to participate fully in the fatal accident inquiry proceedings.

Reason for taking power

4. This power allows the Scottish Ministers to provide for the financial conditions which a family member must meet to be set out in regulations.
Choice of procedure

5. By virtue of section 37(1) of the Legal Aid (Scotland) Act 1986 the regulations would be subject to the negative procedure. The new section 10A would disapply the financial test in section 15(1) of the 1986 Act, so any regulations under section 36(2)(b) of the 1986 Act amending the amounts specified in section 15 would not bite on legal aid for participation in FAls for the specified relatives. Since the new power to make regulations for financial conditions is in a new section, and not listed in section 37(2) as subject to affirmative procedure, it would be subject to negative procedure. Regulations affecting financial conditions in the Legal Aid (Scotland) Act 1986 (for example regulations under section 36(2)(b) referred to) are usually subject to affirmative procedure.
INTRODUCTION

1. As required under Rule 9.7.8B of the Parliament’s Standing Orders, this Supplementary Financial Memorandum is published to accompany the Inquiries into Fatal Accidents and Sudden Deaths etc. (Scotland) Bill (introduced into the Scottish Parliament on 19 March 2015) as amended at Stage 2.

2. The Memorandum has been prepared by the Scottish Government. It does not form part of the Bill and has not been endorsed by the Parliament. It should be read in conjunction with the original Financial Memorandum published to accompany the Bill as introduced.

3. This Supplementary Financial Memorandum addresses the financial impact of Stage 2 amendments on the Bill where they would substantially alter any of the costs.

SECTION 2 – MANDATORY INQUIRIES

4. Section 2(3A) of the Bill was added at Stage 2 by amendment and provides for mandatory fatal accident inquiries (FAIs) for compulsorily detained mental health patients. Section 3(2)(f) and (g) provides for an investigation or inquiry by the Mental Welfare Commission for Scotland (MWCS) to be an exception under which the Lord Advocate can decide not to hold a mandatory FAI. Such investigations are not, however, carried out in relation to natural cause or expected deaths where there has been no apparent ill-treatment, neglect or deficiency in care.

5. The new requirement for mandatory FAIs would affect every natural cause and expected mental health death (including those which are completely unrelated to the patient’s mental condition) and any other death in which the MWCS did not carry out an investigation. In 2012-13, the MWCS reported on 78 deaths of patients subject to compulsion, 58 of which were natural cause deaths. Assuming that only those natural cause deaths were not subject to a MWCS investigation, this would mean that there would be up to 58 additional FAIs per annum, in a typical year, which would potentially double the present number of FAIs (currently 50-60 per annum). The potential costs of such additional FAIs are estimated below by reference to the cost impact on the Crown Office and Procurator Fiscal Service (COPFS), the Scottish Courts and Tribunals Service (SCTS) and the Scottish Legal Aid Fund.
Estimated cost to COPFS and SCTS of preparing and conducting an FAI

<table>
<thead>
<tr>
<th></th>
<th>1 day FAI</th>
<th>1 week FAI</th>
<th>Lengthy FAI</th>
</tr>
</thead>
<tbody>
<tr>
<td>COPFS¹</td>
<td>£9,494</td>
<td>£13,122</td>
<td>£94,701</td>
</tr>
<tr>
<td>SCTS²</td>
<td>£2,000</td>
<td>£10,000</td>
<td>£90,000</td>
</tr>
<tr>
<td>Total</td>
<td>£11,494</td>
<td>£23,122</td>
<td>£184,701</td>
</tr>
</tbody>
</table>

6. The one-day FAI is based on a straightforward mandatory FAI heard over one day or less. The one week FAI is based on a week-long mandatory FAI. The lengthy FAI is based on an FAI involving complex medical evidence (the length of 45 days has been used for the SCTS cost as an example). The impact on SCTS relates to the accommodation, services, staff and judiciary it provides for the purposes of FAIs.

7. The following assumptions were made in estimating the existing costs in the above table. The costs for SCTS are based on the actual court sitting days for the hearing and, as such, do not include preparation work, including preliminary hearings. They also exclude any additional costs if the FAI is held outside a sheriff court room. The estimates for COPFS for the one-day FAI and the one-week FAI assume that administrative and legal staff costs were mid-range; the legal costs for COPFS for the lengthy FAI were, however, calculated at the equivalent of the Civil Service Grade 6 level (£53,060 - £64,733).

8. These figures suggest that, potentially, an extra 58 FAIs per annum could cost in the region of £0.66 million per annum even if they were all one day hearings, which is unlikely. The overall costs to COPFS and SCTS are likely to be much higher. An upper range of £1.34 million may be experienced in the event that a fatality resulted in each of the 58 cases having a week long inquiry.

9. This would also have an implication for the legal aid budget, particularly if the changes proposed by section 10A of the Bill are taken forward. If the number of FAIs were to double, the Scottish Legal Aid Board estimates it might be expected that the legal aid bill for those inquiries to increase expenditure from the Legal Aid Fund by around £0.5m to £1m. The combined effect of this section and section 10A is detailed at paragraph 39.

10. There will, in addition, be unquantifiable costs associated with the attendance of doctors, nurses and other medical staff at FAIs in terms of backfilling when they are attending the inquiry, possibly for several days.

SECTION 7A – FAMILY LIAISON CHARTER

11. The Solicitor General gave a commitment during Stage 1 evidence on the Bill to consult on, and produce, a charter of investigation milestones, which will address concerns over keeping bereaved families informed about death investigations and will complement the provisions in the Bill to make the FAI system more efficient.

¹ Includes administrative, precognition, Victim Information & Advice (VIA), legal, pathology and witness costs.
² Based on the basic approximate cost of an FAI sitting in a sheriff court, which includes judicial and staff costs as well as running costs.
12. Although COPFS does currently conduct face to face meetings with many families and provide them with regular updates, the charter will introduce a standardised approach to communication with all bereaved families, whilst allowing some flexibility to tailor communication according to the wishes of the family involved. It is likely therefore that there will be a significant increase in face to face meetings with families and more contact either by phone or letter depending on the preference of the family involved. This amounts to a significant commitment to the frequency/regularity of contact made with all families which will have a corresponding financial impact on COPFS.

13. It is proposed that, in cases requiring further investigation with a view to deciding whether criminal proceedings should be instigated and/or whether an FAI should be held, the Crown Office will make contact with bereaved families by twelve weeks after the date that the death has been reported to COPFS. They will offer the family a personal meeting within 14 days to give them an update on the progress of the death investigation. They will also give them an idea of the likelihood of criminal proceedings and the possibility of an FAI.

14. It is also proposed that the charter will explain the different stages of a death investigation and set out the commitments of the Crown Office in terms of keeping in touch with relatives. It is proposed that they will contact the families every six weeks after the initial contact. The charter will also include a Frequently Asked Questions section and links to further information.

15. COPFS will be working towards implementation of the commitments to coincide with the passing of the Bill but, recognising how important these commitments are, will be endeavouring where possible to meet those commitments in the interim.

16. There are currently around 11,500 deaths reported to the Scottish Fatalities and Investigation Unit (SFIU) of COPFS per year. 93% of cases were closed within 12 weeks which means that the remaining 7% (805) are being further investigated beyond the 12 week period. There are 50 Health and Safety Division (HSD) of COPFS workplace cases over and above this figure. Therefore, there are roughly 855 (805+50) deaths per year which require further investigation.

17. HSD advise that in all 50 cases they would have a minimum of two meetings per case. So there is an assumption that in all HSD cases a 12 week meeting will take place. SFIU advise that, in approximately one third of cases being further investigated, they currently have face to face meetings. It is estimated that the commitment in the charter will therefore result in 537 additional 12 week meetings. COPFS advise that each will require one day of the time of a senior procurator fiscal depute and three hours of the time of a Victim Information and Advice (VIA) officer.

18. Thereafter it is expected that six week meetings will take place in around half of cases (428) and that there will be around four extra meetings per case per annum. This will equate to around 1710 extra meetings per annum. COPFS again advise that each will require one day of the time of a senior procurator fiscal depute and three hours of the time of a VIA officer. In the other cases contact with the family is expected to be by letter and this will again amount to around 1710 additional contacts per annum. COPFS advise that each will in such cases take one hour of the time of a senior procurator fiscal depute.
19. COPFS estimate that the resource implications of implementing the charter for liaison with bereaved families will amount to around £1 million. This is arrived at by the calculation of the time commitment of COPFS staff explained in paragraphs 17 and 18. COPFS are considering the efficiency savings that can be made in other areas of the business to meet some of the costs as part of their business and budget planning.

SECTION 8 – REASONS FOR NOT HOLDING AN INQUIRY

20. Section 8 of the Bill was amended at Stage 2 to require the Lord Advocate to give reasons in writing to persons specified in subsection (2) where it is decided that an inquiry is not to be held into the death of a detained mental health patient under section 2(3A) if the Mental Welfare Commission for Scotland has carried out an investigation or an inquiry under section 3(2)(f) or (g).

21. It is thought that it is likely that the discretion would be exercised in no more than 20 cases per annum. Such letters are likely to take an hour to draft and the hourly cost of the staff who would undertake this task is £45 so the total cost is likely to be up to £900.

SECTION 10A – AVAILABILITY OF CIVIL LEGAL AID

22. Section 10A of the Bill was amended at Stage 2 by amendment and will make civil legal aid available under the Legal Aid (Scotland) Act 1986 (“the 1986 Act”) at an FAI to relatives of a person in relation to whose death the inquiry is taking place, by removing the need to satisfy the statutory merits tests (thus treating them as automatically satisfied) and subject to a different financial eligibility test.

23. It does so by:
   - specifying that the Scottish Legal Aid Board is required to consider any such relative as having satisfied the statutory tests at section 14 of the 1986 Act of having probable cause and it being reasonable in the particular circumstances of the case to grant legal aid; and
   - disapplying the financial eligibility test set out at section 15 of the 1986 Act and requiring Ministers to make provision for alternative (and presumably more generous) financial eligibility conditions by way of regulations, which will allow relatives to participate at all FAI proceedings.

24. For the purposes of being eligible for legal aid in this way, a relative is:
   - The person’s spouse or civil partner at the time of the person’s death;
   - Someone living with the person as if married at the time of their death;
   - Where there is no spouse, civil partner or someone living with the person as if married at the time of their death, the person’s nearest known relative.

25. The following table shows the number of grants of legal aid in FAIs over the past five years. The costs have been constructed to show lifetime costs of cases summed back on to the
year the FAI case started, to demonstrate what the potential impact could be of a small increase in case numbers:

<table>
<thead>
<tr>
<th></th>
<th>2009/10</th>
<th>2010/11</th>
<th>2011/12</th>
<th>2012/13</th>
<th>2013/14</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of legal assistance applications for FAIs</td>
<td>33</td>
<td>38</td>
<td>16</td>
<td>10</td>
<td>18</td>
</tr>
<tr>
<td>Number of legal aid certificates paid for FAIs</td>
<td>27</td>
<td>25</td>
<td>10</td>
<td>8</td>
<td>8</td>
</tr>
<tr>
<td>Average payment per certificate</td>
<td>£88,950</td>
<td>£36,970</td>
<td>£18,124</td>
<td>£4,405</td>
<td>£16,966</td>
</tr>
<tr>
<td>Range of certificate payments</td>
<td>£1,470 to £389,591</td>
<td>£197 to £166,103</td>
<td>£161 to £110,891</td>
<td>£823 to £9,411</td>
<td>£1,764 to £82,894</td>
</tr>
<tr>
<td>Total paid from the Legal Aid Fund for FAIs</td>
<td>£2,401,661</td>
<td>£924,261</td>
<td>£181,236</td>
<td>£35,239</td>
<td>£135,727</td>
</tr>
</tbody>
</table>

26. In terms of actual expenditure per year, the cost to the Legal Aid Fund was £1,799,800 in 2011-12, £534,900 in 2012-13, and £137,900 in 2013-14. SLAB estimates expenditure in 2014-15 to be around £259,000 net.

27. Making the changes to eligibility in section 10A would increase the number of relatives receiving legal aid for FAI proceedings, but it is difficult to predict the increased cost. It might be reasonable to expect that there would be at least one grant of legal aid in most proceedings.

<table>
<thead>
<tr>
<th>Financial Year</th>
<th>Total number of FAIs commenced</th>
</tr>
</thead>
<tbody>
<tr>
<td>2011/12</td>
<td>63</td>
</tr>
<tr>
<td>2012/13</td>
<td>46</td>
</tr>
<tr>
<td>2013/14</td>
<td>33</td>
</tr>
<tr>
<td>2014/15</td>
<td>59</td>
</tr>
</tbody>
</table>

28. Based on these figures, removing the reasonableness test for relatives seeking legal aid in FAI cases could see the number of grants multiply four or five times if it meant that relatives would receive legal aid in every case. As can be seen, legal aid expenditure on these cases varies widely from year to year, but an additional base cost of at least £0.5 million per year might be expected. Where multiple grants of legal aid are made to families involved in an FAI, this could increase substantially. On the basis of an average of three grants per FAI £3.5 million additional expenditure might be expected per annum. This is very likely to be variable from year to year and expenditure could swing considerably from year to year.

29. Total spend from the Legal Aid Fund in 2013/14 was £150.5 million.

**SECTION 27A – REPORTS**

30. Section 27A was added to the Bill at Stage 2 and requires the Scottish Ministers to prepare a report at the end of the financial year setting out:
31. All of this information will be published by SCTS under sections 26(1) and 27(5A) of the Bill. It is expected that this will be published on the SCTS website. It is, therefore, anticipated that it will be relatively easy for Scottish Government officials to access the required information for the production of the report. There is, for example, no intention that there will be analysis of recommendations or responses. It is, therefore, expected that the cost of the duty to prepare a report (which would only repeat the figures on the SCTS website), to lay a copy of the report before the Scottish Parliament and to publish the report would not be significant.

SECTION 30 – INITIATING FURTHER PROCEEDINGS

32. Section 30 of the Bill has been amended to provide for the sheriff holding a hearing to give participants and the procurator fiscal the opportunity to make representations about whether further proceedings which are to be held under section 28 of the Bill (due to new evidence coming to light which would have materially affected a finding or recommendation in the sheriff’s determination at the original inquiry) should be a re-opened and continued inquiry or a completely fresh inquiry.

33. It is not expected that the power to initiate further inquiry proceedings will be used very often. It will only be invoked in the public interest, with a high test in section 28(2) and (3) for the definition of new evidence, and it is therefore expected to be used rarely. The costs of additional proceedings, including the hearing to permit the sheriff to hear the views of the procurator fiscal and the participants as to the form of the new proceedings, will be managed as part of the flux of FAIs. Those affected by this provision are likely to be those involved in the original inquiry.

SUMMARY OF ADDITIONAL COSTS

Costs on the Scottish Administration

34. The parts of the Scottish Administration affected by the proposals will mainly be COPFS and SCTS. The impact on each body is set out above under the impact of the provision which implies additional cost.

35. The additional cost of FAIs into deaths of detained mental health patients to COPFS and SCTS is £0.66 million but this could rise to £1.34 million.
36. The additional cost of implementing the commitments in the family liaison charter by COPFS is estimated to be £1 million and COPFS will be seeking efficiency savings in other areas of the business to meet some of the costs. It is also expected that some of the cost will be managed as part of the flux and unpredictability of numbers of deaths requiring investigation and inquiry by COPFS.

Costs on local authorities

37. The Scottish Government does not anticipate any additional costs on local authorities.

Costs on other bodies, individuals and businesses

38. The Scottish Government does not anticipate any additional costs on other bodies, individuals and businesses other than those specified above, specifically SLAB. As noted in paragraph 10, there will be unquantifiable costs on the NHS as a result of the amendment extending mandatory inquiries to deaths of compulsorily detained mental health patients.

39. The additional cost of FAIs to SLAB as a result of the changes in the rules on eligibility for legal aid may be expected to be at least £0.5 million but this may rise significantly if multiple families are involved in any particular case such as the Glasgow bin lorry tragedy. On the basis of an average of three grants per FAI £3.5 million additional expenditure might be expected per annum. This is very likely to be variable from year to year and expenditure could swing considerably from year to year. The £3.5 million does not include the costs of the amendment extending mandatory inquiries to deaths of compulsorily detained mental health patients. As set out in paragraph 9, additional costs for the mental health change could equate to around £500,000 to £1 million. Total additional costs could therefore equate to £4.5 million per annum.
Inquiries into Fatal Accidents and Sudden Deaths etc.  
(Scotland) Bill

Marshalled List of Amendments selected for Stage 3

The Bill will be considered in the following order—

Sections 1 to 41  Schedules 1 and 2
Long Title

Amendments marked * are new (including manuscript amendments) or have been altered.

Section 2

Paul Wheelhouse
2  In section 2, page 1, line 23, leave out <, (3A)>

Paul Wheelhouse
3  In section 2, page 2, line 7, leave out subsection (3A)

Paul Wheelhouse
4  In section 2, page 2, leave out lines 24 and 25

Section 3

Elaine Murray
36  In section 3, page 3, line 3, after <person> insert <—
   (a)>

Paul Wheelhouse
5  In section 3, page 3, line 3, leave out <, (3A)>

Elaine Murray
37  In section 3, page 3, line 5, at end insert—
   <(b) within section 2(3A) if satisfied that the death is from natural causes.>

Elaine Murray
38  In section 3, page 3, line 6, leave out <(1)> and insert <(1)(a)>
In section 3, page 3, leave out lines 13 to 15

In section 3, page 3, line 16, leave out <(1)> and insert <(1)(a)>

In section 4, page 3, line 29, leave out <, (3A)>

In section 8, page 5, leave out lines 19 to 24 and insert "Where it is decided that an inquiry is not to be held into the death of a person ("A"), the Lord Advocate must give reasons in writing if requested to do so by—">

In section 10, page 6, line 27, leave out "representative of A’s"

In section 10, page 6, line 27, leave out "or staff association" and insert "or similar body, representing the interests of workers in connection with the employment or occupation concerned"

In section 10, page 6, line 28, leave out second "a" and insert "the"

In section 10, page 6, line 28, leave out from "staff" to end of line 29 and insert "body,"

In section 10A, page 7, line 22, at end insert—

"( ) In subsection (2) of section 37 (parliamentary procedure), after “13(4),” insert “15(2B),”."
Paul Wheelhouse  
13 Leave out section 10A  

Section 26  

Paul Wheelhouse  
14 In section 26, page 14, leave out line 21  

Section 27A  

Paul Wheelhouse  
15 In section 27A, page 15, line 37, leave out <during that year>  

Paul Wheelhouse  
16 In section 27A, page 15, line 39, leave out <during that year>  

Section 30  

Paul Wheelhouse  
17 In section 30, page 17, line 40, at end insert—

< ( ) Where the sheriff makes an order under subsection (2C)(a), the Scottish Courts and Tribunals Service must publish, in such manner as it considers appropriate, a notice stating that the original determination has been set aside.>  

Section 33  

Paul Wheelhouse  
18 In section 33, page 19, line 21, leave out second <or>  

Paul Wheelhouse  
19 In section 33, page 19, line 22, leave out <27(5A)(c)> and insert <27(5A)(b) or (c)>  

Section 34  

Paul Wheelhouse  
20 In section 34, page 20, line 32, leave out <(including transitional provision)>  

Section 40  

Paul Wheelhouse  
21 In section 40, page 22, line 8, after <sections> insert <34(6).>
Paul Wheelhouse
22 In section 40, page 22, line 8, after <41> insert <and schedule 1>

Schedule 1

Paul Wheelhouse
23 In schedule 1, page 23, line 8, leave out <after> and insert <before>

Paul Wheelhouse
24 In schedule 1, page 23, line 8, leave out <(ba)> and insert <(c)>

Paul Wheelhouse
25 In schedule 1, page 23, line 12, leave out <after paragraph (c)(ii)> and insert <in paragraph (c), after sub-paragraph (ia)>

Paul Wheelhouse
26 In schedule 1, page 23, line 13, leave out <(iii)> and insert <(ib)>

Paul Wheelhouse
27 In schedule 1, page 23, line 14, leave out <(7)> and insert <(6A)>

Paul Wheelhouse
28 In schedule 1, page 23, line 15, leave out <(8)> and insert <(6B)>

Paul Wheelhouse
29 In schedule 1, page 23, line 20, leave out from <for> to first <rules> in line 21 and insert <after “draft fees rules” insert “>>

Paul Wheelhouse
30 In schedule 1, page 23, line 22, leave out from <for> to first <rules> in line 23 and insert <after “draft fees rules” insert “>>

Paul Wheelhouse
31 In schedule 1, page 23, line 23, at end insert—
    <( ) in subsection (3), after paragraph (b) insert—
        “(c) under section 34(1) of the Inquiries into Fatal Accidents and Sudden Deaths etc. (Scotland) Act 2015.”.

Paul Wheelhouse
32 In schedule 1, page 23, line 24, leave out <subsection (1) of>
Paul Wheelhouse

33 In schedule 1, page 23, line 26, leave out <2(8)> and insert <2(6B)>

Paul Wheelhouse

34 In schedule 1, page 23, line 28, leave out paragraph 2

Schedule 2

Paul Wheelhouse

35 In schedule 2, page 26, line 10, at end insert—

<Tribunals (Scotland) Act 2014>

(1) Paragraph 13 of schedule 9 of the Tribunals (Scotland) Act 2014 (transitional and consequential) is amended in accordance with this paragraph.

