The Scottish Parliament
Pàrlamaid na h-Alba

Official Report

JUSTICE COMMITTEE

Tuesday 12 May 2015

Session 4

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JUSTICE COMMITTEE
15th Meeting 2015, Session 4

CONVENER

*Christine Grahame (Midlothian South, Tweeddale and Lauderdale) (SNP)

DEPUTY CONVENER

*Elaine Murray (Dumfriesshire) (Lab)

COMMITTEE MEMBERS

*Christian Allard (North East Scotland) (SNP)
*Jayne Baxter (Mid Scotland and Fife) (Lab)
*Roderick Campbell (North East Fife) (SNP)
*John Finnie (Highlands and Islands) (Ind)
*Alison McInnes (North East Scotland) (LD)
*Margaret Mitchell (Central Scotland) (Con)
*Gil Paterson (Clydebank and Milngavie) (SNP)

*attended

THE FOLLOWING ALSO PARTICIPATED:

Detective Chief Superintendent Robbie Allan (Police Scotland)
Cathy Asante (Scottish Human Rights Commission)
Patricia Ferguson (Glasgow Maryhill and Springburn) (Lab)
Michael Matheson (Cabinet Secretary for Justice)
Carla McCloy-Stevens (Scottish Government)
Alistair McNab (Health and Safety Executive)
Iain Miller (Glasgow City Council)
Jake Molloy (National Union of Rail, Maritime and Transport Workers)
Dr Gary Morrison (Mental Welfare Commission for Scotland)
Ian Tasker (Scottish Trades Union Congress)

CLERK TO THE COMMITTEE

Tracey White

LOCATION

The Mary Fairfax Somerville Room (CR2)

Scottish Parliament

Justice Committee

Tuesday 12 May 2015

[The Convener opened the meeting at 10:00]

Subordinate Legislation

Proceeds of Crime Act 2002 (Cash Searches: Constables in Scotland: Code of Practice) Order 2015 [Draft]

The Convener (Christine Grahame): Good morning. I welcome everyone to the Justice Committee's 15th meeting in 2015. I ask everyone to switch off mobile phones and other electronic devices, as they interfere with broadcasting even when they are switched to silent. No apologies have been received. I welcome to the committee Patricia Ferguson, who has an interest in today's meeting because of her proposed member's bill.

Agenda item 1 is consideration of an affirmative instrument. I welcome to the meeting Michael Matheson, Cabinet Secretary for Justice, and Scottish Government officials Lee-Anne Barclay, policy officer, organised crime and police powers unit, and Carla McCloy-Stevens, solicitor, legal directorate.

Cabinet secretary, I believe that you want to make a brief opening statement in advance of the debate on the instrument.

The Cabinet Secretary for Justice (Michael Matheson): Thank you, convener, and good morning. I am grateful for the opportunity to speak to the committee about the draft Proceeds of Crime Act 2002 (Cash Searches: Constables in Scotland: Code of Practice) Order 2015. It proposes to bring into operation a revised code of practice in connection with the exercise by constables in Scotland of the powers conferred by section 289 of the Proceeds of Crime Act 2002.

Section 289 of the 2002 act allows constables to search individuals and premises for cash that is recoverable property, or is intended for use in unlawful conduct, and which is not less than the minimum amount—currently £1,000. It forms part of a suite of measures that provide for the search for such cash and its seizure and forfeiture.

The search powers are subject to certain limits and conditions and generally require the prior approval of a sheriff. As a further safeguard, section 293 of the 2002 act requires the Scottish ministers to provide a code of practice for constables in Scotland, to ensure that they exercise their search powers appropriately, fairly and proportionately.

The code has been in operation for more than 12 years and was last revised in 2009. The current revision is a result of amendments that have been made to section 289 of the 2002 act by section 63 of the Policing and Crime Act 2009. Those amendments are due to come into force on 1 June 2015. They insert new provisions into section 289 of the Proceeds of Crime Act 2002 that enable constables to search vehicles for cash in certain circumstances.

Currently, under section 289 of the 2002 act, a constable may search a vehicle if it is located on premises that are already the subject of a search and the constable has lawful authority to be there. The new power will allow a constable to search a vehicle when it appears to be under the control of an identifiable person and is in a public place. If the constable has reasonable grounds to suspect that there is recoverable cash in the vehicle, he or she may require the person to permit entry to, and search of, the vehicle.

The new powers may be used when a vehicle is within the environs of a dwelling, but only if the constable has reasonable grounds for believing that the person who is in control of the vehicle does not reside in the dwelling and that the vehicle is there without the permission of a person who does reside there.

Accordingly, the revision of the code will simply apply the existing guidance and standards of practice to the new powers for searches of vehicles.

I am happy to answer any questions that members may have.

The Convener: Thank you very much, cabinet secretary. The first question is from John Finnie.

John Finnie (Highlands and Islands) (Ind): Good morning, cabinet secretary. You said that the powers generally require the authorisation of a sheriff. When would a sheriff's authorisation not be required?

Michael Matheson: It might be impractical in some circumstances because of the immediacy of the situation in which the constable is able to undertake the search. When constables are not able to get authorisation from a sheriff, they should seek authorisation from a senior officer of the rank of inspector or above to proceed with such a search. If there are circumstances in which that is not possible, constables can conduct the search but they must then go through a process that involves reporting the details of the situation, what the outcome was and why the search was undertaken without the normal authorisation process.

There is an oversight process for cases in which that approach has been taken, whereby the appropriate person that the legislation provides for can consider the matter and look at whether the constable exercised their powers appropriately under the code of practice.

John Finnie: What would the avenue of redress be when the powers had not been properly exercised?

