Justice Committee

Petition PE1501

I am writing to you in response to your request of 7 November 2014 that the Crown Office and Procurator Fiscal Service (COPFS) provide information on “the level of investigation carried out into the 4,000 deaths classed as self-inflicted in the last five years”.

As previously explained in letter dated 13 February 2014 to the Public Petitions Committee there are around 13,000 deaths reported to COPFS annually, of which around 800 are classed as “self inflicted”. It might be helpful to explain that the figure of around 800 deaths annually was arrived at from statistics published by the National Records of Scotland (NRS) of what are described as “probable suicides” which includes deaths which are the result of intentional self-harm or events of undetermined intent. This information can be accessed using the following links:


Since mid 2009 COPFS has provided NRS with information about the nature of death for “traumatic/suspicious” deaths by the Procurator Fiscal completing and submitting a Form and indicating the most appropriate category for that death on a balance of probabilities. The categories under that section of the form are: accident; intentional self-harm; assault; and undetermined intent. As explained NRS collectively group those deaths categorised as intentional self harm and undetermined intent in producing figures for “probable” suicides in Scotland. Prior to 2009 a different system existed for COPFS notifying NRS of deaths understood to be a suicide although the changes made had little effect on the overall total number of probable suicides recorded by NRS.

COPFS operates a live operational database and its use is not designed for statistical or research purposes. It is not possible other than by a manual check of cases to establish the level of investigation into each of the cases involving self inflicted deaths over the last 5 years. A manual check would be too resource and time intensive impacting on the current work of COPFS. It may be possible, if you wish it, for some of these cases to be dip sampled as representative of the 4,000 cases.

That said, the Scottish Fatalities Investigation Unit (SFIU) have been able to provide some general information on the approach to such investigations which I hope you will find useful.

All investigations by Procurators Fiscal in respect of deaths in Scotland begin by ascertaining the cause of death. The vast majority of deaths reported are as a result of natural causes and do not require further investigation once the cause of death has been ascertained by expert medical examination. In the vast majority of these
categories of death the cause and circumstances of death are uncontroversial. Those few deaths that do tend to require further investigation include, where the circumstances are as a result of accident, medical error or potential criminality.

Most deaths reported to the Procurator Fiscal which require further explanation are reported initially because a doctor is unable to confirm the cause of death and therefore unable to issue a death certificate often as the Doctor available to confirm certification of death has no knowledge of the patient. The requirement to report deaths which cannot be immediately certified by a doctor is necessary not only in order to minimise the risk of undetected homicide or other crime but also in pursuance of the public interest to eradicate dangers to health and life, to allay public anxiety and to ensure that full and accurate statistics are compiled.

The level of investigation involved for each death will differ according to the unique facts and circumstances of the death. The views and wishes of nearest relatives and any concerns they have are important and may inform the approach taken to any given investigation as these will always be important considerations for COPFS in deciding the level of investigation required and the approach to be adopted in that investigation. It is recognised by COPFS that Article 2 of the European Convention of Human Rights places a procedural duty on the state to carry out an effective investigation into deaths and that in order for an investigation to be effective this must involve the nearest relatives to an appropriate extent and therefore the nearest relatives may have an input into the investigation where they wish to do so.

As a generality deaths which raise the possibility of being caused by self-inflicted injury which are reported to the Crown for investigation are as follows:

(a) Deaths where there are clearly no suspicious circumstances and there is a strong basis on the facts and circumstances to indicate it was self inflicted/suicide for example where there is an obvious mechanism of death suggesting suicide and a suicide note has been left.

(b) Deaths where there are clearly no suspicious circumstances and the facts indicate it was self inflicted/suicide but where the mechanism/cause of death requires further investigation for example where it appears that the deceased has taken drugs to end their life but toxicology is required to confirm that.

(c) Deaths where there are clearly no suspicious circumstances but from the facts it is not clear that the deceased intended to take their own life.

(d) Deaths where there are clearly no suspicious circumstances and the facts indicate it was self inflicted/suicide but the background circumstances necessitate a more detailed investigation for example where the deceased was either under medical care or had recently been so perhaps for depression and concerns have been raised about the standard of care or where perhaps a critical incident review has taken place.

(e) Deaths where suspicious circumstances cannot be ruled out and a full investigation is required in order to rule out homicide.

Currently all of the above categories will at the very least involve: the review of the police report by a Procurator Fiscal with specialist training in deaths investigation and instruction of a post mortem; contact with the nearest relatives informing them of
the need for a post mortem; review of the final post mortem report and full statements that have been ingathered by the police once these are available; and corresponding with the nearest relatives offering them a meeting.

In relation to categories (a) and (b) above this will be the level of involvement for most cases although for category (b) any toxicology report will also have to be reviewed and depending on the results of that toxicology it may also be necessary to investigate the possibility of criminal proceedings if for example the presence of controlled drugs is found and/or where the initial investigation indicate that the drugs involved were supplied illegally. Where any of the deaths under these categories fall under section 1(2)(a)(ii) of the Fatal Accidents and Sudden Deaths Inquiry (Scotland) Act 1976 necessitating a mandatory FAI there will be the following additional aspects to the investigation: the Procurator Fiscal will order health records (and if the person died in prison any prison records) and on receipt these will be reviewed along with the full statements, the post mortem report and any other relevant additional records; there will be contact with the nearest relatives informing them of the proceedings and offering them a meeting once the post mortem report is received and a level of contact will be maintained with the family throughout the preparation for FAI commensurate with the wishes of the particular family involved; the FAI will be conducted. It will be for the family to decide if they wish to be separately represented at the FAI; the nearest relatives will be formally informed of the determination and offered a final meeting before the case is closed.