(2) In sub-paragraph (2)(b)(ii), in the inserted text, for “(ii)” substitute “(iza)”.

(3) In sub-paragraph (4), in the inserted text, for “(7)” substitute “(6ZA)”.

(4) In sub-paragraph (9), in subsection (1) of inserted section 13A, for “(c)(ii)” substitute “(c)(iza)”.

(5) In sub-paragraph (10)(b), in the inserted text, for “2(7)” substitute “2(6ZA)”.>
Groupings of Amendments for Stage 3

This document provides procedural information which will assist in preparing for and following proceedings on the above Bill. The information provided is as follows:

- the list of groupings (that is, the order in which amendments will be debated). Any procedural points relevant to each group are noted;
- the text of amendments to be debated during Stage 3 consideration, set out in the order in which they will be debated. THIS LIST DOES NOT REPLACE THE MARSHALLED LIST, WHICH SETS OUT THE AMENDMENTS IN THE ORDER IN WHICH THEY WILL BE DISPOSED OF.

Groupings of amendments

Note: The time limits indicated are those set out in the timetabling motion to be considered by the Parliament before the Stage 3 proceedings begin. If that motion is agreed to, debate on the groups above each line must be concluded by the time indicated, although the amendments in those groups may still be moved formally and disposed of later in the proceedings.

**Group 1: Mandatory inquiries: persons detained under mental health legislation**

2, 3, 4, 36, 5, 37, 38, 6, 39, 7, 8

Debate to end no later than 35 minutes after proceedings begin

**Group 2: Participation of trade unions and similar bodies in inquiries**

9, 10, 11, 12

**Group 3: Availability of civil legal aid**

1, 13

**Group 4: Sheriff’s determination and recommendations**

14, 15, 16, 17, 18, 19

**Group 5: Inquiry rules: role of the Scottish Civil Justice Council**

20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35

Debate to end no later than 1 hour after proceedings begin
Note: (DT) signifies a decision taken at Decision Time.

**Inquiries into Fatal Accidents and Sudden Deaths etc. (Scotland) Bill - Stage 3:**
The Bill was considered at Stage 3.

The following amendments were agreed to (without division): 4, 5, 6, 7, 8, 9, 10, 11, 12, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34 and 35.

The following amendments were agreed to (by division)—
2  (For 94, Against 14, Abstentions 0)
3  (For 94, Against 14, Abstentions 0)
13 (For 61, Against 46, Abstentions 0).

The following amendments were disagreed to (by division)—
1  (For 45, Against 63, Abstentions 0).

The following amendments were not moved: 36, 37, 38 and 39.

**Inquiries into Fatal Accidents and Sudden Deaths etc. (Scotland) Bill:** The Minister for Community Safety and Legal Affairs (Paul Wheelhouse) moved S4M-15113—That the Parliament agrees that the Inquiries into Fatal Accidents and Sudden Deaths etc. (Scotland) Bill be passed.

After debate, the motion was agreed to (DT).
The next item of business is stage 3 proceedings on the Inquiries into Fatal Accidents and Sudden Deaths etc (Scotland) Bill. To deal with amendments, members should have the bill as amended at stage 2, which is SP Bill 63A; the marshalled list, which is SP Bill 63AML; and the groupings, which is SP Bill 63AG. The division bell will sound and proceedings will be suspended for five minutes for the first division of the afternoon. The period of voting for the first division will be 30 seconds. Thereafter, I will allow a voting period of one minute for the first division after a debate. Members who wish to speak in the debate on any group of amendments should press their request-to-speak button as soon as possible after I call the group. Members should now refer to the marshalled list of amendments.

Section 2—Mandatory inquiries

The amendments in this group relate to mandatory fatal accident inquiries for patients detained under mental health legislation. Such inquiries were introduced at stage 2 by amendments that were lodged by Margaret Mitchell and agreed to by the Justice Committee.

Margaret Mitchell’s amendments mean that there will be a mandatory fatal accident inquiry into every death of a person detained under mental health legislation, unless certain exceptions apply. The Scottish Government’s amendments in the group seek to reverse the effect of Margaret Mitchell’s amendments. Amendment 4 removes a redundant definition of “mental disorder”, which is not referred to in the bill and which should be removed whether or not the other amendments in the group are agreed to. The definition is no longer required as it is relevant only in relation to patients receiving treatment in hospital voluntarily.

Subsequent to stage 2, several bodies wrote to the Scottish Government and MSPs to express their opposition to Margaret Mitchell’s stage 2 amendments and offer their support for the reversal of those amendments at stage 3. That is what the Government’s amendments in the group seek to do.

The Royal College of Psychiatrists said:

“it is stigmatising to suggest mental health care and treatment should be subject to special scrutiny in relation to patient deaths”.

The Scottish Association for Mental Health, which is a charity that supports and campaigns for people with mental health problems, says that the stage 2 amendments

“are disproportionate and could add to the distress of bereaved families”.

The British Medical Association Scotland said:

“There are of course deaths which would benefit from further investigation, but it is more appropriate for the fiscal to make the decision than to have a mandatory FAI for all cases.”

The amendments were not supported by the Mental Welfare Commission for Scotland, which believed that the provision was disproportionate and would not achieve the aim of national learning. Penumbra and the mental health nursing forum Scotland also expressed their opposition.

I understand members’ concerns that we must ensure that proper care is given to those who are detained by the state due to their mental health problems, especially as they are some of the most vulnerable people in our society. However, I believe that the systems that are in place and the statutory review that will soon be undertaken best ensure that that will happen.

Currently, the Mental Welfare Commission for Scotland may undertake an investigation when it is alleged that a mental health patient may have been subject or exposed to ill-treatment, neglect, or some other deficiency in care or treatment.

The chief medical officer issued a formal circular to practitioners in November this year that made it mandatory for all deaths that occur while the person is subject to compulsory treatment under mental health legislation to be reported to the procurator fiscal. That ensures not only that an independent investigation can be carried out by the procurator fiscal to establish whether there is any issue of criminality but that, if there is no criminality and it is in the public interest, perhaps because of a suspicion of a deficiency in care or treatment, the Lord Advocate can hold a discretionary FAI. That demonstrates that, if no FAI is to be held, it does not mean that there has been no investigation of the death. Indeed, of the 5,500 death investigations that are carried out each year by the Crown Office and Procurator Fiscal Service, only 50 to 60 lead to an FAI. As for all the other deaths that are reported to the Crown Office, the circumstances have been explored by the procurator fiscal.
In addition, section 37 of the Mental Health (Scotland) Act 2015 requires a statutory review of the arrangements for investigating the death of a patient who was detained in hospital by virtue of the Mental Health (Care and Treatment) (Scotland) Act 2003 or the Criminal Procedure (Scotland) Act 1995, or who was admitted voluntarily to hospital for the purpose of receiving treatment for a mental disorder. That provision was inserted by an amendment that was lodged by Dr Richard Simpson and supported unanimously by the Parliament. On the instruction of the Minister for Sport, Health Improvement and Mental Health, the Scottish Government this week laid an order commencing the provision, which will come into force on 24 December. Any change to FAIs in relation to such cases would pre-empt the review, which has been and will be widely welcomed by stakeholders. Indeed, in its stage 3 briefing to MSPs, the Mental Welfare Commission considers the review to be an “important opportunity to create a system of investigation of non-natural deaths of psychiatric patients which is proportionate, streamlined and effective.”

Although not a primary consideration of the potential impact, it is important to note that, as detailed in the supplementary financial memorandum to the bill, mandatory FAIs for detained mental health patients would effectively double the number of FAIs held per year. It would mean that one out of every two FAIs would relate to a mental health patient, which would be disproportionate and would, in my view and in the view of stakeholders, cause unnecessary distress to the families of the deceased.

I suspect that Dr Elaine Murray’s amendments have been lodged to mitigate that impact, as they would mean that the Lord Advocate may decide that an inquiry is not to be held into a death, if satisfied that the death is from natural causes. Perhaps that is an acknowledgment by Dr Murray that the provision, via an exception, in Margaret Mitchell’s stage 2 amendments for the Lord Advocate not to hold a mandatory FAI if there has been a Mental Welfare Commission investigation is not enough. However, amendment 37, in Dr Murray’s name, could give rise to practical issues of interpretation and application. There is no definition of “natural causes”, and it also raises more questions than it answers. For example, on what basis would the Lord Advocate be satisfied that the death was from natural causes? How is the phrase “natural causes” to be defined for the purposes of the provision? The amendment could also lead to challenges, by judicial review, to the Lord Advocate’s decision not to hold an FAI if, for example, the family believed that the death was not from natural causes.

For those reasons, the Government wishes to reverse Margaret Mitchell’s stage 2 amendments in order to return the bill to the original policy in respect of the treatment of mental health patients. As Dr Murray’s amendments are based on Margaret Mitchell’s stage 2 amendments remaining in the bill, Dr Murray has nothing to gain by pressing her amendments if those provisions are removed.

For the reasons that I have outlined, the Government opposes the amendments lodged by Elaine Murray. As the Scottish Government’s position is supported by a broad range of mental health organisations that work on the front line and which represent mental health patients and those who work with and care for them—to recap, the Mental Welfare Commission for Scotland, the Royal College of Psychiatrists, BMA Scotland, Penumbra, the mental health nursing forum Scotland and Enable—I ask Elaine Murray not to move her amendments.

I move amendment 2.

Elaine Murray (Dumfriesshire) (Lab): At stage 2, the committee agreed by majority vote to amend the bill to require a mandatory fatal accident inquiry when a person who is in compulsory detention under the Mental Health (Care and Treatment) (Scotland) Act 2003 dies. The amendment accorded with Lord Cullen’s recommendations in his review and had been supported during his consultation by organisations such as Enable. I also note that the deaths of patients in compulsory detention in England and Wales are subject to a coroner’s inquest.

The bill as amended also allowed the Lord Advocate to make an exception where the circumstances of the death had been established through an investigation under section 11 of the 2003 act. However, it did not allow the Lord Advocate to make an exception where the death was from natural causes, which would not be subject to investigation under the 2003 act. Therefore, the death from natural causes of persons who had been compulsorily detained would always be subject to a mandatory inquiry without any exception, which could be unnecessary and distressing to friends and family.

Amendment 37 would enable the Lord Advocate to make an exception for deaths from natural causes. Two thirds of people who die in compulsory detention die of natural causes, and there should be no requirement to conduct an FAI into those deaths.

However, since the bill was amended, we have received representations from a number of professional organisations and, crucially, organisations that represent people with mental health conditions and their families that urge us to remove the provisions in question. The Mental Welfare Commission believes that the priority
should be to establish the review of the arrangements for investigating the deaths of detained patients and that legislating at this stage would pre-empt the results of that review.

Carer representatives from the Royal College of Psychiatrists in Scotland advised that the delays involved in the FAI process would have a “significant and negative” impact on bereaved carers. Penumbra agrees with the views of the MWC and the Royal College of Psychiatrists. Enable made the original submission to Lord Cullen, but its briefing, which was sent to us yesterday, was ambiguous, so I contacted its policy officer to clarify its position. She advised me by email that Enable has accepted the Government’s position on the amendments, provided that there is a firm commitment that the review into the investigation of deaths of detained patients that is required by section 37 of the Mental Health (Scotland) Act 2015 is progressed as a matter of urgency. As the minister has said, that review is the result of an amendment that was lodged by my colleague Richard Simpson and unanimously supported by Parliament.

The Minister for Sport, Health Improvement and Mental Health wrote to the chair of the Health and Sport Committee, Duncan McNeil, earlier this week to advise that he intended to lay an order yesterday, which will come into force on 24 December and will clarify the deadline for the review’s completion. If the minister can confirm that that order has been laid and can advise us of the deadline for the review’s completion, I will consider that the stage 2 amendments have made an important contribution to the debate and to the acceleration of the review.

The Minister for Sport, Health Improvement and Mental Health (Jamie Hepburn): I confirm that I have laid that order. As Paul Wheelhouse said, it will come into effect on 24 December and will clarify the deadline for the review’s completion. If the minister can confirm that that order has been laid and can advise us of the deadline for the review’s completion, I will consider that the stage 2 amendments have made an important contribution to the debate and to the acceleration of the review.

The Deputy Presiding Officer: Dr Murray, could you come to a close, please?

Elaine Murray: In light of those assurances, I will not press my amendments, and Labour will support the Government amendments that remove the stage 2 amendments.

The Deputy Presiding Officer: Three members have requested to speak. I ask for contributions to be kept as short as possible.

Margaret Mitchell (Central Scotland) (Con): The reality is that, if amendment 3 is agreed to, adults in the mental health system who are detained on a compulsory basis will have fewer human rights than criminals in custody do. I remain of the view, which was originally stated by Enable, that deaths of people who are detained under the Mental Health (Care and Treatment) (Scotland) Act 2003 should be included in the mandatory category. Individuals who have been deprived of their liberty in the mental health system should have the same protection as those who are detained in a prison or a police cell.

Roderick Campbell (North East Fife) (SNP): Since we heard evidence on this matter at stage 1, things have moved on. At stage 1, the Scottish Human Rights Commission said that there was a gap in relation to the protection of the right to life for those in mental health detention. Indeed, the Mental Welfare Commission, while opposing mandatory inquiries, also commented that it thought that the current system was inadequate.

We have moved on, with the review under section 37 of the 2015 act, the order that Jamie Hepburn has referred to and the chief medical officer’s circular. In the light of all that and of all that has been said, we should be content to support the Government’s amendment.

A final point in relation to mandatory inquiries is that we should perhaps take account of the fact that, in the House of Commons, the Labour MP for Stockport is seeking to scrap the chief coroner’s current guidance that there should automatically be an inquest into the deaths of people who are subject to deprivation of liberty safeguards or are in state detention, because of the distress that that causes to many families of sufferers of dementia.

Alison McInnes (North East Scotland) (LD): Margaret Mitchell’s stage 2 amendment that required a mandatory FAI in relation to the death of any patient who dies while receiving treatment for a mental disorder was further amended by my amendment to remove the reference to voluntary patients. As the minister said, the bill as it now stands provides for a mandatory FAI for any patient who dies while detained under the Mental Health (Care and Treatment) (Scotland) Act 2003, and it provides an opt-out for the Lord Advocate. In effect, that flipped the previous arrangements, whereby the Lord Advocate could, if he considered it appropriate, order an FAI. I supported that move at stage 2, as the Scottish Human Rights Commission had advised that steps needed to be taken to ensure that the systems of investigation met the requirements of article 2 of the ECHR and to remedy the current gaps and confusion in the system.

15:15 I hope that we can all agree that, when the state has responsibility for someone’s care and health, there should be a full and independent process to
ascertain the reason for their death. Nevertheless, I acknowledge that there is disagreement over whether the FAI route is the right process, and I have further reflected on the evidence that was submitted by SAMH, the BMA, the Royal College of Psychiatrists and the Mental Welfare Commission, which all oppose the mandatory FAI approach, arguing that it is disproportionate, that it adds significantly to workload and, perhaps most compelling for me, that it risks stigmatisation and would increase the distress of bereaved families.

On balance, I have concluded that there is a more proportionate and less distressing way to proceed that involves reform of the whole system of notifications and investigation instead of focusing solely on FAIs. I will, therefore, support the Government's amendments, which will remove the provision. However, today, when Jeremy Hunt is at Westminster saying that he is profoundly shocked by the failure to investigate the unexpected deaths of mental health patients in a particular national health service trust in England, we cannot be complacent. Therefore, in supporting the amendments, I urge the minister to lose no time in proceeding with the review that was agreed to in the Mental Health (Scotland) Act 2015, and I ask him to pay particular heed to the view of SAMH that there is a particular issue relating to suicides that happen while people are in care.

The Deputy Presiding Officer: I did ask members to be brief.

John Finnie (Highlands and Islands) (Ind): I supported Margaret Mitchell's position at stage 2. However, like other members, particularly Elaine Murray and Alison McInnes, I have heard compelling evidence not only from the practitioners but from those who support the people who are in these circumstances. Therefore, I shall support the Government's position today.

Paul Wheelhouse: I will keep this brief, because I am conscious of the time. Members have raised the issue of human rights, and I thank Alison McInnes, John Finnie and Elaine Murray for their responses.

The chief medical officer's circular and the Crown Office guidance on reporting deaths to the procurator fiscal have been issued so that the deaths of detained patients can be independently investigated in accordance with article 2 of the ECHR. That strengthens the realisation in Scotland of the right to life that is enshrined in that article. The longstanding Scottish tradition of Crown discretion is well suited to the requirements of European law. Nevertheless, I take on board Alison McInnes's point, and the minister has indicated that the review that is required by section 37 of the Mental Health (Scotland) Act 2015 will look at the matter more comprehensively.

The Deputy Presiding Officer: The question is, that amendment 2 be agreed to. Are we agreed?

Members: No.

The Deputy Presiding Officer: There will be a division. As it is the first division of the stage and this afternoon, I will suspend the meeting for five minutes. Thereafter, there will be a 30-second division.

15:17

Meeting suspended.

15:22

On resuming—

The Deputy Presiding Officer: We proceed with the division on amendment 2.

For

Adam, George (Paisley) (SNP)
Adamson, Clare (Central Scotland) (SNP)
Allan, Dr Alasdair (Na h-Eileanan an Iar) (SNP)
Allard, Christian (North East Scotland) (SNP)
Baker, Claire (Mid Scotland and Fife) (Lab)
Baker, Richard (North East Scotland) (Lab)
Beamish, Claudia (South Scotland) (Lab)
Beattie, Colin (Midlothian North and Musselburgh) (SNP)
Biagi, Marco (Edinburgh Central) (SNP)
Bibby, Neil (West Scotland) (Lab)
Boyack, Sarah (Lothian) (Lab)
Brodie, Chic (South Scotland) (SNP)
Brown, Keith (Clackmannanshire and Dunblane) (SNP)
Burgess, Margaret (Cunningham South) (SNP)
Campbell, Aileen (Clydesdale) (SNP)
Campbell, Roderick (North East Fife) (SNP)
Chisholm, Malcolm (Edinburgh Northern and Leith) (Lab)
Coffey, Willie (Kilmarnock and Irvine Valley) (SNP)
Constance, Angela (Almond Valley) (SNP)
Cunningham, Roseanna (Perthshire South and Kinross-shire) (SNP)
Dey, Graeme (Angus South) (SNP)
Don, Nigel (Angus North and Mearns) (SNP)
Doris, Bob (Glasgow) (SNP)
Dornan, James (Glasgow Cathcart) (SNP)
Dugdale, Kezia (Lothian) (Lab)
Eadie, Jim (Edinburgh Southern) (SNP)
Ewing, Annabelle (Mid Scotland and Fife) (SNP)
Ewing, Fergus (Inverness and Nairn) (SNP)
Fabiani, Linda (East Kilbride) (SNP)
Fee, Mary (West Scotland) (Lab)
Ferguson, Patricia (Glasgow Maryhill and Springburn) (Lab)
Findlay, Neil (Lothian) (Lab)
Finnie, John (Highlands and Islands) (Ind)
FitzPatrick, Joe (Dundee City West) (SNP)
Gibson, Kenneth (Cunninghame North) (SNP)
Gibson, Rob (Caithness, Sutherland and Ross) (SNP)
Grahame, Christine (Midlothian South, Tweeddale and Lauderdale) (SNP)
Grant, Rhoda (Highlands and Islands) (Lab)
Gray, Iain (East Lothian) (Lab)
Hepburn, Jamie (Cumbernauld and Kilsyth) (SNP)
Hilton, Cara (Dunfermline) (Lab)
Hume, Jim (South Scotland) (LD)
Hyslop, Fiona (Linlithgow) (SNP)
Ingram, Adam (Carrick, Cumnock and Doon Valley) (SNP)
Johnstone, Alison (Lothian) (Green)
Keir, Colin (Edinburgh Western) (SNP)
Amendment 2 agreed to.

The question is, that amendment 3 be agreed to. Are we agreed?

Members: No.

Amendment 3 moved—[Paul Wheelhouse].
McArthur, Liam (Orkney Islands) (LD)
McCulloch, Margaret (Central Scotland) (Lab)
McDougall, Margaret (West Scotland) (Lab)
McInnes, Alison (North East Scotland) (LD)
McKelvie, Christina (Hamilton, Larkhall and Stonehouse) (SNP)
McLeod, Aileen (South Scotland) (SNP)
McLeod, Fiona (Strathkelvin and Bearsden) (SNP)
McMahon, Michael (Uddingston and Bellshill) (Lab)
McMahon, Siobhan (Central Scotland) (Lab)
McMillan, Stuart (West Scotland) (SNP)
McTaggart, Anne (Glasgow) (Lab)
Murray, Elaine (Dumfriesshire) (Lab)
Neil, Alex (Airdrie and Shotts) (SNP)
Paterson, Gil (Clydebank and Milngavie) (SNP)
Pentland, John (Motherwell and Wishaw) (Lab)
Rennie, Willie (Mid Scotland and Fife) (LD)
Robertson, Dennis (Aberdeenshire West) (SNP)
Robison, Shona (Dundee City East) (SNP)
Salmond, Alex (Aberdeenshire East) (SNP)
Simpson, Dr Richard (Mid Scotland and Fife) (Lab)
Stevenson, Stewart (Banffshire and Buchan Coast) (SNP)
Stewart, David (Highlands and Islands) (Lab)
Stewart, Kevin (Aberdeen Central) (SNP)
Sturgeon, Nicola (Glasgow Southside) (SNP)
Swinney, John (Perthshire North) (SNP)
Urquhart, Jean (Highlands and Islands) (Ind)
Watt, Maureen (Aberdeen South and North Kincardine) (SNP)
Wheelhouse, Paul (South Scotland) (SNP)
White, Sandra (Glasgow Kelvin) (SNP)
Wilson, John (Central Scotland) (Ind)
Yousaf, Humza (Glasgow) (SNP)
Against
Brown, Gavin (Lothian) (Con)
Buchanan, Cameron (Lothian) (Con)
Carlaw, Jackson (West Scotland) (Con)
Davidson, Ruth (Glasgow) (Con)
Fergusson, Alex (Galloway and West Dumfries) (Con)
Fraser, Murdo (Mid Scotland and Fife) (Con)
Goldie, Annabel (West Scotland) (Con)
Johnstone, Alex (North East Scotland) (Con)
Lamont, John (Strathclyde) (Con)
McGirr, Jamie (Highlands and Islands) (Con)
Mline, Nanette (North East Scotland) (Con)
Mitchell, Margaret (Central Scotland) (Con)
Scott, John (Ayr) (Con)
Smith, Liz (Mid Scotland and Fife) (Con)

Amendment 3 agreed to.
Amendment 4 moved—[Paul Wheelhouse]—and agreed to.

Section 3—Mandatory inquiries: exceptions
Amendment 36 not moved.
Amendment 5 moved—[Paul Wheelhouse]—and agreed to.
Amendments 37 and 38 not moved.
Amendment 6 moved—[Paul Wheelhouse]—and agreed to.
Amendment 39 not moved.

Section 4—Discretionary inquiries
Amendment 7 moved—[Paul Wheelhouse]—and agreed to.

Section 8—Reasons for decision not to hold an inquiry
Amendment 8 moved—[Paul Wheelhouse]—and agreed to.

Section 10—Persons who may participate in the inquiry
The Deputy Presiding Officer: That brings us to group 2, which is on the participation of trade unions and similar bodies in inquiries. Amendment 9, in the name of the minister, is grouped with amendments 10 to 12.

Paul Wheelhouse: The Scottish Government was happy to accept an amendment lodged at stage 2 by Elaine Murray that gives a statutory right of participation at a fatal accident inquiry to a trade union or staff association, although I said that we would consider whether the wording could be improved at stage 3. We have now held those discussions with Dr Murray and I am pleased to say that she indicated that she was content with the proposed amendments.

Dr Murray explained that her amendment was intended to cover sectors in which trade union membership was not permitted by law, such as the police. However, the term “staff association” does not have a recognised legal meaning. It could arguably cover the likes of internal equality networks or even sports or social associations. Consideration has been given to alternative wording that would deliver the policy intention.

Amendments 10 and 12 will cover bodies that are similar to trade unions—for example, in sectors where trade union membership is prohibited—and makes it clear that the body concerned must represent the interests of workers in connection with the employment or occupation during which the accident resulting in the death happened. That is intended to exclude bodies of workers that have a purely social function—for example, a sports association—and bodies that represent workers’ interests more generally, such as political bodies.

Amendment 10 also makes it clear that the requirement that the representation of workers’ interests must be

“in connection with the employment or occupation concerned”

also applies to the trade union.

Amendment 9 makes it clear that participation should be for a trade union or similar body itself
and not for a representative. Amendment 11 is consequential.

I hope that Elaine Murray and other members will welcome those amendments, which clarify and improve on the original stage 2 amendment.

I move amendment 9.

Elaine Murray: As the minister said, at stage 2, I introduced an amendment into section 10 to give a trade union or staff association representative of a person killed in the course of their employment the statutory right to participate in a fatal accident inquiry into the person’s death. The bill gives that statutory right to the person’s employer and to health and safety inspectors, and I felt that it was important that the participation of trade union or staff association representatives should be given parity, not least for the support that they can provide to the deceased’s family.

The amendment was accepted unanimously, but I recognised that the wording probably needed tidying up. The definition of “staff association” caused some problems, but I was keen that, if a police officer, for example, died in the course of their employment—which, sadly, happens more often in that profession than in most—the Scottish Police Federation or the Association of Scottish Police Superintendents should have equal rights to attend to the equivalent trade unions.

The amendments in group 2 revise the wording while retaining the policy intention of my stage 2 amendment and, therefore, we are happy to support them.

15:30

The Deputy Presiding Officer: No other member has requested to speak, so I ask the minister to wind up.

Paul Wheelhouse: I am happy to leave it at that.

Amendment 9 agreed to.

Amendments 10 to 12 moved—[Paul Wheelhouse]—and agreed to.

Section 10A—Availability of civil legal aid

The Deputy Presiding Officer: Group 3 is on the availability of civil legal aid. Amendment 1, in the name of Patricia Ferguson, is grouped with amendment 13.

Patricia Ferguson (Glasgow Maryhill and Springburn) (Lab): I support amendment 1, in my name, and I oppose amendment 13, in the name of the minister.

My stage 2 amendment, which was agreed to by the Justice Committee, sought to ensure that one of the key findings of Lord Cullen’s report on FAIs would be implemented—namely, that civil legal aid would be available to the families of the bereaved to allow them to be represented at an FAI.

As the Parliament is aware, the bill has its genesis in the review of FAIs that was undertaken by Lord Cullen at the request of the Scottish Government. Lord Cullen made two particularly important points in relation to legal aid for families who wish to participate in FAIs. The first was that relatives often believe that the procurator fiscal attends an FAI to look after their interests if they are unrepresented, but the Crown Office and Procurator Fiscal Service’s own guidance makes it clear that that is not the case and indicates that role of the procurator fiscal is to represent to the court any matter that affects the public interest, not that of the bereaved families. Indeed, the procurator fiscal is perfectly entitled to decline to put questions on behalf of the families.

The second point that Lord Cullen made was that FAIs take place regardless of whether relatives consent to them. If relatives want to participate, their ability to do so without representation is limited, and they are at a considerable disadvantage in comparison with other parties. Indeed, the Faculty of Advocates stated in evidence to Lord Cullen that

“it is impossible for relatives to participate effectively in important inquiries without legal representation”,

while Sheriff J P Murphy observed that the relatives

“should not be expected to be capable of self-representation in the traumatic situation of an FAI. I have never seen a lay person do it adequately.”

My stage 2 amendment had the effect of disapplying the normal financial conditions and thresholds, and it required ministers to come forward with a special scheme of conditions for relatives who were involved in FAIs. I was deliberately not prescriptive about what those regulations should be but instead left to ministers the job of drawing up a scheme that would implement those intentions. I did so in the context of a presumption that legal aid would be available and that families would be able to be represented throughout the process and would not find that the cash had run out part way through an FAI, as has happened.

Amendment 13 would have the impact of removing the entire provision, which would mean that bereaved families would not have access to legal aid. It seems to me that that is a basic principle, and it is one that I hope Parliament will uphold by rejecting amendment 13.

Amendment 1 seeks to ensure that when ministers bring forward the scheme for legal aid that was agreed to at stage 2, as I hope they will, they are required to do so by affirmative
resolution. That would ensure that Parliament had the opportunity to consider whether the provisions of the Scottish Government’s scheme fulfilled Parliament’s objectives.

I move amendment 1.

Paul Wheelhouse: As Patricia Ferguson said, this group of amendments relates to the provision for legal aid for FAIs. Patricia Ferguson’s amendment 1 is relevant only if her stage 2 amendment on legal aid remains part of the bill and, for reasons that I will explain, amendment 13 will reverse that amendment.

The bill as amended at stage 2 now provides for the establishment of a family charter, which will, as one of its effects, formalise the engagement between the bereaved family and the Crown Office and Procurator Fiscal Service. Among the issues that the charter will cover, the procurator fiscal will engage with the family on matters where they seek clarity on the circumstances of the death of their loved one from the FAI to inform the Crown’s questions of witnesses, which will seek to serve the public interest, as Patricia Ferguson said.

At present, if the bereaved family wish to ask questions that the fiscal cannot ask in the public interest, they may be entitled to legal aid. They will typically qualify for legal aid if they meet the eligibility criteria. The key tests for agreeing legal aid are about probable cause and reasonableness. Probable cause will always be satisfied where a relative has a right to participate in a fatal accident inquiry, so the main question for the Scottish Legal Aid Board will often be about reasonableness.

To give a real-life example of the reasonableness test in action, I am aware of an example in which a relative was granted legal aid to explore specific mental health issues of the deceased that had been raised prior to that person’s death. I make it clear that the reasonableness test will always be satisfied where a relative or their children have explored with the family as part of the family charter what areas the family is keen to explore in the course of the inquiry, so the family may be at a genuine disadvantage if it is ruled that they are ineligible for legal aid?

Paul Wheelhouse: The point that I was making, which I will come to in more depth, was that, if there was clearly a disagreement on the line of questioning that the Crown might want to take and what the family might want to explore, perhaps because that was not relevant to the public interest, there would be a case to be made on probable cause and reasonableness. In practice, bereaved relatives already get access to legal aid for fatal accident inquiries. The point that I am making is that we do not need a provision in the bill to enable legal aid to be made available when there is probable cause and reasonableness. That already happens under the current regulations.

The provisions as they stand allow us to ensure that legal aid is available for a wide range of matters and that help is given where it is needed most. That contrasts with the approach in England and Wales, where cuts to legal aid mean that there is no longer access to legal help with specific types of family, medical, housing and welfare benefits problems. In certain cases, people even have to provide evidence that they or their children have been victims of domestic abuse or violence in order to access legal aid. We are trying to maintain the breadth of legal aid and the principles that underpin it.

Removing the tests for one type of proceeding—in this case, fatal accident inquiries—would, more importantly, undermine the general approach to and principles of legal aid in Scotland: that is, the principles of probable cause and reasonableness. If amendment 13 is not passed, that will in effect mean virtually automatic legal aid for fatal accident inquiries. It is simply not necessary for all parties to fatal accident inquiries to be legally represented. I take on board Annabel Goldie’s point about something developing during an inquiry, but the procurator fiscal will obviously have explored with the family as part of the family charter what areas the family is keen to explore and what their concerns are about the inquiry prior to going in. That is an innovation as part of the bill. It is simply not necessary for all parties to be legally represented, as the procurator fiscal already has a duty to bring forward evidence about the circumstances of the death.

Johann Lamont (Glasgow Pollok) (Lab): Does the minister accept that many people in our constituencies feel that they are very poorly served by the fatal accident inquiry system and are entirely excluded, and that they have no confidence in the prosecution service? The minister is saying that we do not have to look at that and everything is okay. In fact, the real problem is that people are not able to engage when they have concerns about how their rights
are being represented. Surely Patricia Ferguson’s amendment addresses that.

**Paul Wheelhouse:** I listened to Johann Lamont’s point. I merely point out that we have a bill on the back of Lord Cullen’s review to reform the fatal accident inquiry process and we have the innovation of the milestone charter, or family charter as it is dubbed for the purposes of the bill, which was brought about by the line of questioning that Patricia Ferguson took and the Solicitor General’s thoughts on the matter. That significantly moves us forward in making the fatal accident inquiry process much more engaged with families. There is a formal process in which families will engage and be communicated with throughout to ensure that they are part of the process and feel that their points are being addressed by the procurator fiscal and the inquiry process.

I hope that, with the passage of time, Ms Lamont will see that the system is being reformed to make it more family friendly. The main purpose of an FAI is to establish the facts around a death and to prevent further deaths from happening—clearly, we all share that aim. I reassure the member that the Crown Office and Procurator Fiscal Service is doing everything that it can to make the process more aligned with families’ interests and to consult families on the line of questioning.

The change that Patricia Ferguson has proposed would be at the expense of the fundamental principles of the FAI and legal aid systems, and it would force us to look at alternative controls on legal aid. However, the issue is not just about the effect on legal aid. One of the key aims of the bill, which I hope is shared across the chamber, is to make FAIs less adversarial, but funding legal representation to raise concerns and questions that would be similar to those covered by the procurator fiscal in the public interest would achieve the exact opposite in some circumstances. If all parties at FAIs were legally represented, regardless of need, inquiries would inevitably become more adversarial, longer and more expensive. The key consideration is the potential for more adversarial and lengthier FAIs.

Those concerns were highlighted in consultation responses by those who are involved in the running of FAIs. The Sheriffs Association said:

“It is only where there is a conflict of interest between the procurator fiscal and the next of kin that there should be a necessity for separate representation. That is a matter that should be explored and determined fully by SLAB before legal aid is granted.”

Lord Gill, in his consultation response while serving as Lord President, argued that increased legal aid for families of the deceased would lead to questions at FAIs becoming about blame, which is for civil litigation, instead of about ascertaining the circumstances and causes of death. He also stated:

“The allowance of legal aid would negate the priorities of economy and expeditiousness that the proposals”—that is, of the bill—“should achieve.”

Only yesterday, Lord Carloway said in a letter to me:

“There is no substantial reason why those seeking legal aid for representation at an FAI should be subject to less arduous financial tests than other applicants in other situations. It is difficult to justify a more lenient regime for the former than for, say, a victim of a road traffic accident who has suffered injuries of maximum severity.”

He went on:

“Should family members be routinely represented, the inquiry risks losing its essential inquisitorial character and acquiring an unhelpful and inappropriate, and quite possibly prolonged, adversarial focus.”

**The Deputy Presiding Officer:** Minister, I would be grateful if you would begin to conclude.

**Paul Wheelhouse:** I will, Presiding Officer.

I believe that our goal of making FAIs less adversarial is the right one. We should do what we can to avoid making FAIs more adversarial and thereby creating greater difficulty in finding the truth with the aim of preventing a recurrence of a death. In doing so, it is important to preserve the principles that underpin the legal aid system. I urge members to support amendment 13 and reject amendment 1.

**Margaret Mitchell:** Like the majority of members of the Justice Committee, I supported the provisions on legal aid for bereaved families in fatal accident inquiries under the terms of Patricia Ferguson’s amendment 60 at stage 2, which I considered to be proportionate and balanced. The key point is that the Crown Office and Procurator Fiscal Service represents the public interest and not specifically the interests of relatives. It is therefore only right and fair that legal aid should be available to ensure that those interests are represented. Further, the measure was another of Lord Cullen’s recommendations that was not included in the bill. If the Government uses its parliamentary majority to remove the provision, that will further fuel the view that the grave concerns about the absence of checks and balances in the decision making of the Scottish National Party majority Government are well founded.

**Roderick Campbell:** I have listened to the debate with some interest. One matter that still puzzles me slightly about the Opposition’s approach is that we had Lord Cullen before the Justice Committee at stage 1 and nobody asked
him a question on the issue. I accept that the issue arose at stage 2, but he was not asked about it then. If it was an important issue that the Government had not accepted in Lord Cullen’s report, one would have anticipated that Opposition members would have wanted to question him on it, but that did not happen.

Patricia Ferguson rightly referred to the bits in Lord Cullen’s report that touch on the matter. As she pointed out, Lord Cullen stated:

“the procurator fiscal is independent of any party, including the relatives, and should not be regarded as their representative at the FAI. He or she is entitled to decline to put questions for the relatives.”

However, Patricia Ferguson did not point out that Lord Cullen went on to say:

“I note that the COPFS state in their guidance that, where necessary, the procurator fiscal will indicate to the relatives ‘that it is unlikely that [he or she] will be able adequately to represent their interest and concerns at the Inquiry and that separate representation is considered appropriate’.

That is the key. The minister also referred to Lord Carloway’s comments about the number of times when the interests of the family and the procurator fiscal do not diverge. Clearly, when they do diverge there should be an opportunity to obtain legal aid, but I hope that the milestone charter means that situations in which people feel that they have been deprived of that opportunity will be few and far between.

15:45
Johann Lamont: Will the member give way?
Roderick Campbell: I have just finished speaking.

The Deputy Presiding Officer: The member has indicated that he has finished his speech, I am afraid. I call Patricia Ferguson to wind up the debate.

Patricia Ferguson: I am slightly confused by what Roderick Campbell said. The whole point of having stage 2 is to enable matters to be brought up that have not been dealt with at stage 1. I do not know whether Mr Campbell is arguing that we should not have stage 2 at all.

Mr Campbell read out a passage from Lord Cullen’s very good report on FAIs, which I will read again, for the avoidance of doubt. He quoted from guidance that provides that, in a case in which the procurator fiscal cannot represent the family, they will indicate

“that it is unlikely that [he or she] will be able adequately to represent their interest and concerns at the Inquiry and that separate representation is considered appropriate.”

Yes, and we need the money to pay for that. Families in such a situation will not always have resources to fall back on to enable them to secure representation.

In all this, it seems strange to me that the qualifications for legal aid for an FAI are currently the same as they are for any civil litigation, which means that probable cause must be identified. It seems odd to me to apply the concept of probable cause to an FAI, because, as the minister says, an FAI is not litigation between parties. The approach seems bizarre.

The minister mentioned the charter, which I very much welcome. If the point of having the charter is that the minister accepts that families need more information and require to be kept informed, surely families must also have the right to be considered to have an interest in an FAI—an interest that will be meaningful only if they are represented.

Paul Wheelhouse: I accept the member’s point about the need for families to be represented where the procurator fiscal is perhaps taking an approach that is different from the approach that they want to be taken. When probable cause and reasonableness kick in, families who can demonstrate a relevant interest in the FAI—as opposed to people who do not have an interest—can be represented in the inquiry. I gave the example of someone whose relative dies in prison, who would very likely get legal aid, because of the difficulties that are faced by someone who loses a loved one in such a situation. That is an example of how probable cause is demonstrated and the reasonableness test is applied.

Patricia Ferguson: I think that I am right in saying that, after a death in custody, civil legal aid is automatically granted to enable the family to be represented at a fatal accident inquiry. I will stand corrected if I am not right about that.

The point is that a family who want to be represented at a fatal accident inquiry will not necessarily know that there is an issue about probable cause until they are some way into the FAI process. How do we cope with that? Is the minister saying that we will halt fatal accident inquiries willy-nilly to allow the Scottish Legal Aid Board to reconsider a case before an FAI resumes?

Paul Wheelhouse: Will the member give way?
Patricia Ferguson: No. I heard what the minister said, and I have to say that it was not particularly helpful—[Interruption.]

The Deputy Presiding Officer: Order, please.

Patricia Ferguson: If the minister will give me a minute to respond to what has been said, I will give way later.

The charter does not provide for the procurator fiscal to represent the family. It makes it easier for
the family to get information during the process, but it does not allow the procurator fiscal to act on their behalf. At the moment and in future, the procurator fiscal will represent the public interest, which is a different thing.

Paul Wheelhouse: I am grateful to the member for giving way.

In many cases, there might be a good alignment between the public interest and the interests of the family. Where that is not the case, there is a very high chance—subject to the financial eligibility test, as with other forms of legal aid—that the relatives will have access to legal aid to enable them to take forward a line of questioning that might not be taken forward by the procurator fiscal.

I reassure the member that the arrangements that already apply will be strengthened by the family charter. There is a process to ensure that the procurator fiscal discusses the kinds of questions that the families would like to be considered.

The Deputy Presiding Officer: Patricia Ferguson, please begin to draw to a close.

Patricia Ferguson: Thank you, Presiding Officer. I am close to finishing.

I know that the minister is trying to be helpful, but it will not work with the process. Family members will not know that there will be a difference between their interest and the public interest until they see the line of questioning.

None of us wants to see FAIs being adversarial. In my view—I am not quoting from anyone here—FAIs are likely to be more adversarial if people do not have the right to representation. It stands to reason. It is a basic principle that bereaved family members who are having to go through the trauma of a fatal accident inquiry should be assisted by the state in doing so.

I press amendment 1.

The Deputy Presiding Officer: The question is, that amendment 1 be agreed to. Are we agreed?

Members: No.

The Deputy Presiding Officer: There will be a division.