Deaths falling under Category (c) above may include a wide range of facts and circumstances. Often it is difficult to conclude with precision what the intentions were of the deceased. For instance where death has been caused by a drugs overdose this may have been either intentional or accidental and it is important not to make any assumptions. The nature and level of investigation required will very much depend on the surrounding facts and circumstances and level of concerns expressed by nearest relatives during the investigation.

In relation to deaths falling under category (d) above the level of investigation will necessarily be more involved. This may involve amongst other things: a thorough and independent investigation into the deceased’s mental health treatment or other treatment prior to the death; a review of any Critical incident or other internal review that may have taken place; consideration of any action taken by others, for instance Health Boards, to avoid a similar event occurring in the future; in these cases there may well be significant interaction with the nearest relatives depending on their wishes and this may involve meetings to ascertain any further concerns they have and to advise them of the outcome of investigations as they progress; when investigations are complete a detailed report will normally be submitted for the consideration of Crown Counsel who will decide whether there should be a discretionary FAI; if Crown Counsel instruct that no FAI is to be held then the nearest relatives will be informed and offered a meeting and if an FAI is held the nearest relatives will be advised of their right to be represented and after conclusion of the FAI and receipt of the determination offered a final meeting before the case is closed.

Some deaths falling under this category may raise concerns in terms of Health and Safety Legislation. For instance where there is some indication that inadequate risk
assessments have been carried out, these cases will be referred to the Health and Safety Division (HSD) of Crown Office and further investigation will be undertaken. HSD have indicated that they have around six such investigations ongoing at any one time.

In relation to category (e) COPFS guidance states that any deaths where suspicion cannot be ruled out must be investigated as a suspicious death until such time as the Procurator Fiscal is satisfied that there are no longer reasonable grounds to suspect that the death may be homicidal or caused by the criminal act of any other person. In order to rule out homicidal or criminal acts, a detailed further investigation will be required and again much will depend on the facts and circumstances but these additional investigations may include a variety of matters such as a full forensic examination of the locus including fingerprint examination, DNA analysis, toxicological examinations, examination of any available CCTV evidence and analysis of mobile phones and other devices. As with category (d) there will also likely be similar interaction with the nearest relatives.

SFIU is the central point for liaising with the nearest relatives of a deceased’s family. One exception to this would be in category (e) above, where the Procurator Fiscal is investigating a suspicion of homicide. In this type of case, the COPFS Victim and Information Advice Service (VIA) will normally oversee liaison with relatives. SFIU provides general information to nearest relatives on the investigation of deaths by the Procurator Fiscal; it engages and consults with families of the deceased throughout each investigation keeping them apprised of the outcome of investigations; and it provides them with reasons where the Lord Advocate decides not to apply for an FAI. This engagement is done sensitively, an assessment having been made in each case as to the most appropriate method of communication in line with the expressed wishes of individual relatives and therefore this may be done by letter, telephone or by face-to-face meetings. In many instances different relatives may wish to have different types of response and this is accommodated.

Liaison with the deceased’s family forms an integral part of any deaths investigation. There of course cannot be a “one size fits all” approach to death investigations as each death has its own unique facts and circumstances and the level and type of interaction with the family will very much depend on the needs, concerns and wishes of the family.

Where the family of the deceased wish to be advised of the information uncovered as a result of the investigation then SFIU will appraise them of what the investigation has found and share all relevant information as far as possible. If family members wish to have sight of evidence obtained during the investigation such as pathology or other expert reports and photographs then this will be disclosed in as sensitive a way as possible. For instance sometimes the post mortem report disclosure will be arranged through the family GP where, for example medical terms require to be explained and the family prefer that is done in such a setting. Any further investigation that may be required as a result of additional matters which may be raised by family members will be considered and, if appropriate, instructed and the results explained.
Finally, if as I understand it is being proposed by the petitioner that it should be mandatory to hold an FAI into all deaths where the investigation by the Procurator Fiscal concludes that it appears most likely that the death was a result of self inflicted injury or cannot rule out the possibility of self inflicted injury this would be a real concern. Article 2 of the European Convention of Human Rights does not go so far as to require all proceedings following an investigation into a violent death to be public. The degree of public scrutiny required may vary from case to case: Anguelova v Bulgaria (2004) 38 EHRR 31; Ramsahai v The Netherlands (2008) 46 EHRR 43. It is the experience of COPFS that most families in such circumstances do not wish a mandatory Inquiry in public to take place and this raises important considerations in terms of Article 8 of the convention, the right to respect for private and family life.

I hope you find this information helpful. COPFS did consider whether we could provide you with some specific examples in order to illustrate the level of investigation that is sometimes required into these types of deaths however we have refrained from doing so as there was a risk that families may feel that this would potentially identify individual circumstances relating to a death of a loved one and we would not want to add to any distress already experienced by them. If you require any further information then I will be happy to assist.

Catherine Dyer
Crown Agent and Chief Executive
21 January 2015