For

Baker, Claire (Mid Scotland and Fife) (Lab)
Baker, Richard (North East Scotland) (Lab)
Beamish, Claudia (South Scotland) (Lab)
Bibby, Neil (West Scotland) (Lab)
Boyack, Sarah (Lothian) (Lab)
Brown, Gavin (Lothian) (Con)
Carlaw, Jackson (West Scotland) (Con)
Chisholm, Malcolm (Edinburgh Northern and Leith) (Lab)
Davidson, Ruth (Glasgow) (Con)
Dugdale, Kezia (Lothian) (Lab)

Against

Fee, Mary (West Scotland) (Lab)
Ferguson, Patricia (Glasgow Maryhill and Springburn) (Lab)
Ferguson, Alex (Galloway and West Dumfries) (Con)
Findlay, Neil (Lothian) (Lab)
Finnie, John (Highlands and Islands) (Ind)
Fraser, Murdo (Mid Scotland and Fife) (Con)
Goldie, Annabel (West Scotland) (Con)
Grant, Rhoda (Highlands and Islands) (Lab)
Gray, lain (East Lothian) (Lab)
Hilton, Cara (Dunfermline) (Lab)
Hume, Jim (South Scotland) (LD)
Johnstone, Alex (North East Scotland) (Con)
Johnstone, Alison (Lothian) (Green)
Lamont, Johann (Glasgow Pollok) (Lab)
Lamont, John (Ettrick, Roxburgh and Berwickshire) (Con)
Macintosh, Ken (Eastwood) (Lab)
Malik, Hanzala (Glasgow) (Lab)
McArthur, Liam (Orkney Islands) (LD)
McCulloch, Margaret (Central Scotland) (Lab)
McDougall, Margaret (West Scotland) (Lab)
McGrigor, Jamie (Highlands and Islands) (Con)
McInnes, Alison (North East Scotland) (LD)
McMahon, Michael (Uddingston and Bellshill) (Lab)
McMahon, Siobhan (Central Scotland) (Lab)
McTaggart, Anne (Glasgow) (Lab)
Mitchell, Margaret (Central Scotland) (Con)
Murray, Elaine (Dumfries and Galloway) (Lab)
Pearson, Graeme (South Scotland) (Lab)
Pentland, John (Motherwell and Wishaw) (Lab)
Rennie, Willie (Mid Scotland and Fife) (LD)
Scott, John (Ayr) (Con)
Simpson, Dr Richard (Mid Scotland and Fife) (Lab)
Smith, Liz (Mid Scotland and Fife) (Con)
Stewart, David (Highlands and Islands) (Lab)
Wilson, John (Central Scotland) (Ind)

Dey, Graeme (Angus South) (SNP)
Don, Nigel (Angus North and Mearns) (SNP)
Doris, Bob (Glasgow) (SNP)
Dornan, James (Glasgow Cathcart) (SNP)
Eddie, Jim (Edinburgh Southern) (SNP)
Ewing, Annabelle (Mid Scotland and Fife) (SNP)
Ewing, Fergus (Inverness and Nairn) (SNP)
Fabiani, Linda (East Kilbride) (SNP)
FitzPatrick, Joe (Dundee City West) (SNP)
Gibson, Kenneth (Cunninghame North) (SNP)
Gibson, Rob (Caithness, Sutherland and Ross) (SNP)
Graham, Christine (Midlothian South, Tweeddale and Lauderdale) (SNP)
Hepburn, Jamie (Cumbernauld and Kilsyth) (SNP)
Hyslop, Fiona (Linlithgow) (SNP)
Ingram, Adam (Carrick, Cumnock and Doon Valley) (SNP)
Keir, Colin (Edinburgh Western) (SNP)
Kidd, Bill (Glasgow Anniesland) (SNP)
Lochhead, Richard (Moray) (SNP)
Lyle, Richard (Central Scotland) (SNP)
MacAskill, Kenny (Edinburgh Eastern) (SNP)
MacDonald, Angus (Falkirk East) (SNP)
MacDonald, Gordon (Edinburgh Pentlands) (SNP)
Mackay, Derek (Renfrewshire North and West) (SNP)
MacKenzie, Mike (Highlands and Islands) (SNP)
Mason, John (Glasgow Shettleston) (SNP)
Matheson, Michael (Falkirk West) (SNP)
Maxwell, Stewart (West Scotland) (SNP)
McAlpine, Joan (South Scotland) (SNP)
McDonald, Mark (Aberdeen Donside) (SNP)
McKelvie, Christina (Hamilton, Larkhall and Stonehouse) (SNP)
McLeod, Aileen (South Scotland) (SNP)
McLeod, Fiona (Strathkelvin and Bearsden) (SNP)
McMillan, Stuart (West Scotland) (SNP)
Milne, Nanette (North East Scotland) (Con)
Neil, Alex (Airdrie and Shotts) (SNP)
Paterson, Gil (Clydebank and Milngavie) (SNP)
Roberson, Dennis (Aberdeenshire West) (SNP)
Robison, Shona (Dundee City East) (SNP)
Salmond, Alex (Aberdeenshire East) (SNP)
Stevenson, Stewart (Banffshire and Buchan Coast) (SNP)
Stewart, Kevin (Aberdeen Central) (SNP)
Sturgeon, Nicola (Glasgow Southside) (SNP)
Swinney, John (Perthshire North) (SNP)
Urqhart, Jean (Highlands and Islands) (Ind)
Watt, Maureen (Aberdeen South and North Kincardine) (SNP)
Wheelhouse, Paul (South Scotland) (SNP)
White, Sandra (Glasgow Kelvin) (SNP)
Yousaf, Humza (Glasgow) (SNP)

The Deputy Presiding Officer: The result of the division is: For 45, Against 63, Abstentions 0.

Amendment 1 disagreed to.

Amendment 13 moved—[Paul Wheelhouse].

The Deputy Presiding Officer: The question is, that amendment 13 be agreed to. Are we agreed?

Members: No.

The Deputy Presiding Officer: There will be a division.

For
Adam, George (Paisley) (SNP)
Adamson, Clare (Central Scotland) (SNP)
Allan, Dr Alasdair (Na h-Eileanan an Iar) (SNP)
Allard, Christian (North East Scotland) (SNP)
Baker, Claire (Mid Scotland and Fife) (Lab)
Baker, Richard (North East Scotland) (Lab)
Bibby, Neil (West Scotland) (Lab)
Boyack, Sarah (Lothian) (Lab)
Brown, Gavin (Lothian) (Con)
Buick, Cameron (Lothian) (Con)
Carlaw, Jackson (West Scotland) (Con)
Chisholm, Malcolm (Edinburgh Northern and Leith) (Lab)
Davidson, Ruth (Glasgow) (Con)
Dugdale, Kezia (Lothian) (Lab)
Fee, Mary (West Scotland) (Lab)
Ferguson, Patricia (Glasgow Maryhill and Springburn) (Lab)
Fergusson, Alex (Galloway and West Dumfries) (Con)
Findlay, Neil (Lothian) (Lab)
Fraser, Murdo (Mid Scotland and Fife) (Con)
Goldie, Annabel (West Scotland) (Con)
Grant, Rhoda (Highlands and Islands) (Lab)
Gray, Iain (East Lothian) (Lab)
Hilton, Cara (Dunfermline) (Lab)
Hume, Jim (South Scotland) (LD)
Johnstone, Alex (North East Scotland) (Con)
Johnstone, Alison (Lothian) (Green)
Lamont, Johann (Glasgow Pollok) (Lab)
Lamont, John (Ettrick, Roxburgh and Berwickshire) (Con)
MacIntosh, Ken (Eastwood) (Lab)
Malik, Hanzala (Glasgow) (Lab)
McArthur, Liam (Orkney Islands) (LD)
McCulloch, Margaret (Central Scotland) (Lab)

Gibson, Kenneth (Cunninghame North) (SNP)
Gibson, Rob (Caithness, Sutherland and Ross) (SNP)
Grahame, Christine (Midlothian South, Tweeddale and Lauderdale) (SNP)
Hepburn, Jamie (Midlothian South, Tweeddale and Lauderdale) (SNP)
Hyslop, Fiona (Linlithgow) (SNP)
Ingram, Adam (Carrick, Cumnock and Doon Valley) (SNP)
Keir, Colin (Edinburgh Western) (SNP)
Kidd, Bill (Glasgow Anniesland) (SNP)
Lochhead, Richard (Moray) (SNP)
Lyle, Richard (Central Scotland) (SNP)
MacAskill, Kenny (Edinburgh Eastern) (SNP)
MacDonald, Angus (Falkirk East) (SNP)
MacDonald, Gordon (Edinburgh Pentlands) (SNP)
Mackay, Derek (Renfrewshire North and West) (SNP)
MacKenzie, Mike (Highlands and Islands) (SNP)
Mason, John (Glasgow Shettleston) (SNP)
Matheson, Michael (Falkirk West) (SNP)
Maxwell, Stewart (West Scotland) (SNP)
McAlpine, Joan (South Scotland) (SNP)
McDonald, Mark (Aberdeen Donside) (SNP)
McKelvie, Christina (Hamilton, Larkhall and Stonehouse) (SNP)
McLeod, Aileen (South Scotland) (SNP)
McLeod, Fiona (Strathkelvin and Bearsden) (SNP)
McMillan, Stuart (West Scotland) (SNP)
Neil, Alex (Airdrie and Shotts) (SNP)
Paterson, Gil (Clydebank and Milngavie) (SNP)
Roberson, Dennis (Aberdeenshire West) (SNP)
Robison, Shona (Dundee City East) (SNP)
Salmond, Alex (Aberdeenshire East) (SNP)
Stevenson, Stewart (Banffshire and Buchan Coast) (SNP)
Stewart, Kevin (Aberdeen Central) (SNP)
Sturgeon, Nicola (Glasgow Southside) (SNP)
Swinney, John (Perthshire North) (SNP)
Urqhart, Jean (Highlands and Islands) (Ind)
Watt, Maureen (Aberdeen South and North Kincardine) (SNP)
Wheelhouse, Paul (South Scotland) (SNP)
White, Sandra (Glasgow Kelvin) (SNP)
Yousaf, Humza (Glasgow) (SNP)

Against
Baker, Claire (Mid Scotland and Fife) (Lab)
Baker, Richard (North East Scotland) (Lab)
Beamish, Claudia (South Scotland) (Lab)
Bibby, Neil (West Scotland) (Lab)
Boyack, Sarah (Lothian) (Lab)
Brown, Gavin (Lothian) (Con)
Buick, Cameron (Lothian) (Con)
Carlaw, Jackson (West Scotland) (Con)
Chisholm, Malcolm (Edinburgh Northern and Leith) (Lab)
Davidson, Ruth (Glasgow) (Con)
Dugdale, Kezia (Lothian) (Lab)
Fee, Mary (West Scotland) (Lab)
Ferguson, Patricia (Glasgow Maryhill and Springburn) (Lab)
Fergusson, Alex (Galloway and West Dumfries) (Con)
Findlay, Neil (Lothian) (Lab)
Fraser, Murdo (Mid Scotland and Fife) (Con)
Goldie, Annabel (West Scotland) (Con)
Grant, Rhoda (Highlands and Islands) (Lab)
Gray, Iain (East Lothian) (Lab)
Hilton, Cara (Dunfermline) (Lab)
Hume, Jim (South Scotland) (LD)
Johnstone, Alex (North East Scotland) (Con)
Johnstone, Alison (Lothian) (Green)
Lamont, Johann (Glasgow Pollok) (Lab)
Lamont, John (Ettrick, Roxburgh and Berwickshire) (Con)
MacIntosh, Ken (Eastwood) (Lab)
Malik, Hanzala (Glasgow) (Lab)
McArthur, Liam (Orkney Islands) (LD)
McCulloch, Margaret (Central Scotland) (Lab)
Amendment 17 relates to what happens when the Lord Advocate decides that further proceedings should be initiated either by reopening an inquiry or, exceptionally, by holding a fresh inquiry. In the interests of transparency, the bill does not provide for the withdrawal of the original determination from publication. It should, however, be made clear by means of the publication of a notice that the original determination has been set aside. Amendment 17 ensures that, at the point that the sheriff makes an order for further proceedings, the Scottish Courts and Tribunals Service must publish a notice explaining that the determination has been set aside. An interested person going to the SCTS website will therefore see all of the relevant information together.

Amendments 18 and 19 are technical amendments to section 33 relating to further inquiry proceedings. They relate to where a recommendation was made in the original determination by the sheriff but a recommendation in the same terms is not made in the new determination. In such circumstances, the SCTS must withdraw from publication notices to such recommendations and any notices published in relation to them.

Amendment 19 requires the SCTS to withdraw from publication notices that state that part of a response to a recommendation has been withheld from publication, in addition to those published that state that the whole of a response has been withheld or that no response was given. Amendment 18 is consequential to amendment 19.

I move amendment 14.

Amendment 14 agreed to.

Section 27A—Reports

Amendments 15 and 16 moved—[Paul Wheelhouse]—and agreed to.

Section 30—Initiating further proceedings

Amendment 17 moved—[Paul Wheelhouse]—and agreed to.

Section 33—Further inquiry proceedings: compliance with recommendations

Amendments 18 and 19 moved—[Paul Wheelhouse]—and agreed to.

Section 34—Power to regulate procedure etc

The Deputy Presiding Officer: Group 5 is on inquiry rules: role of the Scottish Civil Justice Council. Amendment 20, in the name of the minister, is grouped with amendments 21 to 35.
Paul Wheelhouse: Amendments 20 to 35 are highly technical in nature.

Amendments 21 and 22, together with amendment 34, are the key substantive amendments in this group. They add section 34(6) and schedule 1 to the list of sections that will come into force the day after royal assent. That is to permit the Scottish Civil Justice Council to begin work early in the new year on drafting rules for FAIs to replace the Fatal Accidents and Sudden Deaths Inquiry Procedure (Scotland) Rules 1977. The SCJC currently has no powers to do so.

Amendment 34 removes paragraph 2 of schedule 1. That removes the transitional arrangement for the Scottish ministers to make regulations for FAI rules before the SCJC takes on the responsibility. Amendment 20 is consequential to amendment 34.

Amendment 31 inserts a new paragraph into section 4(3) of the Scottish Civil Justice Council and Criminal Legal Assistance Act 2013 to make it clear that the Court of Session’s power to make inquiry rules is not prejudiced by the SCJC’s specific statutory function of preparing draft FAI rules.

Amendments 23 to 30, 32, 33 and 35 are technical remodelling of existing provisions, which do not have any substantive effect. They are needed because the Scottish Civil Justice Council will now take on the role of drafting FAI rules before it takes on the role of drafting rules for the Scottish tribunals.

Amendment 35 makes some minor consequential tidying-up changes to the Tribunals (Scotland) Act 2014.

I move amendment 20.

Amendment 20 agreed to.

Section 40—Commencement

Amendments 21 and 22 moved—[Paul Wheelhouse]—and agreed to.

Schedule 1—Procedure rules

Amendments 23 to 34 moved—[Paul Wheelhouse]—and agreed to.

Schedule 2—Modification of enactments

Amendment 35 moved—[Paul Wheelhouse]—and agreed to.
recent, the Fatal Accidents and Sudden Deaths Inquiry (Scotland) Act 1976, has served Scotland for nearly 40 years. It is right that the law should now be reformed and modernised and I pay tribute to Lord Cullen, who carried out a most thorough review of the legislation, which has brought us to this point.

There is a reason why I have sought to put the system of death investigation and of fatal accident inquiries in Scotland into context and to explain its historical derivation. Procurators fiscal investigate some 5,500 sudden, suspicious or unexplained deaths every year. Clearly many of those investigations will result in criminal proceedings.

In many cases, the fiscal will conclude that no further investigation or inquiry is necessary. Only around 50 to 60 cases per annum proceed to a full fatal accident inquiry before a sheriff. The Scottish Government firmly believes that this system incorporates and permits a necessary and beneficial degree of flexibility. Cases that have led to public concern will almost certainly lead to an FAI before a sheriff, while those that do not, by and large, will not.

One of the strengths of vesting all death investigation powers in a single public officer is that when homicide has been excluded, the prosecutor's duty is not at an end, whereas if suspicious circumstances emerge in the course of investigating what had appeared to be an expected death, the prosecutor is already aware of the circumstances.

Deaths as a result of an accident in the course of employment and deaths in legal custody will automatically result in mandatory FAIs. Under the bill, deaths of children in secure accommodation and deaths in police custody, irrespective of the location of the death, will also now result in mandatory inquiries.

In all other cases, discretion is given to the Lord Advocate and the Crown Office to decide whether an FAI is required in the public interest. It is right that they should have that discretion, since the Crown will first have to establish whether there has been any behaviour in relation to the death that merits criminal prosecution. Only after that decision has been taken will consideration be given to the need for an FAI where it is not mandatory.

Lord Gill, the former Lord President, indicated in his evidence to the Justice Committee that it was right that the Crown Office should exercise discretion rather than the law becoming too inflexible, which would lead to many FAIs being held from which no lessons would be learned yet the bereaved family or families would suffer the distress of a public examination of the circumstances of the death of their loved one.

Under the bill, it will now be possible for the Lord Advocate to judge whether it would be in the public interest for an FAI to be held into the death of a person normally resident in Scotland who dies or is killed abroad. In coming to that decision, the Lord Advocate will have to take into account whether there has already been an adequate investigation of the death in the country where it took place. He or she will also have to consider whether there is a realistic prospect that an investigation in Scotland by the Crown Office will be able to properly establish the circumstances of the death, given that it will have to rely on liaison with, and the co-operation of, the legal and Government authorities in the country in which the death took place.

Nevertheless, the Government believes that the bill is a major advance in the law of death investigation in Scotland, particularly as it will be possible to hold an FAI without the body being repatriated to this country. That is still a requirement for a coroner's inquest to be held in such circumstances in the rest of the UK. The requirement for the repatriation of the body was removed from the bill at the suggestion of the Justice Committee, to whose members I extend my thanks for their thoughtful and thorough consideration of the bill. There is therefore now parity in the bill in terms of a death occurring on the Scottish mainland, in the offshore North Sea oil and gas area, or abroad.

I should add that the system in Scotland is quite different from that under coroners in the rest of the UK. Under the coroners' system, the coroner is responsible for the investigation of the death or deaths, but the coroner also presides over the inquest. In Scotland, the procurator fiscal investigates the death but if an FAI is mandatory or is ordered by the Lord Advocate, the fiscal will present the evidence to a full judicial inquiry before a sheriff. We believe that that system combines and embodies the necessary elements of effective investigation, separation of powers and judicial independence to determine authoritatively the circumstances of the death and any precautions that might have been taken and which should be taken in the future to prevent deaths in similar circumstances.

The bill contains new provisions that require participants at FAIs to whom a sheriff has directed a recommendation to respond, setting out how they propose to implement the recommendation or, if they do not intend to comply, explaining why not. Patricia Ferguson lodged an amendment at stage 2 that requires Scottish ministers to produce an annual report on responses to recommendations. Taken as a package, we believe that the proposals on requiring responses to sheriffs' recommendations and the annual report will provide a transparent record of what
has happened in relation to those recommendations. The report will highlight whether participants have responded to the recommendations, although if the experience under a similar system for coroners' inquests is a guide, very high response rates may be expected.

Patricia Ferguson lodged another amendment at stage 2, which provides statutory underpinning for the family liaison charter that the Solicitor General for Scotland promised during evidence at stage 1. The charter will keep bereaved families fully informed of the progress of a death investigation and the likelihood of criminal proceedings or the potential for a fatal accident inquiry.

Patricia Ferguson did, of course, introduce her own member’s bill on fatal accident inquiries. Although she chose to withdraw her bill at stage 1, it is appropriate to acknowledge and pay tribute to all the hard work that she has devoted to addressing the various issues surrounding death investigations and FAIs. I thank her for the collaborative way in which she has engaged with the Government on the bill.

Elaine Murray lodged an amendment at stage 2 on trade union participation at FAIs. The Scottish Government accepted the amendment, subject to amending the provision to ensure that it properly reflected the policy intention. I am grateful to Elaine Murray, too, for discussing that with me, which has resulted in our amending the provision to ensure that it means that bodies similar to trade unions that represent workers who are not permitted to join trade unions will be able to participate at FAIs.

I pay tribute, too, to Flt Lt James Jones, who drew to the attention of the Justice Committee the anomaly that deaths of service personnel in the course of their duties in Scotland do not at present automatically result in a fatal accident inquiry, although a discretionary inquiry may be held. That fact was not raised by Lord Cullen in his review, nor was the matter raised during the Government’s consultation on its legislative proposals. It is a credit to the Justice Committee’s system of evidence taking that the issue was identified during its deliberations.

The matter will now be progressed by means of a section 104 order under the Scotland Act 1998, which will be brought forward at the Westminster Parliament because the issue engages the reservation of defence matters and the armed forces. I indicated during the stage 1 debate that we have received agreement in principle from the UK Government for that change. The Scottish Government will continue to work with the UK Government to put in place the necessary order next year.

The bill is not the end of the reforms of the system of fatal accident inquiries. In addition to the section 104 order to which I have referred, the Scottish Civil Justice Council will prepare rules for FAIs under section 34 of the bill that will complement and supplement the bill’s provisions. The rules will provide the kind of comprehensive, self-contained set of rules that Lord Cullen recommended were necessary for FAIs. It will therefore not be necessary in future to supplement the fairly sparse existing rules for FAIs with rules that were written for adversarial civil litigation, which may not lend themselves to an inquisitorial fact-finding process.

The involvement of the Scottish Civil Justice Council will ensure that the new draft bespoke rules for FAIs benefit from structured, co-ordinated stakeholder input. The rules will cover matters such as preliminary hearings, which will now be the norm for FAIs; the agreement so far as possible of uncontroversial evidence before the start of an FAI; greater case management powers for sheriffs, in line with the general thrust of the reforms under the Courts Reform (Scotland) Act 2014; and the new provisions for further inquiry proceedings where new evidence comes to light. The intention is that the new act, the rules and the section 104 order will all be commenced at the same time. As it will take some months to work up suitable and comprehensive rules under the new act, it is anticipated that commencement will not be until later in 2016.

The Scottish Government’s bill provides for a coherent, proportionate, modernised system of fatal accident inquiries fit for the 21st century. It seeks to provide what Lord Cullen desired: practical measures for a system of inquiry that is effective, efficient and fair. We believe that that is what the bill does and we hope that the legislation will be able to serve for even longer than the 1976 act. I commend the motion in my name and ask members to support it.

I move,

That the Parliament agrees that the Inquiries into Fatal Accidents and Sudden Deaths etc. (Scotland) Bill be passed.

16:10

Elaine Murray (Dumfriesshire) (Lab): As we have heard, fatal accident inquiries into the circumstances of deaths are undertaken in the public interest in order to determine the time, place and cause of death and to establish whether lessons can be learned in order to prevent similar fatalities in the future. They are intended to be inquisitorial rather than adversarial, and they do not attempt to allocate criminal guilt. I think that we all agree that they should continue to operate in that manner.
The current legislation has for some time been recognised as being inadequate. As long ago as March 2008, shortly after Lord Cullen was asked to conduct his review of the fatal accident inquiry process, a debate was held in Parliament on the inadequacies of the system, and members' speeches were informed by their direct knowledge of the experiences of their constituents.

Nine of Patricia Ferguson’s constituents died when ICL Plastics Group’s Stockline Plastics Ltd factory exploded in May 2004, and it was because of frustrations with the delays in the system—a judge-led public inquiry was not held for four years—that Ms Ferguson introduced to Parliament in November last year her proposal for the Inquiries into Deaths (Scotland) Bill. She had consulted on draft proposals in August 2013, and Lord Cullen had reported his findings in 2009. The Scottish Government responded in 2011, but did not introduce its bill until after Patricia Ferguson’s bill had been introduced. This may seem to be cynical, but I wonder whether the Inquiries into Fatal Accidents and Sudden Deaths etc (Scotland) Bill would be with us today if Patricia Ferguson had not started the ball rolling with her member’s bill.

Nevertheless, having been introduced in March, the Fatal Accidents and Sudden Deaths etc (Scotland) Bill has progressed fairly rapidly. As members know, Patricia Ferguson agreed to withdraw her bill and instead to work with the Government on amendments. Her bill sought to introduce time limits within which certain decisions should be taken and family members informed. During the stage 1 evidence taking, the Solicitor General for Scotland advised the Justice Committee of her intention to draw up a charter that would advise what bereaved families could expect with regard to communication, and a copy of the draft charter was circulated to committee members over the summer. At stage 2, Patricia Ferguson, in agreement with the Government, submitted an amendment to put that charter on a statutory basis. She and the Scottish Government also agreed on an amendment to require ministers to prepare an annual report on sheriffs’ recommendations relating to FAIs, and some clarifying amendments have been agreed to this afternoon.

I mention those two amendments because one of the Justice Committee’s recommendations was that the bill be amended to include some additional aspects of Patricia Ferguson’s bill. Even as amended, the bill does not address all the issues that she hoped to cover in her bill, but she will speak in the open debate and will, no doubt, comment on those issues. Neither does the bill address all of Lord Cullen’s recommendations, although it may be that the Government plans to bring some of those things into effect later on. However, the bill improves on the current legislation and is, therefore, welcome.

I am pleased that my modest stage 2 amendment was accepted so that the bill now gives representatives of the trade union of which the deceased was a member at the time of their death an automatic right to attend a fatal accident inquiry, thereby giving the trade union parity with the deceased’s employer. My original amendment also mentioned staff associations because I was keen for bodies such as the Scottish Police Federation and the Association of Scottish Police Superintendents to have the same entitlement to attend an inquiry when one of their members has died. I am grateful to the Scottish Government for improving the way in which that was expressed in its stage 3 amendments.

The Government amended the bill at stage 2 to enable an FAI to be held when a death has occurred abroad, even if the body cannot be repatriated. There are circumstances, for example deaths at sea, in which retrieval of the body is not possible. There being no possibility of a burial or a cremation ceremony is very upsetting for families—even without the law also debarring the possibility of a fatal accident inquiry being held in the public interest.

At stage 1, Flt Lt James Jones brought to us the issue of service personnel who die in service in Scotland. I am pleased that the United Kingdom Parliament is discussing that and I hope that there will be a resolution of the issue. I, too, am grateful to Flt Lt Jones for drawing our attention to the issue.

Patricia Ferguson also lodged an amendment that had majority support in the committee and which would have ensured that families could be legally represented through the complexities of a fatal accident inquiry by removing the reasonableness test for eligibility for legal aid. We are disappointed that the Scottish Government has chosen to delete that provision today, because it continued to have the support of all the opposition parties in Parliament, especially given Ms Ferguson’s erudite explanation of the need for families to be confident at the commencement of the FAI process that they will receive legal aid.

It is notable that the families of people who die in prison are now treated differently in this regard from the families of people who die at work or in the streets.

The committee, on majority vote, also amended the bill at stage 2 to implement Lord Cullen’s recommendation to make FAIs mandatory when people die when they are in compulsory mental health detention. At the time, we were supported by third sector organisations, including Enable, in their submissions to Lord Cullen’s review, and we
had also been told that coroner’s inquiries are mandatory in such circumstances in England and Wales.

However, several organisations, health professionals and—crucially—mental health patients and their families subsequently wrote to both the Government and MSPs to ask that the amendments be deleted from the bill and for the bill to revert to the original wording, which provides for discretionary FAIs in such circumstances. As I said during consideration of the stage 3 amendments, my correspondence yesterday with Enable indicated that it would be content with that change, so long as adequate assurances are given that the review of the investigation that is required by section 37 of the Mental Health Act 1983, of deaths of patients who, at the time of death, are detained in hospital under mental health law, is progressed as a matter of urgency. We heard today that the order to do that was laid yesterday and that the review will be undertaken as soon as possible. It was worth while to amend the bill at stage 2, in order to get that reassurance today. I know that everybody will grateful for that.

Despite our disappointment about the deletion of Patricia Ferguson’s amendment on legal aid, we believe that the bill has been improved by comparison with Patricia Ferguson’s bill and by the subsequent amendments that were agreed at stages 2 and 3. We will support it in this evening’s vote.

16:16

Margaret Mitchell (Central Scotland) (Con): I acknowledge Patricia Ferguson’s significant involvement in this legislative process following the withdrawal of her own bill, and her co-operation with the Scottish Government at stage 2. I thank the witnesses and stakeholders for their insightful evidence, which has informed the committee’s scrutiny of the bill.

It is not surprising that, 30 years after the system of FAIs was enacted, significant reform and modernisation of it were required. In 2009, Lord Cullen’s review of the law governing FAIs made a number of important recommendations, many of which are provided for by the bill.

During its stage 1 scrutiny, the Justice Committee identified a number of weaknesses that needed to be addressed at stage 2. For example, a common criticism from bereaved families was about the long delays before the commencement of inquiries, which can be aggravated by patchy communication from the Crown Office and Procurator Fiscal Service. Concern was expressed about the fact that the Scottish Government did not include a provision reflecting Lord Cullen’s recommendation that early hearings should be held, especially because early hearings would not only require the procurator fiscal to keep relatives informed of the progress of the investigation but would, crucially, focus attention on holding the FAI as quickly as possible.

However, following the commitment of the Solicitor General to produce a milestone charter outlining what families can expect from the COPFS in relation to timings of investigations and decision making, the committee came to the view that early hearings are no longer necessary.

In relation to FAIs into deaths abroad, the Justice Committee questioned the requirement that the body must be repatriated to Scotland for the FAI to be held. Taking into account evidence that occasionally exceptional circumstances would render that impossible, the Scottish Government amended the bill accordingly at stage 2.

I turn to the stage 2 amendments on legal aid for families and the amendments on mandatory inquiries—albeit with an opt-out for the Lord Advocate—into the deaths of individuals who have been detained compulsorily under mental health legislation. The recommendations from Lord Cullen were not provided for by the bill as introduced, but amendments to provide for them were voted for by a majority of the Justice Committee at stage 2. I still consider that the amendments relating to mental health detainees struck the right balance between ensuring that the mandatory FAI would not be carried out unnecessarily and ensuring the protection of the deceased’s rights. Moreover, the amendment that dealt with legal aid recognised that the Lord Advocate represents not the interest of the families but the public interest.

Today, the Scottish Government has overturned both those amendments. Two consequences will flow from that, the first of which is the laying bare of the total absence of checks and balances in the decision making of this Scottish National Party majority Government. That continues to be, justifiably, an issue of grave concern.

Christian Allard (North East Scotland) (SNP): It has been said by Margaret Mitchell and in other contributions that, somehow, this has not been a proper democratic process. However, it has been. A Government cannot accept everything that the Opposition wants; if it did, the bill would be an Opposition bill. What is the point of being in Government if the Government cannot direct some part of the legislation? Some parts are approved—some parts are not. I also remind the member that she herself has a member’s bill that has been accepted.

The Deputy Presiding Officer: Point made. Thank you very much.
Margaret Mitchell: The point is that the SNP has a majority on seven out of nine subject committees in the—

Christine Grahame (Midlothian South, Tweeddale and Lauderdale) (SNP): What about Westminster?

Margaret Mitchell: I accept Ms Grahame’s sedentary remark, but there are checks and balances in the Westminster Government; indeed, that has been proved quite recently by decisions that have been made by the House of Lords. The point is that there are no checks and balances on this majority Government, because we were never supposed to have a majority Government. As a result, we have had this despicable decision on Patricia Ferguson’s amendment on legal aid.

James Dornan (Glasgow Cathcart) (SNP): Will Margaret Mitchell give way?

The Deputy Presiding Officer: The member is just closing.

Margaret Mitchell: There is no doubt that individuals who are detained under mental health legislation are among the most vulnerable people in society, but today the SNP Government has ensured that they will not be afforded the same protections as criminals who die in custody. Although the bill will, in general, have a positive impact on bereaved families’ experiences of the FAI system in Scotland, I believe that the Scottish Government can take little comfort or pride in how it has discriminated against vulnerable mental health detainees.

The Deputy Presiding Officer: We now move to the open debate.

16:22

Christian Allard (North East Scotland) (SNP): I have already made the point, but I will make it again: it is very important that members understand the strength of this Parliament, particularly in respect of the fact that Opposition members can introduce member’s bills. That is fantastic—it is a very great thing. Not only that—I will come back to this at the end of my speech—but a person can, by giving evidence to a committee, change a bill. It is quite incredible that not only Opposition members but people who give evidence to committees can contribute to the drafting of a bill. I am, of course, talking about retired Flt Lt Jones.

As a member of the Justice Committee, I am delighted to see the passage of another of the many bills that the committee has scrutinised this year. I thank committee members and the clerks, who will be delighted that this is the second stage 3 that we have done this week.

The bill will modernise the fatal accident inquiry process and make it effective, efficient and fair. I think that, following recent events, it is right that I remind Parliament that the interest of families in a fatal accident inquiry is in ascertaining the circumstances around and the cause of a death. The primary concern for all of us must be that we do not confuse a fatal accident inquiry with procedures in civil courts in which questions of blame are addressed. It is very important that we see that principle through, but it is clear that at stage 1, stage 2 and now stage 3, some members have wanted to move towards a more adversarial kind of inquiry. I do not think that that will help the process; it will certainly not help the family to get more of an understanding from the process.

There are two things that I would like to address quickly—one has been mentioned already. Scotland will be the first jurisdiction in the UK to allow inquiries into deaths that have occurred abroad without repatriation of the body of the deceased. It is important that families and the public understand that that will be the case only in exceptional circumstances. As the minister said, we have gone beyond the practice in England and Wales, and quite rightly so. He also said:

“it is a very important advance that that possibility should exist, particularly as that is not the case in England and Wales.”—[Official Report, Justice Committee, 3 November 2015; c 18.]

I very much welcome that, and the reassurance that it will give to many people in Scotland and people who are working abroad in sometimes challenging conditions. I am thinking in particular about oil workers from the north-east of Scotland who work across the world.

The second point that I would like to address concerns retired Flt Lt James Jones, who gave evidence to the committee. It is fantastic to see that one person can make so much difference. I very much look forward to the passage of the order under section 104 of the Scotland Act 1998 that will ensure that those who risk their lives for us can be assured of appropriate inquests. That is particularly important when we ask them again and again to make the ultimate sacrifice overseas. Once again, I thank retired Flt Lt James Jones for coming to the committee because, without his efforts, that provision might not have been possible.

The lessons of the past have been learned, and I look forward to a fair settlement for service personnel in Scotland.

16:26

Patricia Ferguson (Glasgow Maryhill and Springburn) (Lab): This afternoon, when we pass the bill—as we will, with Labour support—we will
make some significant changes to the FAI system. However, I cannot help but observe that we have missed the opportunity to make some radical and important changes to the FAI system at the same time.

Lord Cullen’s review, which the Scottish Government ordered, was a good one, but as colleagues probably know, it did not go far enough for me. However, it obviously went too far for the Scottish Government.

As members know, I introduced a bill on this subject. I am grateful to the clerks to the Justice Committee for their assistance with that and to the legislation team in the Parliament, as well as to Patrick McGuire of Thompsons Solicitors, who was most helpful. I also thank the members of the committee, who were helpful and accommodating and carefully considered the bill that I proposed. As members know, the committee’s decision was that the best vehicle to take forward some of the issues was the Government’s bill, and the committee urged us to co-operate to take forward the issues that were being discussed.

The areas on which we agreed, such as the charter, will make a difference to families. The charter will make it easier for them to understand the process and get information in advance of an FAI and, I hope, during the process. The annual report of the recommendations that are made by sheriffs in considering fatal accident inquiries will also be important. I am glad that the Government eventually agreed that that report should be laid before Parliament because, if we are not going to do post-legislative scrutiny of bills such as this one, it is important that we at least consider the outcomes that are laid before us.

I am extremely disappointed that the Government did not agree to accept my stage 2 amendment about civil legal aid. We have perhaps rehearsed the debate on that enough this afternoon, but it is remarkable that, although—rightly—someone who has perhaps been involved in the death of a person in custody will still get legal aid, bereaved families whose family member has died as a result of an accident at work will not have legal aid guaranteed to them. The Parliament has done those families a disservice today.

Others have referred to this point already, but there is an important question about scrutiny in the Parliament. I will not make a big point of this but, when all the Opposition parties agree that there is a point that is worth pursuing and do so because they have a genuine concern and have aired and discussed the issues, it is sad that the Scottish Government has chosen to use its majority to vote that down. I have no compunction about saying that I know that the relevant amendment was agreed to at stage 2 only because there is no Government majority on the committee. I am grateful to all those members who gave the matter careful consideration, whether or not they voted for the proposal in committee or today.

My interest in FAls was sparked by the death of nine members of the community at the Stockline factory in my constituency and the terrible wait that the families had for a fatal accident inquiry. Elaine Murray mentioned that. I hope that the recommendations that we agree to today and the bill that will emerge as a result of our deliberations will ensure that, in the future, families do not have to have the experience that those nine families had over a prolonged period of four years.

16:31

Alison McInnes (North East Scotland) (LD):
The legislation that governs the fatal accident inquiry system is nearly 40 years old, and it has been six years since Lord Cullen reported on his review into the matter. Therefore, we can all agree that the bill has been a long time in coming. I am pleased that we have finally reached the home straight in reforming and modernising the FAI system.

At the outset, I praise Patricia Ferguson for the work that she undertook, the tenacity that she showed and her professionalism in the work that she did, which, ultimately, led to this Scottish Government bill. The bill as introduced included a number of improvements to the fatal accident inquiry system. It set out the requirement to hold a mandatory FAI for the death of a child in secure accommodation and for deaths under police arrest. It allowed FAls to be reopened if new evidence was found and it required bodies that were affected by a sheriff’s determination to formally respond and set out what actions they had taken. Those were all welcome improvements.

However, as other members have said, not all of Lord Cullen’s recommendations were included. In particular, the decision was taken not to include within the mandatory category the deaths of people who were detained under mental health legislation. That changed at stage 2 but was reverted this afternoon during consideration of stage 3 amendments. As I said earlier, I have concluded on balance that there is a more proportionate and less distressing way to proceed that involves reform of the whole system of notifications and investigations.

Nevertheless, the debate that was generated has been worth while, and I am sure that there is a greater understanding among all involved that a more rigorous and coherent system for investigating the deaths of those who are detained for mental health reasons is required. An additional safeguard has already been put in place.
whereby all deaths of people who are detained under the Mental Health (Care and Treatment) (Scotland) Act 2003 and the Criminal Procedure (Scotland) Act 1995 will end up on the procurator fiscal’s desk for his attention. I also welcome the minister’s assurances this afternoon about the timetable for the review and hope that the review will pay particular attention to deaths by suicide while people were detained.

At stage 2, I pressed the minister on whether it would be appropriate to extend the requirement to hold a mandatory FAI to two further categories: the death of a child who was looked after by the state, even if they lived with their parents or guardians at the time of their death, and—this is a niche area—the death of a patient with dementia who, immediately before their death, received prolonged treatment using psychotropic medication. We know that such medication causes sedation, confusion and movement difficulty and that the overuse of those drugs in such situations has been implicated in an increased risk of stroke. A number of organisations, including the Mental Welfare Commission, have raised concerns about the widespread use of those drugs in care home settings, and the most vulnerable people in our society deserve our attention. I was pleased, in relation to both those categories, to receive assurances from the minister that attention was focused on those areas, and I therefore did not press my amendments.

I welcome the Government’s recognition of the need for a national child death review system to review the deaths of all children and young people and not just those in care. I understand that the steering group’s work to develop a model for that system is on-going, and I look forward to learning of its outcomes. I was also grateful to the minister for acknowledging that the prolonged use of psychotropic medication for dementia patients could be explored in the wider review, and I will continue to pursue the matter.

As I said, Patricia Ferguson was tenacious in her pursuit of improvements. Like her, I am disappointed that the amendment on legal aid that she secured at stage 2 has been removed this afternoon. Nevertheless, she should feel content that she has improved the original bill.

Fatal accident inquiries are held in the public interest, but behind every death is a family and those who knew and loved the deceased person—people who are seeking answers. Ms Ferguson’s amendments will ensure that they will be part of the process and kept informed.

Overall, I support the bill and the changes that it will make to the current system. The Lib Dems will support the bill at decision time.

16:35

Christine Grahame (Midlothian South, Tweeddale and Lauderdale) (SNP): I hear rumbles about the Scottish National Party’s overall majority. For eight years in here, we had a Labour-Liberal coalition majority, with a majority on every single committee. I cannot recall—on any occasion—ever managing to get an amendment through. Let us just park that one for a start, because there is no overall SNP majority on the Justice Committee.

Elaine Murray: Will the member take an intervention?

Christine Grahame: No, I am going to proceed, because I have heard enough. We had eight years of that approach.

I very much welcome the legislation and commend the work of Justice Committee members, which has increased the relevance and potency of the bill. I congratulate Patricia Ferguson, because much that she did in pursuing her own bill persuaded the Government to change its legislation. Indeed, Paul Wheelhouse is a minister who listens and who collaborates, where possible, with other members who do not always agree.

Deaths of service personnel have been mentioned. We had the bizarre situation in which there could be a discretionary FAI for Scottish service personnel who died outwith the UK, but no discretionary FAI if they died in service in Scotland. In fact, there could be an inquiry in England, but nothing in Scotland. To the best of my knowledge, the only FAI that has taken place involving Scottish service personnel was the Mull of Kintyre Chinook helicopter crash, and that was simply because civilians were on the helicopter.

It is wonderful that we are to move away from that approach. I congratulate Westminster—it is not often that members will hear me say that—because it is going to move a section 104 order under the Scotland Act 1998. That relates to schedule 2 of the bill. That will be welcomed not only by families, but by the wider Scottish community. However, will the minister confirm that the change will apply to historical cases of the deaths of Scottish service personnel in Scotland? Will we be able to have FAIs into incidents that have already taken place?

My colleague Christian Allard referred to FAIs into deaths of Scottish residents abroad. Again, it seemed bizarre that a body had to be brought home for a discretionary FAI to be held. Obviously, there are circumstances in which there is no body to retrieve, for example if someone is lost at sea. If it is possible to pursue a discretionary FAI without a body, why not do that? I am glad that the Government has moved on that issue.
I turn to Patricia Ferguson’s bill. As I said, much that she did persuaded the Government to move in its legislation. The family liaison charter is very important. The idea of making the sheriff’s recommendations binding was initially attractive, but once we went into the detail, we began to realise that there would have been huge unintended consequences—and not only in terms of the parties that might have to be called to an FAI, widening its scope enormously.

For example, let us say that a widget was found to be faulty. The FAI could ask who manufactures these widgets and who operates them. It could involve people all over the world. Suddenly, there is a raft of ramifications, with all those people coming into it. That makes the proposal difficult. Now recommendations and the responses to them will be published, but the reality is that many faults that take place will be remedied before the issue even gets to an FAI, because it would be a very foolish employer that did not, as soon as an incident happened, look to his practices.

Time limits were another issue. There would be huge problems in having mandatory time limits for FAIs. For example, there are many questions about whether the bin lorry FAI went ahead too quickly. There can be good reasons why an inquiry might not be done straight away. A health and safety inquiry or an aviation inquiry, for example, may be necessary before an FAI and for the Crown Office and Procurator Fiscal Service to decide whether to go any further with a prosecution.

I support the bill. The original legislation is so old. That does not necessarily mean that all statute is past its sell-by date, but that piece of legislation is.

16:39

John Finnie (Highlands and Islands) (Ind): Article 2 of the European convention on human rights creates a right to life and, with it, the duty on the state to investigate the loss of life. That is a duty that our state has not taken lightly, does not take lightly and will not take lightly in the future.

During the passage of the bill, there were a number of interesting discussions, of which the discussion on mental health was one. Members have been willing to move their positions on various matters throughout the process. I have certainly been persuaded to do so. That shows the nature of the scrutiny that has taken place and the willingness to engage. I am pleased about that.

Like many members, I commend Patricia Ferguson. The family charter—the milestone charter—is significant. It will be a challenge for the Crown Office and Procurator Fiscal Service to service that properly, because dealing with any death is an emotive thing.

The minister talked about the history of the legislation. The bill forms part of an evolving situation. Lord Cullen reported in 2009 and some administrative issues were initially picked up. However, the bulk of his recommendations required primary legislation. That is why we have reached this point, and we know that the Scottish Government did not take up all his recommendations.

I was happy to lend my support to making legal aid available. Of course I am disappointed about what happened on that. Who knows what a future Green majority Administration will do when it comes to wielding power? It is a case of arithmetic.

Christine Grahame: There will not be any aeroplanes.

John Finnie: Christine Grahame is right that there will not be any aeroplanes.

Members’ experiences are all different. I have experience of an FAI into a death in custody. It was a harrowing experience for everyone who was involved. I was there to ensure that the federated ranks were represented, and they were indeed represented by a lawyer. The finding was that there had been no disregard for the welfare of the individual who sadly lost his life—quite the reverse—but it was a searching experience for everyone. An FAI is certainly not a forum for laypeople—that is the most important thing for me to say—so Elaine Murray’s stage 2 amendment on trade union and staff association representation, which has now been refined, is welcome.

Another matter that may sound dry but which is important is case management. The less trauma that can be associated with the process, the better.

The provisions on allowing FAIs to be reopened and reconvened are important. I have already dealt with an inquiry from a constituent about an historical case. It is clear that the provisions in the bill will not apply to that case, and we need to send a message that the bill will not cover FAIs that are covered by the 1976 act.

Any death is traumatic, but a death where there are no remains is additionally traumatic. Many of the issues that relate to the absence of a body have been sensitively dealt with, which will be reassuring to people.

I imagine that families are completely unconcerned whether an inquiry is mandatory or discretionary, because they just want answers. The family charter will play an important role in that regard. Likewise, the provisions on deaths
abroad, including those of service personnel, are to be welcomed.

There was a lot of discussion about FAI findings, on which Christine Grahame touched. Our initial thoughts on what can or cannot be achieved are often shaped by what we hear. There are challenges in that regard, but the important point is that the initial purpose of an FAI is to understand the cause of the death and to put in place mechanisms to avoid a repetition.

Public interest is also important, as is public reassurance. The bill will play its part in providing some public reassurance, and I will certainly support it at decision time.

16:43

Annabel Goldie (West Scotland) (Con): I welcome the stage 3 debate on the Inquiries into Fatal Accidents and Sudden Deaths etc (Scotland) Bill and I share in the tributes that have already been paid to the Justice Committee, Patricia Ferguson and the many witnesses and stakeholders who helped to inform the legislative process.

As the bill concludes its parliamentary passage, it is worth reflecting on its purpose, which is to implement the 36 recommendations of the Cullen review that require primary legislation some six years after they were published. The review was timely because the relevant legislation was elderly and had not necessarily kept pace with other developments in the justice system, not least the incorporation of the European convention on human rights into UK law.

The test is whether the bill achieves the policy objective of reforming and modernising the law that governs the holding of fatal accident inquiries in Scotland. My party’s assessment is that it does that, and we shall support it at decision time. There are some very positive and noteworthy provisions in the bill, not least the requirement that sheriffs’ determinations should be published and that anyone who was party to the inquiry and to whom a recommendation is addressed should have to respond accordingly. Just as the Justice Committee did at stage 1, I urge the Scottish Government to find ways of ensuring that sheriffs’ recommendations are respected.

At stage 2, Patricia Ferguson lodged a welcome amendment to the bill to place a statutory obligation on the Lord Advocate to produce a family liaison charter. The issues surrounding the Crown Office and Procurator Fiscal Service’s often intermittent communication with bereaved families are well documented. Although numerous reasons can undoubtedly be adduced for such spasmodic contact, it exacerbates what is already an extremely difficult and sensitive time for relatives, so the cross-party support for that amendment was very welcome, and I join other members in acknowledging Patricia Ferguson’s considerable work to reform FAls.

I was troubled by the removal from the bill of Patricia Ferguson’s provision to ensure that families receive legal aid. I think that FAls are an entirely different beast from civil litigation hearings, and I am not sure that that distinction was appreciated.

I want to comment briefly on what the Justice Committee said in its stage 1 report on the lack of clarity surrounding the purpose of an FAI that is held in the public interest. There is a real misunderstanding in this area, which serves to raise the expectations of families. There needs to be greater transparency, and there is an obligation on the parties involved to provide that. How does the fatal accident inquiry relate to other investigations involving fatalities and to the role of the family or families affected? Greater transparency would help to demystify a complex system, while at the same managing the expectations of what the inquiry will ultimately achieve.

Despite the fact that they received support from all but the SNP members of the Justice Committee, Margaret Mitchell’s stage 2 amendments were removed in toto from the bill today. I noted the minister’s comments that the provisions did not attract wide support from stakeholders, although perhaps that is because the policy intent was not fully understood.

It is worth noting that Lord Cullen acknowledged that FAls should be held into the deaths of those who are detained by the state, especially those who are most vulnerable, and that such FAls are in the public interest. My colleague Margaret Mitchell sought only to put that recommendation on a statutory footing. It is unfortunate that that has been overturned, and it has implications for our unicameral parliamentary system, for the robustness of scrutiny and for the legitimate power and authority of a scrutinising committee by majority to change a bill. Airbrushing out such change at stage 3 is unimpressive.

That said, the bill is a good one that will receive the support of my party, and it will have a positive impact on the system of FAls in Scotland.

16:48

Graeme Pearson (South Scotland) (Lab): The absence of rancour in the debate and the support that exists across the chamber for the bill reflect well on the work that has been done by the members of the Justice Committee, my colleague Patricia Ferguson and those who gave evidence to the committee at stages 1 and 2.
We do well to remember that some 5,000 deaths a year are reviewed by the authorities and that somewhere short of 60 of them are subject to fatal accident inquiries. We should remember that the FAI is designed, quite properly, to determine the circumstances of a death, not to apportion blame. However, as John Finnie indicated, an FAI can be extremely difficult and upsetting for family members, close friends and those who were involved in the circumstances surrounding a death. They hear details—often for the first time—that have implications for how they might respond to the evidence.

In examining the circumstances of a death, it is right that a sheriff should act in a thorough and proper manner to examine all the circumstances of the death, and that can sometimes be extremely harrowing.

In those circumstances, it is good to know that general agreement has been achieved on some important elements. The evidence of the British Medical Association, the Scottish Association for Mental Health, the Mental Welfare Commission for Scotland and others has helped to point the Parliament in a direction that will ensure that a fatal accident inquiry will not be held in all circumstances in which someone who faced mental health conditions died.

The opportunity for the Crown to intervene in the appropriate circumstances to decide on a fatal accident inquiry is appropriate and commensurate with the circumstances that we face annually. I have confidence that is based on experience that the Procurator Fiscal Service has the ability to make the appropriate decisions in most circumstances.

Elaine Murray’s amendments provided value to the discussion in enabling the ventilating of all the issues. I am happy that, at the end of the process, we have come to a decision that I certainly feel comfortable with.

The Government’s agreement to include representation from trade unions and staff associations in relation to relevant deaths while people were engaged in employment is a very helpful way forward in advising how we should deal with them.

The other important element has been establishing grounds for the investigation of deaths of citizens that occurred abroad. That subject has caused a great deal of upset for many families in Scotland to date. Seeing some form of solution is important and should give comfort to many relatives.

I am disappointed that amendment 1, in the name of Patricia Ferguson, which was an attempt to provide some kind of equality of representation, was rejected. The issue has been fully ventilated, and I do not intend to go into the circumstances again, but I have certainly been present when procurators fiscal have made it clear to families that they were there to represent the public interest, not the families’ concerns. Families have found that very difficult to understand. I implore the minister to ensure that the family liaison charter is seen as very valuable guidance for the fiscal service in future so that its culture can take on board the changes in the responsibilities that we expect of it in dealing with fatal accident inquiries.

The minister’s reference to the duties of coroners in England and Wales did not assist the debate. That was largely irrelevant, as the system in Scotland has always been different and families have always had a more positive experience here. We should invest in those circumstances rather than rely on the comfort that it is worse elsewhere. I am not particularly interested in how the matter is dealt with in other jurisdictions, unless that advises us of ways to improve ours.

To return to Patricia Ferguson’s amendments, I hope that the Government will bear that in mind. If experience tells us that we have gone in the wrong direction, and if we find that relatives who meet the new circumstances are challenged, as I suspect they will be, we must make an early change to make legal aid the norm.

The presence of lawyers at fatal accident inquiries does not necessarily mean the introduction of new conflicts. If the nature of fatal accident inquiries and the purpose of holding them are made clear to lawyers—if it is made clear that they are there to determine the facts and not to engage in legal exchanges—I am sure that we can find a more productive way of going forward.

In conclusion, I make it clear that we support the principles behind the bill and will vote in support of it. I am grateful to the minister for his approach in dealing with many of the questions and exchanges that have occurred during stages 1 to 3.

The Presiding Officer (Tricia Marwick): I call Paul Wheelhouse to wind up the debate. I can give you eight minutes, Mr Wheelhouse.

16:54

Paul Wheelhouse: I record my thanks to members for their contributions to the debate.

Before I go through the detail, it is important to address the point that Graeme Pearson raised about procurators fiscal being able to point people towards legal aid. I will consider that and see what we can do with the Crown Office and Procurator Fiscal Service and the Scottish Legal Aid Board to ensure that people are aware of the options that are available to them if they feel that the procurator fiscal will not take forward a certain line
of questioning. I have tried to reassure members that we are aware of the issue, but I will take forward that point and see whether there is something that we can put in the family liaison charter to make that more explicit.

The bill provides the legislative framework that is needed to implement Lord Cullen's recommendations. Of course, the detail of the procedure will be provided in comprehensive bespoke rules that will be written purely for fatal accident inquiries, whereas, until now, such inquiries have had to rely on the ordinary cause rules in the sheriff court.

Dr Murray raised a point about the delay in introducing the bill, although I should stress that it is a perceived delay. Inevitably, the bill had to wait in a queue of civil reforms, including the Courts Reform (Scotland) Act 2014. It was not delayed until such time as Patricia Ferguson's member's bill was introduced—that was perhaps a happy coincidence, if I can put it that way. We were certainly glad to work closely with Patricia Ferguson. I appreciate the hard work that she put into her bill and the constructive approach that she took after withdrawing her bill in working with the Government on amendments.

The bill builds on the recommendations that Lord Cullen directed to the Crown Office and which have already been implemented by the establishment of the Scottish fatalities investigation unit, which now oversees death investigations in Scotland. The Crown Office has also made a major contribution to the reforms by bringing forward its family liaison charter, which as a result of an amendment by Patricia Ferguson will be put on a statutory footing. The charter, which the Solicitor General for Scotland announced when she gave evidence to the Justice Committee at stage 1, will provide clarity on the information that the bereaved family will be provided with at the different stages of a death investigation. That is why it is possible to foresee information about legal aid being slotted into it. The charter will also give clarity on how and when that information will be communicated to the bereaved family by the Crown Office. It will give choice to bereaved families on how they want to communicate with the Crown, which is important.

I thank the Crown Office for expediting its work on the charter, which included a public consultation on a draft charter over the summer, so that it was available in time for stage 2. As I said, as a consequence of an amendment, the charter will be on a statutory footing. It is entirely appropriate that the Crown Office should take the lead on such matters, given the position of the Lord Advocate as the independent head of the system of death investigation in Scotland. It is worth remembering that section 48(5) of the Scotland Act 1998 makes it clear that

"Any decision of the Lord Advocate in his capacity as head of the systems of criminal prosecution and investigation of deaths in Scotland shall continue to be taken by him independently of any other person."

It is important to note how fatal accident inquiries fit into other investigations of death in Scotland. As has been said, procurators fiscal have a common-law duty to investigate all sudden, suspicious, accidental and unexplained deaths to establish the circumstances and cause of death. Around 11,000 deaths are reported to the Crown Office and Procurator Fiscal Service each year and it investigates about half of those. Some cases are also investigated by other agencies, including the Health and Safety Executive, which Christine Grahame referred to, the air, marine and rail accident investigation branches, the Care Inspectorate and of course the Mental Welfare Commission for Scotland. That sometimes causes a delay in the commencement of a fatal accident inquiry, but those are all important investigations. The Crown Office engages with those agencies and may instruct the police to investigate the circumstances and consider whether criminal charges should be brought, which may lead to a prosecution.

Consideration of criminal proceedings takes primacy, but investigations by the Crown are often held up and delayed by investigations by, for example, the air accidents investigation branch. Members will be aware that there was a considerable delay before the AAIB produced its report into the Clutha tragedy in Glasgow. Those delays are a matter of regret, as they lengthen the period of time before a fatal accident inquiry can take place.

I turn to some of the points that were raised in the debate. Christine Grahame, Christian Allard, Graeme Pearson and John Finnie referred to the issue of deaths abroad. The Justice Committee queried the requirement for the body to be repatriated before an inquiry could be held into the death of a Scot abroad, and I agreed that there may be occasions when a body has been lost or is otherwise not available for examination at a post mortem.

I pay particular tribute to Mr and Mrs Beveridge, who gave evidence to the Justice Committee at stage 1. It was a very brave thing to do. The death of their son Blair Jordan in harrowing circumstances was extremely distressing for them to deal with and I am very grateful to them, as I am sure are members of the Justice Committee, for sharing their personal experience. I hope that Mr and Mrs Beveridge will take some satisfaction from what has happened today, although it will not benefit their family—that would have required
retrospective legislation—because it means that if
someone dies in a situation similar to the one in
which Blair died, the Lord Advocate will have
discretion to hold a fatal accident inquiry.

Circumstances in which a body has been lost at
sea will also be covered. It is right that in such
exceptional circumstances the possibility of a
death investigation and the potential for an FAI
into a death abroad should not be lost. For that
reason, we proposed the amendment at stage 2
that removed the requirement for a body to be
repatriated before a fatal accident inquiry can be
held. We hope that that will help relatives.

The Government recognises the need for
bereaved families to be kept informed of progress
with death investigations, and we think that the
Crown Office’s charter will provide reassurance
and enhance public confidence in the system. The
charter will provide information about the system
and timescales to families, and it will be written in
a way that is understandable and accessible to
everyone. I hope that that goes some way towards
addressing the concern about timescales that
Patricia Ferguson expressed in her bill proposal, in
that the charter will ensure that families are at
least aware of what to expect, with no nasty
surprises in relation to delays that are
encountered, and are kept informed throughout
the process of the likelihood of a criminal
prosecution.

Christine Grahame: I know that the minister is
about to run out of time, but before he does, will
he answer my question about the death of service
personnel in Scotland, for whom mandatory FAIs
were not available?

The minister is indicating that he is coming on to
that, which is excellent. I will sit down.

Paul Wheelhouse: On whether the legislation
in relation to military FAIs will be retrospective, the
answer is no. A discretionary FAI will have been
considered at the time of the incident. However, I
hope that the armed forces community and
families will take comfort from the fact that in the
event of the death of service personnel in Scotland
in future, a fatal accident inquiry will be mandatory.

Alison McInnes referred to the child death
review system. The Scottish Government child
death review working group has submitted its
report to the Scottish ministers, which is currently
being considered by the Scottish Government. I
hope that it will not be long before the outcome is
made available.

The bill will ensure that FAIs remain fact-finding,
inquisitorial judicial hearings, which are held in the
public interest to establish the circumstances of
sudden, suspicious or unexplained deaths, and
deaths the circumstances of which cause public
concern. FAIs are not meant to hold people to
account, as the media occasionally mistakenly
suggest, nor are they held specifically to provide
answers for bereaved families, although they will
normally do so. Questions of blame or guilt are for
civil or criminal proceedings. FAIs are held in the
public interest to establish the cause of death and
to permit the sheriff to make recommendations as
to how deaths in similar circumstances might be
avoided in future.

The bill will also ensure that the system is in
keeping with other justice reforms, including the
use of specialist and summary sheriffs, preliminary
hearings and early agreement of uncontroversial
facts, along with greater scope for location and
accommodation of FAIs. When taken together with
the section 104 order and the new FAI rules that
the Scottish Civil Justice Council will bring forward
next year, the bill represents significant
modernisation and reform of the law on fatal
accident inquiries. I commend the bill to the
Parliament.
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Inquiries into Fatal Accidents and Sudden Deaths etc. (Scotland) Bill

[AS PASSED]

An Act of the Scottish Parliament to make provision for the holding of public inquiries in respect of certain deaths.

Inquiries into certain deaths

1 Inquiries under this Act

5 (1) Where an inquiry is to be held into the death of a person in accordance with sections 2 to 7, the procurator fiscal must—
   (a) investigate the circumstances of the death, and
   (b) arrange for the inquiry to be held.

(2) An inquiry is to be conducted by a sheriff.

10 (3) The purpose of an inquiry is to—
   (a) establish the circumstances of the death, and
   (b) consider what steps (if any) might be taken to prevent other deaths in similar circumstances.

(4) But it is not the purpose of an inquiry to establish civil or criminal liability.

15 (5) In this Act, unless the context requires otherwise—
   (a) “inquiry” means an inquiry held, or to be held, under this Act,
   (b) references to a “sheriff” in relation to an inquiry are to a sheriff of the sheriffdom in which the inquiry is, or is to be, held.

Inquiries into deaths occurring in Scotland

2 Mandatory inquiries

20 (1) An inquiry is to be held into the death of a person which—
   (a) occurred in Scotland, and
   (b) is within subsection (3) or (4).

(2) Subsection (1) is subject to section 3.
The death of a person is within this subsection if the death was the result of an accident which occurred—
(a) in Scotland, and
(b) while the person was acting in the course of the person’s employment or occupation.

The death of a person is within this subsection if, at the time of death, the person was—
(a) in legal custody, or
(b) a child required to be kept or detained in secure accommodation.

For the purposes of subsection (4)(a), a person is in legal custody if the person is—
(a) required to be imprisoned or detained in a penal institution,
(b) in police custody, within the meaning of section 56 of the Criminal Justice (Scotland) Act 2015,
(c) otherwise held in custody on court premises,
(d) required to be detained in service custody premises.

For the purposes of subsections (4)(b) and (5)(a) and (d), it does not matter whether the death occurred in secure accommodation, a penal institution or, as the case may be, service custody premises.

In this section—
“penal institution” means any—
(a) prison (including a legalised police cell within the meaning of section 14(1) of the Prisons (Scotland) Act 1989), other than a naval, military or air force prison,
(b) remand centre, within the meaning of section 19(1)(a) of that Act,
(c) young offenders institution, within the meaning of section 19(1)(b) of that Act,
“secure accommodation” means accommodation provided in a residential establishment, approved in accordance with regulations made under section 78(2) of the Public Services Reform (Scotland) Act 2010, for the purpose of restricting the liberty of children,
“service custody premises” has the meaning given by section 300(7) of the Armed Forces Act 2006.

Mandatory inquiries: exceptions
(1) The Lord Advocate may decide that an inquiry is not to be held into the death of a person within section 2(3) or (4) if satisfied that the circumstances of the death have been sufficiently established during the course of proceedings of a kind mentioned in subsection (2).
(2) The proceedings referred to in subsection (1) are—
(a) criminal proceedings,
(b) an inquiry under section 17(2) of the Gas Act 1965 (accidents),
(c) an inquiry under section 14(2A) of the Health and Safety at Work etc. Act 1974 (power of the Health and Safety Executive to direct investigations and inquiries),
(d) an inquiry under section 1 of the Inquiries Act 2005 (power to establish inquiry),
(e) an inquiry under section 85(1) of the Energy Act 2013 (inquiries).

(3) But subsection (1) does not apply if—

(a) at the time of death, the person was required to be detained in service custody premises, and
(b) the proceedings referred to in that subsection are an inquiry under section 1 of the Inquiries Act 2005.

4 Discretionary inquiries

(1) An inquiry is to be held into the death of a person which occurred in Scotland if the Lord Advocate—

(a) considers that the death—

(i) was sudden, suspicious or unexplained, or
(ii) occurred in circumstances giving rise to serious public concern, and

(b) decides that it is in the public interest for an inquiry to be held into the circumstances of the death.

(2) Subsection (1) does not apply to a death within section 2(3) or (4).

5 Certain deaths and accidents to be treated as occurring in Scotland

(1) For the purposes of sections 2 and 4, the death of a person, or an accident, is to be treated as having occurred in Scotland if it occurred—

(a) in connection with an activity falling within section 11(2) of the Petroleum Act 1998 (application of civil law to offshore activities), and
(b) in a relevant area.

(2) In subsection (1)(b), “relevant area” means an area in respect of which it is provided by Order in Council under section 11(1) of the Petroleum Act 1998 that questions arising out of acts or omissions taking place in the area are to be determined in accordance with the law in force in Scotland.

6 Inquiries into deaths occurring abroad

(1) Subsection (3) applies to the death of a person if—

(a) the death occurred outwith the United Kingdom, and
(b) at the time of death, the person was ordinarily resident in Scotland.

(2) But that subsection does not apply to the death of a person within section 12(2) or (3) of the Coroners and Justice Act 2009 (investigation in Scotland of deaths of service personnel abroad).

(3) An inquiry is to be held into a death to which this subsection applies if the Lord Advocate—
(a) considers that the death—
   (i) was sudden, suspicious or unexplained, or
   (ii) occurred in circumstances giving rise to serious public concern,
(b) considers that the circumstances of the death have not been sufficiently established in the course of an investigation in relation to the death,
(c) considers that there is a real prospect that those circumstances would be sufficiently established in an inquiry, and
(d) decides that it is in the public interest for an inquiry to be held into the circumstances of the death.

7 Inquiries into deaths occurring abroad: service personnel

(1) An inquiry is to be held into the death of a person if—
   (a) the Lord Advocate is notified in relation to the death under section 12(4) or (5) of the Coroners and Justice Act 2009 (investigation in Scotland of deaths of service personnel abroad),
   (b) the death is within subsection (2) or (3), and
   (c) the Lord Advocate—
      (i) decides that it is in the public interest for an inquiry to be held into the circumstances of the death, and
      (ii) does not reverse that decision.
(2) The death of a person is within this subsection if the person was, at the time of death, in custody in circumstances analogous to legal custody (as construed by reference to section 2(5)).
(3) The death of a person is within this subsection if the Lord Advocate considers that the death—
   (a) was sudden, suspicious or unexplained, or
   (b) occurred in circumstances giving rise to serious public concern.
(4) But this section does not apply to a death within subsection (2) if the Lord Advocate is satisfied that the circumstances of the death have been sufficiently established in the course of any criminal proceedings against any person in respect of the death.

Family liaison charter

7A Family liaison charter

(1) The Lord Advocate must prepare a family liaison charter.
(2) A family liaison charter is a document setting out how the procurator fiscal will liaise with the family of a person in relation to whose death an inquiry may or is to be held.
(3) In particular, the charter must set out—
   (a) information to be made available to the family, and
   (b) timescales for the giving of the information.
(4) The Lord Advocate may from time to time revise the charter prepared under subsection (1).
(5) The Lord Advocate must—

(a) consult such persons as the Lord Advocate considers appropriate before preparing the charter under subsection (1) or revising it under subsection (4),

(b) lay the charter or revised charter before the Scottish Parliament, and

(c) publish the charter or revised charter in such manner as the Lord Advocate considers appropriate.

Reasons where inquiry not held

8 Reasons for decision not to hold an inquiry

Where it is decided that an inquiry is not to be held into the death of a person (“A”), the Lord Advocate must give reasons in writing if requested to do so by—

(a) A’s spouse or civil partner at the time of A’s death,

(b) a person living with A as if married to A at the time of A’s death, or

(c) A’s nearest known relative if, at the time of A’s death, A—

(i) did not have a spouse or civil partner, and

(ii) was not living with a person as if married to the person.

Procurator fiscal’s investigation

9 Citation of witnesses for precognition

(1) The procurator fiscal may cite a person to attend for precognition in connection with an investigation under section 1(1)(a).

(2) This section is sufficient warrant for such citation.

(3) Subsection (4) applies where a person cited under subsection (1)—

(a) having been given reasonable notice in the citation, and without reasonable excuse, fails to attend for precognition at the time and place mentioned in the citation, or

(b) does so attend but refuses to give information which is—

(i) within the person’s knowledge, and

(ii) relevant to the investigation.

(4) The sheriff may, on the application of the procurator fiscal, make an order requiring the person to attend for precognition or, as the case may be, give the information at a time and place specified in the order.

(5) A person who fails to comply with an order under subsection (4) commits an offence.

(6) A person who commits an offence under subsection (5) is liable on summary conviction to imprisonment for a term not exceeding 21 days or a fine not exceeding level 3 on the standard scale (or both).
Participants

(1) The following persons may participate in inquiry proceedings in relation to the death of a person (“A”)—

(a) A’s spouse or civil partner at the time of A’s death,

(b) a person living with A as if married to A at the time of A’s death,

(c) A’s nearest known relative if, at the time of A’s death, A—

(i) did not have a spouse or civil partner, and

(ii) was not living with a person as if married to the person,

(d) where the death is within section 2(3)—

(i) A’s employer, if A was acting in the course of the person’s employment,

(ii) an inspector appointed under section 19 of the Health and Safety at Work etc. Act 1974 (appointment of inspectors),

(iii) a trade union, or similar body, representing the interests of workers in connection with the employment or occupation concerned, if A was at the time of A’s death a member of the trade union or body,

(e) any other person who the sheriff is satisfied has an interest in the inquiry.

(2) In this Act—

(a) “inquiry proceedings” means any proceedings under this Act in relation to an inquiry,

(b) references to a participant in an inquiry are references to a person who participates in the inquiry proceedings by virtue of subsection (1).

Location

(1) The Scottish Ministers may by regulations designate places at which a sheriff court may be held for the purposes of this Act (in addition to the places designated by virtue of the Courts Reform (Scotland) Act 2014 for the holding of sheriff courts).

(2) The Scottish Ministers may make regulations under subsection (1) only following the submission of a proposal under subsection (3).

(3) The Scottish Courts and Tribunals Service (“the SCTS”) may, with the agreement of the Lord President of the Court of Session, submit a proposal to the Scottish Ministers for the making of regulations under subsection (1).

(4) Before submitting a proposal to the Scottish Ministers, the SCTS must consult such persons as it considers appropriate.

(5) If, following the submission of a proposal, the Scottish Ministers decide to make regulations, they must have regard to the proposal in deciding what provision to make in the regulations.

(6) The Scottish Ministers may make regulations under subsection (1) only with the consent of—

(a) the Lord President, and
(b) the SCTS.

(7) Regulations under subsection (1)—

(a) may make transitional, transitory or saving provision,

(b) are subject to the affirmative procedure.

12 Jurisdiction in relation to inquiries

(1) Inquiry proceedings may be held in a sheriffdom whether or not there is a connection between the death, or any accident resulting in the death, to which the inquiry relates and the sheriffdom, and a sheriff of the sheriffdom accordingly has jurisdiction in relation to the proceedings.

(2) The Lord Advocate is, after consulting the Scottish Courts and Tribunals Service, to choose the sheriffdom in which proceedings are to be held.

(3) But the sheriff may make an order transferring the proceedings to a sheriff of another sheriffdom.

(4) The sheriff may make an order under subsection (3) only—

(a) after giving the procurator fiscal and the participants in the inquiry an opportunity to make representations about the proposed transfer, and

(b) with the consent of—

(i) the sheriff principal of the sheriffdom of which the sheriff is a sheriff, and

(ii) the sheriff principal of the sheriffdom to which the sheriff proposes to transfer the proceedings.

(5) The sheriff may make such an order—

(a) on the sheriff’s own initiative, or

(b) on the application of the procurator fiscal or a participant in the inquiry.

Inquiries into multiple deaths

13 Inquiry into more than one death

(1) A single inquiry may be held into the deaths of more than one person if it appears to the Lord Advocate that the deaths occurred—

(a) as a result of the same accident, or

(b) otherwise in the same or similar circumstances.

(2) Where an inquiry is held in relation to the deaths of more than one person, references in this Act to the death to which, or person to whom, the inquiry relates are references to each death to which, or person to whom, the inquiry relates.

Pre-inquiry procedure

14 Initiating the inquiry

(1) Where an inquiry is to be held into the death of a person, the procurator fiscal must give the sheriff notice that the inquiry is to be held.

(1A) A notice under subsection (1) must include—
(b) a brief account of the circumstances of the death so far as known to the procurator fiscal, and

(c) any other information required by an act of sederunt under section 34(1).

(2) On receiving notice under subsection (1), the sheriff must make an order—

(a) fixing—

(i) a date and place for the holding of a preliminary hearing in accordance with section 15 (if one is to be held), and

(ii) a date for the start of the inquiry and the place at which it is to be held, and

(b) granting warrant for the procurator fiscal and the participants in the inquiry to cite persons to attend and give evidence at the inquiry.

(3) But the sheriff need not fix a date for the start of the inquiry (and the place at which it is to be held) in the order if—

(a) a preliminary hearing is to be held, and

(b) the sheriff considers that it is not appropriate to fix the date before that hearing.

(4) The sheriff may make an order varying a date or place fixed in an order under subsection (2).

(5) The sheriff must, when fixing a date for the start of the inquiry, have regard to the desirability of holding the inquiry as soon as is reasonably practicable.

Preliminary hearings

(1) At least one preliminary hearing is to be held before the start of an inquiry unless the sheriff dispenses with that requirement in accordance with provision made in an act of sederunt under section 34(1).

(2) Subsection (3) applies where the sheriff dispenses with the requirement to hold a preliminary hearing.

(3) The sheriff may subsequently make an order—

(a) for the holding of such a hearing, and

(b) fixing the date and place for it to be held.

(4) Provision is to be made in an act of sederunt under section 34(1) about—

(a) matters to be dealt with at a preliminary hearing under this Act,

(b) things that the procurator fiscal and the participants in the inquiry must do before such a hearing.

Notice of the inquiry

(1) After the sheriff makes an order under section 14(2) in relation to an inquiry, the procurator fiscal must give notice to the persons mentioned in subsection (2) of the following matters—

(a) the fact that the inquiry is to be held, and

(b) if fixed in the order—

(i) the date and place for the holding of the preliminary hearing,
(ii) the date for the start of the inquiry and the place at which it is to be held.

(2) The persons referred to in subsection (1) are—

(a) a person appearing to the procurator fiscal to be entitled to participate in the inquiry under section 10(1)(a) to (d), and

(b) any other person specified, or in a category of persons specified, in an act of sederunt under section 34(1).

(3) The procurator fiscal must also give public notice of the matters specified in subsection (1)(a) and (b).

(4) Subsection (5) applies where the sheriff makes an order under section 14(4).

(5) The procurator fiscal must—

(a) give notice to the persons mentioned in subsection (2) of the new date or, as the case may be, place fixed in the order, and

(b) give public notice of that fact.

(6) Subsection (7) applies where the sheriff makes an order under section 15(3).

(7) The procurator fiscal must—

(a) give notice to the persons mentioned in subsection (2) of the following matters—

(i) the fact that a preliminary hearing is to be held, and

(ii) the date and place fixed for the holding of the hearing, and

(b) give public notice of those matters.

17 Agreement of facts before an inquiry

(1) Provision is to be made in an act of sederunt under section 34(1) about the agreement, by the procurator fiscal and the participants in an inquiry, of any facts of a kind mentioned in subsection (2) before the start of the inquiry.

(2) The facts referred to in subsection (1) are facts—

(a) in relation to which the procurator fiscal or a participant intends to bring forward evidence at the inquiry, and

(b) which the procurator fiscal or, as the case may be, participant considers are unlikely to be disputed at the inquiry.

The inquiry

18 The powers of the sheriff

(1) The sheriff has all such powers in relation to inquiry proceedings as a sheriff, under the law of Scotland, inherently possesses for the purposes of the discharge of the sheriff’s jurisdiction and competence and giving full effect to the sheriff’s decisions in civil proceedings.

(2) Subsection (1) is subject to—

(a) the other provisions of this Act,

(b) provision made in an act of sederunt under section 34(1).
19  **Evidence and witnesses**

(1) At an inquiry—
   
   (a) the procurator fiscal must bring forward evidence relating to the circumstances of the death to which the inquiry relates,

   (b) a participant in the inquiry may bring forward such evidence.

(2) Without limiting subsection (1), the sheriff may require the procurator fiscal or a participant in the inquiry to bring forward evidence about any matter relating to the circumstances of the death.

(3) The rules of evidence which apply in relation to civil proceedings in the sheriff court (other than a simple procedure case) apply in relation to an inquiry.

(4) Subsection (3) is subject to provision made in an act of sederunt under section 34(1).

(5) The examination of a person at an inquiry does not prevent criminal proceedings being taken against the person.

(6) A person is not required at an inquiry to answer a question tending to show that the person is guilty of an offence.

(7) In subsection (3), “simple procedure case” has the same meaning as in section 72(9) of the Courts Reform (Scotland) Act 2014.

20  **Inquiry to be conducted in public**

(1) Inquiry proceedings are to be conducted in public.

(2) But the sheriff may order that such proceedings (or any part of them) are to be conducted in private.

(3) The sheriff may make an order under subsection (2)—
   
   (a) on the sheriff’s own initiative, or

   (b) on the application of the procurator fiscal or a participant in the inquiry.

21  **Publishing restrictions in relation to children**

(1) Subsection (2) applies where a child is involved in an inquiry.

(2) The sheriff may order that no person may publish any material by which the child may be identified in connection with the inquiry.

(3) Such material includes (but is not limited to)—
   
   (a) the child’s name or address,

   (b) the name of a school attended by the child,

   (c) a picture of the child.

(4) The sheriff may make an order under subsection (2)—
   
   (a) on the sheriff’s own initiative, or

   (b) on the application of the procurator fiscal or a participant in the inquiry.

(5) A person who fails to comply with an order under subsection (2) commits an offence.

(6) A person who commits an offence under subsection (5) is liable on summary conviction to a fine not exceeding level 4 on the standard scale.
(7) It is a defence for a person charged with an offence under subsection (5) to show that the person did not know or have reason to believe that the publication of the material would identify the child in connection with the inquiry.

(8) In this section—

“material” means anything that is capable of being read, looked at, watched or listened to, either directly or after conversion from data stored in another form, “publish” includes in particular—

(a) to publish in a programme service, as defined by section 201 of the Broadcasting Act 1990,

(b) to cause to be published.

22 Offences by bodies corporate etc.

(1) Subsection (2) applies where—

(a) an offence under section 21(5) has been committed by—

(i) a body corporate,

(ii) a Scottish partnership, or

(iii) an unincorporated association other than a Scottish partnership, and

(b) it is proved that the offence was committed with the consent or connivance of, or attributable to neglect on the part of—

(i) a relevant individual, or

(ii) an individual purporting to act in the capacity of a relevant individual.

(2) The individual (as well as the body corporate, partnership or, as the case may be, association) commits the offence and is liable to be proceeded against and punished accordingly.

(3) In subsection (1)(b), “relevant individual” means—

(a) in relation to a body corporate (other than a limited liability partnership)—

(i) a director, manager, secretary or similar officer of the body,

(ii) where the affairs of the body are managed by its members, a member,

(b) in relation to a limited liability partnership, a member,

(c) in relation to a Scottish partnership, a partner,

(d) in relation to an unincorporated association other than a Scottish partnership, an individual who is concerned in the management or control of the association.

23 Assessors

(1) The sheriff may appoint a person (an “assessor”) to assist the sheriff in an inquiry.

(2) The sheriff may appoint a person as an assessor if the sheriff considers that the person has knowledge and expertise in matters that are relevant to the inquiry.

(3) The sheriff may make an appointment under subsection (1)—

(a) on the sheriff’s own initiative, or

(b) on the application of the procurator fiscal or a participant in the inquiry.
24 Expenses

The sheriff may not make any award of expenses in relation to inquiry proceedings.

Findings and recommendations

25 The sheriff’s determination

(1) As soon as possible after the conclusion of the evidence and submissions in an inquiry, the sheriff must make a determination setting out—

(a) in relation to the death to which the inquiry relates, the sheriff’s findings as to the circumstances mentioned in subsection (2), and

(b) such recommendations (if any) as to any of the matters mentioned in subsection (4) as the sheriff considers appropriate.

(2) The circumstances referred to in subsection (1)(a) are—

(a) when and where the death occurred,

(b) when and where any accident resulting in the death occurred,

(c) the cause or causes of the death,

(d) the cause or causes of any accident resulting in the death,

(e) any precautions which—

(i) could reasonably have been taken, and

(ii) had they been taken, might realistically have resulted in the death, or any accident resulting in the death, being avoided,

(f) any defects in any system of working which contributed to the death or any accident resulting in the death,

(g) any other facts which are relevant to the circumstances of the death.

(3) For the purposes of subsection (2)(e) and (f), it does not matter whether it was foreseeable before the death or accident that the death or accident might occur—

(a) if the precautions were not taken, or

(b) as the case may be, as a result of the defects.

(4) The matters referred to in subsection (1)(b) are—

(a) the taking of reasonable precautions,

(b) the making of improvements to any system of working,

(c) the introduction of a system of working,

(d) the taking of any other steps,

which might realistically prevent other deaths in similar circumstances.

(5) A recommendation under subsection (1)(b) may (but need not) be addressed to—

(a) a participant in the inquiry,

(b) a body or office-holder appearing to the sheriff to have an interest in the prevention of deaths in similar circumstances.

(6) A determination is not admissible in evidence, and may not be founded on, in any judicial proceedings of any nature.
26 **Dissemination of the sheriff’s determination**

(1) The Scottish Courts and Tribunals Service (“the SCTS”) must—

(a) publish, in such manner as it considers appropriate, each determination made under section 25(1),

(b) give a copy of each such determination to—

(i) the Lord Advocate,

(ii) each participant in the inquiry,

(iii) each person to whom a recommendation made in the determination is addressed, and

(iv) any other person who the sheriff considers has an interest in a recommendation made in the determination.

(2) The SCTS must, on request, give an office-holder in the Scottish administration, a Minister of the Crown, a department of the Government of the United Kingdom or the Health and Safety Executive a copy of—

(a) a determination made under section 25(1),

(b) the notice given under section 14(1) in relation to the inquiry to which the determination relates,

(c) any transcript of the evidence at the inquiry,

(d) any report or documentary production used in the inquiry.

(3) The SCTS must, on payment of the specified fee, give any other person a copy of any transcript of the evidence at an inquiry, if the person—

(a) makes a request for it within the specified period, and

(b) has an interest in the inquiry.


(5) The sheriff may decide that part of a determination—

(a) is not to be given to a person under subsection (1)(b)(iii) or (iv),

(b) is to be withheld from publication under this section.

(6) After the sheriff has made a determination under section 25(1), the procurator fiscal must give the following information to the Registrar General of Births, Deaths and Marriages for Scotland—

(a) the name and last known address of the person to whose death the determination relates, and

(b) the date, place and cause of the death.

27 **Compliance with sheriff’s recommendations**

(1) A person to whom a recommendation under section 25(1)(b) is addressed—

(a) must, if the person was a participant in the inquiry to which the recommendation relates, give the Scottish Courts and Tribunals Service (“the SCTS”) a response in writing,

(b) may do so in any other case.
A response under subsection (1) must set out—

(a) details of what the respondent has done or proposes to do in response to the recommendation, or

(b) if the respondent has not done, and does not intend to do, anything in response to the recommendation, the reasons for that.

A response under subsection (1)(a) must be given to the SCTS within the period of 8 weeks beginning with the day on which the respondent receives a copy of the determination in which the recommendation is made.

A person who gives a response to the SCTS under subsection (1) may, at the same time, make representations to the SCTS as to the withholding of all or part of the response from publication under subsection (5A).

Where a response is given to the SCTS under subsection (1), the SCTS must, after considering any representations made under subsection (4)—

(a) publish the response in full,

(b) publish the response in part, together with a notice explaining that part of the response has been withheld from publication, or

(c) publish a notice explaining that the whole of the response is being withheld from publication.

The SCTS may withhold the whole of a response given under subsection (1) from publication only if representations are made to that effect under subsection (4).

If no response is given in accordance with subsection (1)(a) by the end of the 8 week period mentioned in subsection (3), the SCTS must publish notice of that fact.

The SCTS must publish a response or notice under subsection (5A) or (7) in such manner as it considers appropriate.

A response under subsection (1) is not admissible in evidence, and may not be founded on, in any judicial proceedings of any nature.

27A Reports

The Scottish Ministers must, as soon as practicable after the end of each financial year, prepare a report setting out—

(a) the number of inquiries that ended during the financial year, and

(b) in relation to such inquiries—

(i) the number in which recommendations requiring a response were made,

(ii) the total number of such recommendations made,

(iii) the number of such recommendations in relation to which a response was received by the Scottish Courts and Tribunals Service under section 27(1),

(iv) the number of such recommendations in relation to which a notice was published under section 27(7).

The Scottish Ministers must—

(a) lay a copy of a report under subsection (1) before the Scottish Parliament, and

(b) publish the report in such manner as they consider appropriate.
(3) In subsection (1), “recommendations requiring a response” means recommendations to which section 27(1)(a) applies.

**Further inquiry proceedings**

28 **Circumstances in which there may be further proceedings**

(1) Where an inquiry into the death of a person has ended, further inquiry proceedings may be held in relation to the death only in accordance with subsection (2).

(2) Further inquiry proceedings are to be held in relation to the death if—

(a) there is new evidence in relation to the circumstances of the death, and

(b) the Lord Advocate—

(i) considers that it is highly likely that a finding or recommendation set out in the determination would have been materially different if the evidence had been brought forward at the inquiry, and

(ii) decides that it is in the public interest for further inquiry proceedings to be held in relation to the circumstances of the death.

(3) For the purposes of subsection (2)(a), “new evidence” is evidence which was not available, and could not with the exercise of reasonable diligence have been made available, at the inquiry.

(4) For the purposes of subsection (1), an inquiry ends when the sheriff makes a determination in the inquiry.

(5) In this section and sections 29 and 30, references to the holding of further inquiry proceedings in relation to a death are references to—

(a) the re-opening and continuation of an inquiry into the death, or

(b) the holding of a fresh inquiry into the death.

29 **Precognition of witnesses**

(1) Subsection (2) applies where the Lord Advocate is considering whether further inquiry proceedings should be held in relation to the death of a person.

(2) The procurator fiscal may cite a person to attend for precognition in connection with that consideration.

(3) This section is sufficient warrant for such citation.

(4) Subsection (5) applies where a person cited under subsection (2)—

(a) having been given reasonable notice in the citation, and without reasonable excuse, fails to attend for precognition at the time and place mentioned in the citation, or

(b) does so attend but refuses to give information which is—

(i) within the person’s knowledge, and

(ii) relevant to the Lord Advocate’s consideration.

(5) The sheriff may, on the application of the procurator fiscal, make an order requiring the person to attend for precognition or, as the case may be, give the information at a time and place specified in the order.
(6) A person who fails to comply with an order under subsection (5) commits an offence.

(7) A person who commits an offence under subsection (6) is liable on summary conviction to imprisonment for a term not exceeding 21 days or a fine not exceeding level 3 on the standard scale (or both).

(8) In this section and section 30, references to the sheriff are references to a sheriff of the sheriffdom in which the inquiry into the person’s death was held.

30 Initiating further proceedings

(1) Where further inquiry proceedings are to be held in relation to the death of a person in accordance with section 28(2), the procurator fiscal must give the sheriff—

(a) notice that such proceedings are to be held, and

(b) a copy of the determination made in relation to the death (“the original determination”).

(1A) A notice under subsection (1)(a) must include—

(c) a brief account of the nature of the new evidence mentioned in section 28(2)(a),

(ca) the Lord Advocate’s view as to whether the further proceedings should consist of—

(i) the re-opening and continuation of the inquiry, or

(ii) the holding of a fresh inquiry, and

(d) any other information required by an act of sederunt under section 34(1).

(2) On receiving notice and a copy of the original determination under subsection (1), the sheriff must make an order fixing a date and place for a hearing under subsection (2A).

(2A) A hearing under this subsection is one at which the sheriff is to give the procurator fiscal and the participants in the inquiry to which the notice under subsection (1)(a) relates the opportunity to make representations about whether the further proceedings should consist of—

(a) the re-opening and continuation of the inquiry, or

(b) the holding of a fresh inquiry.

(2B) After the sheriff makes an order under subsection (2), the procurator fiscal must give notice to the participants in the inquiry to which the notice under subsection (1)(a) relates of the date and place fixed for the hearing.

(2C) After a hearing has been held under subsection (2A), the sheriff must make an order—

(a) setting aside the original determination, and

(b) either—

(i) re-opening and continuing the inquiry into the death, or

(ii) requiring a fresh inquiry to be held into the death.

(3) The sheriff may make an order under subsection (2C)(b)(ii) only if the sheriff considers that it is in the public interest to do so.

(4) Where the sheriff makes an order under subsection (2C)(a), the Scottish Courts and Tribunals Service must publish, in such manner as it considers appropriate, a notice stating that the original determination has been set aside.
Re-opened inquiries

(1) Sections 14 to 17 apply in relation to a re-opened inquiry into the death of a person as they apply in relation to any other inquiry, subject to subsections (2) to (4).

(2) The sheriff must, when making the order under section 30(2C) re-opening the inquiry, also make an order under section 14(2) in relation to the re-opened inquiry (and section 14(1) which requires the procurator fiscal to notify the sheriff that an inquiry is to be held) does not apply).

(3) The procurator fiscal must give notice of the re-opened inquiry under section 16(1), in addition to the persons mentioned in section 16(2), to any person not mentioned in that section—
   (a) who was a participant in the original inquiry proceedings, or
   (b) to whom a recommendation in the determination in those proceedings was addressed by virtue of section 25(5)(b).

(4) The notice required by section 16(1) and (3) must include notice of—
   (a) the fact that the inquiry has been re-opened (and section 16(1)(a) does not apply), and
   (b) the matters to which the new evidence relates.

(5) Evidence may be brought forward at a re-opened inquiry only if it relates to a matter to which the new evidence relates.

(6) But the sheriff may—
   (a) require evidence to be brought forward about any other matter relating to the circumstances of the death, or
   (b) on the application of the procurator fiscal or a participant in the inquiry, allow such evidence to be brought forward.

(7) In this section—
   “new evidence” means the new evidence mentioned in section 28(2)(a),
   “original inquiry proceedings” means the part of an inquiry held before it is re-opened under section 30(2C),
   “re-opened inquiry” means the part of an inquiry held after it is so re-opened.

Fresh inquiries

(1) This section applies where the sheriff makes an order under section 30(2C) setting aside the determination in an inquiry (“the original inquiry”) and requiring a fresh inquiry to be held.

(2) The sheriff must, when making the order, also make an order under section 14(2) in relation to the fresh inquiry (and section 14(1) which requires the procurator fiscal to notify the sheriff that an inquiry is to be held) does not apply).

(3) The procurator fiscal must give notice of the fresh inquiry under section 16(1), in addition to the persons mentioned in section 16(2), to any person not mentioned in that section—
   (a) who was a participant in the original inquiry, or
(b) to whom a recommendation in the determination in that inquiry was addressed by virtue of section 25(5)(b).

(4) The fresh inquiry is to be held in the sheriffdom in which the original inquiry was held (and section 12(2) (which requires the Lord Advocate to choose where the inquiry is to be held) does not apply).

(5) Subsection (4) is subject to section 12(3).

33 Further inquiry proceedings: compliance with recommendations

(1) This section applies where—

(a) a determination (“the original determination”) made in an inquiry into the death of a person has been set aside under section 30(2C)(a), and

(b) the sheriff makes a determination (“the new determination”) in the re-opened inquiry or, as the case may be, the fresh inquiry into the death.

(2) Section 27(1) does not apply in relation to a person to whom a recommendation is addressed in the new determination if a recommendation in the same terms was addressed to the person in the original determination.

(3) Subsection (4) applies where—

(a) a recommendation was addressed to a person in the original determination, but

(b) a recommendation in the same terms is not addressed to the person in the new determination.

(4) The Scottish Courts and Tribunals Service must withdraw from publication—

(a) a response to the recommendation published under section 27(5A)(a) or (b),

(b) a notice published under section 27(5A)(b) or (c) or (7) in relation to the recommendation.

Inquiry procedure rules

34 Power to regulate procedure etc.

(1) The Court of Session may by act of sederunt make provision for or about—

(a) the practice and procedure to be followed in inquiry proceedings,

(b) any matter incidental or ancillary to an inquiry.

(2) Without limiting the generality of subsection (1), the power in that subsection includes power to make provision for or about—

(a) the giving of notice under section 16,

(b) the conduct and management of inquiry proceedings, including the use of technology,

(c) the form of any document to be used in, or in connection with, inquiry proceedings,

(d) the process by which a person becomes a participant in an inquiry,

(e) the representation of the procurator fiscal and participants in inquiry proceedings, including representation of participants by persons who—

(i) are neither solicitors nor advocates, or
(ii) do not have the right to conduct litigation, or a right of audience, by virtue of section 27 of the Law Reform (Miscellaneous Provisions) (Scotland) Act 1990,

(f) witnesses and evidence, including modifying the rules of evidence as they apply to an inquiry,

(g) action to be taken by the procurator fiscal and the participants before the start of an inquiry or a re-opened inquiry,

(h) the fees payable to solicitors and advocates in relation to inquiry proceedings,

(i) the expenses payable to persons attending inquiry proceedings,

(j) the appointment of assessors under section 23(1) (including their functions and the terms on which they may be appointed),

(k) the giving and publication of responses under section 27,

(l) such other matters as the Court thinks necessary or appropriate for the purposes of carrying out or giving effect to the provisions of any enactment (including this Act) relating to inquiry proceedings or matters incidental or ancillary to such proceedings.

(3) An act of sederunt under subsection (1) may make—

(a) incidental, supplemental, consequential, transitional, transitory or saving provision,

(b) provision amending, repealing, or revoking any enactment (including any provision of this Act) relating to matters with respect to which an act of sederunt may be made,

(c) different provision for different purposes.

(4) Before making an act of sederunt under subsection (1) with respect to any matter, the Court of Session must—

(a) consult the Scottish Civil Justice Council, and

(b) take into consideration any views expressed by the Council with respect to that matter.

(5) Subsection (4) does not apply in relation to an act of sederunt that embodies, with or without modifications, draft rules submitted by the Scottish Civil Justice Council to the Court of Session.

(6) Schedule 1 makes further provision in relation to the regulation of the practice and procedure to be followed in inquiry proceedings.

Specialist sheriffs and summary sheriffs

Judicial specialisation in inquiries

(1) The sheriff principal of a sheriffdom may designate one or more sheriffs or summary sheriffs of that sheriffdom as specialists in inquiries for the purposes of this Act.

(2) The sheriff principal may at any time withdraw a designation made under subsection (1).

(3) The Lord President of the Court of Session may designate one or more part-time sheriffs or part-time summary sheriffs as specialists in inquiries for the purposes of this Act.

(4) The Lord President may at any time withdraw a designation made under subsection (3).
(5) The designation of a sheriff, summary sheriff, part-time sheriff or part-time summary sheriff (a “designated judicial officer”) under subsection (1) or (3) does not affect the competence of any other member of the judiciary of the sheriffdom to conduct inquiry proceedings.

(6) Subsection (7) applies where the sheriff principal is exercising any function relating to the allocation of inquiry proceedings.

(7) The sheriff principal must have regard to the desirability of ensuring that inquiry proceedings are conducted by a designated judicial officer.

(8) In subsection (5), the reference to a member of the judiciary of the sheriffdom is to be construed in accordance with section 136(2) of the Courts Reform (Scotland) Act 2014.

36 Summary sheriff: competence to conduct inquiries

A summary sheriff may, in relation to inquiry proceedings, exercise the jurisdiction and powers that attach to the office of sheriff.

General

37 Repeal and modification of enactments

(1) The Fatal Accidents and Sudden Deaths Inquiry (Scotland) Act 1976 is repealed.

(2) Schedule 2 modifies other enactments.

38 Interpretation

In this Act, unless the context requires otherwise—

“advocate” means a member of the Faculty of Advocates,

“child” means a person who has not yet reached the age of 18 years,

“inquiry” has the meaning given by section 1(5),

“inquiry proceedings” has the meaning given by section 10(2)(a),

“participant” is to be construed in accordance with section 10(2)(b),

“procurator fiscal” means any procurator fiscal, assistant procurator fiscal, procurator fiscal depute or person duly authorised to execute the duties of a procurator fiscal,

“re-opened inquiry” has the meaning given by section 31(7),

“solicitor” means a solicitor enrolled in the roll of solicitors kept under section 7 of the Solicitors (Scotland) Act 1980.

39 Ancillary provision

(1) The Scottish Ministers may by regulations make such incidental, supplemental, consequential, transitional, transitory or saving provision as they consider necessary or expedient for the purposes of, in consequence of, or for giving full effect to, any provision of this Act.

(2) Regulations under subsection (1)—

(a) may—
(i) make different provision for different purposes,
(ii) modify any enactment (including this Act),

(b) are subject to—

(i) the affirmative procedure if they add to, replace or omit any part of the text of an Act,
(ii) otherwise, the negative procedure.

40 Commencement

(1) This section and sections 34(6), 38, 39 and 41 and schedule 1 come into force on the day after Royal Assent.

(2) The remaining provisions of this Act come into force on such day as the Scottish Ministers may by regulations appoint.

(3) Regulations under subsection (2) may—

(a) include transitional, transitory or saving provision,
(b) make different provision for different purposes.

41 Short title

The short title of this Act is the Inquiries into Fatal Accidents and Sudden Deaths etc. (Scotland) Act 2015.
SCHEDULE 1
(introduced by section 34(6))

PROCEDURE RULES

Role of the Scottish Civil Justice Council

1 (1) The Scottish Civil Justice Council and Criminal Legal Assistance Act 2013 is amended in accordance with this paragraph.

(2) In subsection (1) of section 2 (functions of the Council)—

(a) before paragraph (c) insert—

“(bb) to review the practice and procedure followed in inquiry proceedings under the Inquiries into Fatal Accidents and Sudden Deaths etc. (Scotland) Act 2015,”,

(b) in paragraph (c), after sub-paragraph (ia) insert—

“(ib) draft inquiry procedure rules,”.

(3) After subsection (6A) of that section insert—

“(6B) For the purposes of this Part, “draft inquiry procedure rules” are draft rules prepared with a view to the making by the Court of Session of an act of sederunt under section 34(1) of the Inquiries into Fatal Accidents and Sudden Deaths etc. (Scotland) Act 2015.”.

(4) In section 4 (Court of Session to consider rules)—

(a) in subsection (1), after “draft fees rules” insert “or draft inquiry procedure rules”,

(b) in subsection (2), after “draft fees rules” insert “or draft inquiry procedure rules”,

(c) in subsection (3), after paragraph (b) insert—

“(c) under section 34(1) of the Inquiries into Fatal Accidents and Sudden Deaths etc. (Scotland) Act 2015.”.

(5) In section 16 (interpretation of Part 1), after the entry relating to draft civil procedure rules insert—

“draft inquiry procedure rules” has the meaning given in section 2(6B),”.

SCHEDULE 2
(introduced by section 37(2))

MODIFICATION OF ENACTMENTS

Gas Act 1965

1 In the Gas Act 1965, section 17(4) (accidents) is repealed.

Health and Safety at Work etc. Act 1974

2 (1) The Health and Safety at Work etc. Act 1974 is amended in accordance with this paragraph.

(2) Section 14(7) (power of the Health and Safety Executive to direct investigations and inquiries) is repealed.
(3) In section 34(1) (extension of time for bringing summary proceedings), for paragraph (d) substitute—

“(d) an inquiry into any death that may have been so caused is held under the Inquiries into Fatal Accidents and Sudden Deaths etc. (Scotland) Act 2015.”.

2A In schedule 3 of the Oil and Gas (Enterprise) Act 1982, paragraph 34 is repealed.

2B In section 4(6) of the Anatomy Act 1984 (lawful examinations), for “Fatal Accidents and Sudden Deaths Inquiry (Scotland) Act 1976” substitute “Inquiries into Fatal Accidents and Sudden Deaths etc. (Scotland) Act 2015”.

2C(1) The Merchant Shipping Act 1995 is amended in accordance with this paragraph.

(2) In section 108(6)(a)(iii) (returns of births and deaths in ships, etc.), for “Fatal Accidents and Sudden Deaths Inquiry (Scotland) Act 1976” substitute “Inquiries into Fatal Accidents and Sudden Deaths etc. (Scotland) Act 2015”.

(3) In section 271(6)(c) (inquiries into deaths of crew members and others), for “enquiry is to be held under the Fatal Accidents and Sudden Deaths Inquiry (Scotland) Act 1976” substitute “inquiry is to be held under the Inquiries into Fatal Accidents and Sudden Deaths etc. (Scotland) Act 2015”.

2D In schedule 4 of the Criminal Procedure (Consequential Provisions) (Scotland) Act 1995, paragraph 10 is repealed.

2E In schedule 4 of the Petroleum Act 1998, paragraph 9 is repealed.

2F In section 31(1)(i) of the Freedom of Information Act 2000 (law enforcement), for “Fatal Accidents and Sudden Deaths Inquiry (Scotland) Act 1976” substitute “Inquiries into Fatal Accidents and Sudden Deaths etc. (Scotland) Act 2015”.

30 In schedule 4 of the Scottish Public Services Ombudsman Act 2002, in paragraph 2(2), for “Fatal Accidents and Sudden Deaths Inquiry (Scotland) Act 1976 (c.14)” substitute “Inquiries into Fatal Accidents and Sudden Deaths etc. (Scotland) Act 2015”.

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**Freedom of Information (Scotland) Act 2002**

2H(1) The Freedom of Information (Scotland) Act 2002 is amended in accordance with this paragraph.

(2) In section 34(2)(a) (investigations by Scottish public authorities and proceedings arising out of such investigations), for “Fatal Accidents and Sudden Deaths Inquiry (Scotland) Act 1976 (c.14)” substitute “Inquiries into Fatal Accidents and Sudden Deaths etc. (Scotland) Act 2015”.

(3) In section 37(3) (court records, etc.), for “Fatal Accidents and Sudden Deaths Inquiry (Scotland) Act 1976 (c.14)” substitute “Inquiries into Fatal Accidents and Sudden Deaths etc. (Scotland) Act 2015”.

**Police, Public Order and Criminal Justice (Scotland) Act 2006**

2I (1) The Police, Public Order and Criminal Justice (Scotland) Act 2006 is amended in accordance with this paragraph.

(2) In section 33A(b)(ii) (general functions of the Police and Investigations Review Commissioner), for “Fatal Accidents and Sudden Deaths Inquiry (Scotland) Act 1976 (c.14)” substitute “Inquiries into Fatal Accidents and Sudden Deaths etc. (Scotland) Act 2015”.

(3) In section 41B(2)(b)(ii) (serious incidents involving the police), for “Fatal Accidents and Sudden Deaths Inquiry (Scotland) Act 1976 (c.14)” substitute “Inquiries into Fatal Accidents and Sudden Deaths etc. (Scotland) Act 2015”.

(4) In section 41C(2)(b)(ii) (investigation of matters in the public interest), for “Fatal Accidents and Sudden Deaths Inquiry (Scotland) Act 1976 (c.14)” substitute “Inquiries into Fatal Accidents and Sudden Deaths etc. (Scotland) Act 2015”.

**Scottish Commission for Human Rights Act 2006**

2J In section 14(9) of the Scottish Commission for Human Rights Act 2006 (power to intervene), for “Fatal Accidents and Sudden Deaths Inquiry (Scotland) Act 1976 (c.14)” substitute “Inquiries into Fatal Accidents and Sudden Deaths etc. (Scotland) Act 2015”.

**Armed Forces Act 2006**

2K In schedule 16 of the Armed Forces Act 2006, paragraph 72 is repealed.

**Coroners and Justice Act 2009**

2L In the Coroners and Justice Act 2009, section 50 (amendments to the Fatal Accidents and Sudden Deaths Inquiry (Scotland) Act 1976) is repealed.

**Energy Act 2013**

3 (1) The Energy Act 2013 is amended in accordance with this paragraph.

(2) In section 85 (inquiries), subsections (7) and (8) are repealed.

(3) In schedule 10 (provisions relating to offences), in paragraph 3(1)(d), for “a public inquiry under the Fatal Accidents and Sudden Deaths Inquiry (Scotland) Act 1976” substitute “an inquiry under the Inquiries into Fatal Accidents and Sudden Deaths etc. (Scotland) Act 2015”.
Inquiries into Fatal Accidents and Sudden Deaths etc. (Scotland) Bill
Schedule 2—Modification of enactments

Tribunals (Scotland) Act 2014

4 (1) Paragraph 13 of schedule 9 of the Tribunals (Scotland) Act 2014 (transitional and consequential) is amended in accordance with this paragraph.

(2) In sub-paragraph (2)(b)(ii), in the inserted text, for “(ii)” substitute “(iza)”.

(3) In sub-paragraph (4), in the inserted text, for “(7)” substitute “(6ZA)”.

(4) In sub-paragraph (9), in subsection (1) of inserted section 13A, for “(c)(ii)” substitute “(c)(iza)”.

(5) In sub-paragraph (10)(b), in the inserted text, for “2(7)” substitute “2(6ZA)”.

Inquiries into Fatal Accidents and Sudden Deaths etc. (Scotland) Bill
[AS PASSED]

An Act of the Scottish Parliament to make provision for the holding of public inquiries in respect of certain deaths.

Introduced by: Michael Matheson
Supported by: Paul Wheelhouse
On: 19 March 2015
Bill type: Government Bill