Michael Matheson: That would be a matter for the appropriate person, who would consider how the powers had been utilised and how the constable had undertaken the search. They would consider referring the matter to the chief constable of the force in which the constable is serving to ensure that the process had been properly adhered to. Any other legal challenges to the search would obviously be a matter for the courts to consider.

John Finnie: I understand that a practice is already in place for such situations, but I imagine that if the investigation is to be conducted within the category of proceeds of crime, it would require some pre-planning. Searches are always better undertaken under warrant rather than on a discretionary basis.

Michael Matheson: The reality is that the vast majority of the searches that are undertaken under proceeds of crime legislation are based on intelligence, and when a sheriff has given authorisation in the form of a warrant. That tends to be the practical reality of the situation, although there will be exceptions, which is why the code of practice sets out the arrangements and why the legislation contains a provision for the appropriate person to have oversight of how the powers have been applied.

The Convener: But we are not just talking about the proceeds of crime, are we? The power can be used if there is deemed to be reasonable grounds for suspecting that the cash will be used for the purposes of crime.

Michael Matheson: No, the code of practice is for the purpose of the 2002 act.

The Convener: Does the code apply only to the proceeds of crime and not to cash for the purposes of crime?

Michael Matheson: It applies only to the Proceeds of Crime Act 2002.

The Convener: The policy note refers to cash that:

"is intended by any person for use in unlawful conduct, and which is not less than the minimum amount".

So the policy objectives included in the policy note include circumstances in which the cash "is intended by any person for use in unlawful conduct".

Michael Matheson: The powers apply if they are being exercised under the Proceeds of Crime Act 2002 and not for any other areas.

The Convener: I understand. However, the powers apply not only to recoverable property that has come from crime but to cash that might be used thereafter for the purposes of crime.

Michael Matheson: Yes.

The Convener: I just wanted to clarify that point—it is early for me, but I think that I have worked out what it means.

Roderick Campbell (North East Fife) (SNP): The policy note states:

"Copies of the revised code will be available ... for consultation by the police and by members of the public if they so wish."

How will the existence of the code of practice be made known to the public should they wish to look at it?

Michael Matheson: The code of practice will be available in all police stations in Scotland and on the Scottish Government's website, so it will be readily available.

Margaret Mitchell (Central Scotland) (Con): I have a more general question. Given the difficulties surrounding the communication of stop-and-search policy to rank-and-file officers in Police Scotland, are you confident that the revised code of practice will be properly communicated to rank-and-file officers?

Michael Matheson: The new power is entirely separate from other forms of stop and search and does not relate to them. The existing code of practice has been in place for a good number of years and no issues have been raised about how it has been operating. The code of practice was revised in 2009 but it has been in place since—

Carla McCloy-Stevens (Scottish Government): It has been in place since December 2002.

Michael Matheson: The code that we operate in Scotland is very similar to the code that operates in other parts of the UK.

Margaret Mitchell: The gist of my question was about communication. The code was revised in 2009, prior to the existence of Police Scotland and the communication problems that have resulted since its establishment.

Michael Matheson: I am confident that the code of practice will be adhered to and properly utilised by officers.

Margaret Mitchell: And properly communicated to them.

Michael Matheson: There is already a process in place, so that has been happening since 2002 and no problems have arisen.

Margaret Mitchell: We shall see.

The Convener: Margaret Mitchell has expressed some scepticism as usual, but that is all right.

Elaine Murray (Dumfriesshire) (Lab): I see that the current minimum amount is £1,000. Has that changed since 2009? How was the figure determined?

Michael Matheson: The figure has not changed; it is still at the same level.

Elaine Murray: That is the level that was established in the original legislation.

Michael Matheson: Yes.

The Convener: Were any concerns raised during the Scottish Human Rights Commission consultation? The clerk's paper says that there were "few representations" and that they were "generally very positive". Were there any negative responses?

Michael Matheson: From the Scottish Human Rights Commission?

The Convener: Yes.

Michael Matheson: No.

The Convener: Did it not object to the proposal at all?

Michael Matheson: No.

The Convener: Were there any negative responses whatsoever?

Michael Matheson: No.

The Convener: That is fine. Thank you very much.

Right, that is the question period over. We now move on to agenda item 2, which is the formal debate on motion S4M-13076.

Motion moved,

That the Justice Committee recommends that the Proceeds of Crime Act 2002 (Cash Searches: Constables in Scotland: Code of Practice) Order 2015 [draft] be approved.—[*Michael Matheson.*]

Motion agreed to.

The Convener: As members are aware, we are required to report on all affirmative instruments. Are members content to delegate to me the authority to sign off the committee's report?

Members *indicated agreement.*

The Convener: I thank you, cabinet secretary, and your officials, for attending the meeting. I suspend the meeting for a couple of minutes to allow witnesses to change over.

10:10

Meeting suspended.

10:11

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?

10:15

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 or impact on criminal investigations 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 proceedings 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 procurator 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.

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 on which we have a specific view. We raised in relation to the Mental Health (Scotland) Bill that the gap needed to be addressed, but as it has not been taken up in the discussions on that bill, we think that the Inquiries into Fatal Accidents and Sudden Deaths etc (Scotland) Bill could be a good opportunity to take it forward.

Margaret Mitchell: On the specific point about the family's involvement, the recommendation in the Cullen report, which was not included in the bill for financial reasons, was that the reasonableness test for legal aid should be dropped in the interests of the family having a better chance of securing legal representation. What is your view on that?

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 sift 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. [*Interruption*.] 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.

12:00

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.

12:04

Meeting suspended.

12:05

On resuming—

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: Thankfully 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.

12:21

On resuming—

The Convener: We move to agenda item 4. Are members content to delegate to me, as is usual practice, the authority to consider and approve witness expenses claims in relation to the Inquiries into Fatal Accidents and Sudden Deaths etc (Scotland) Bill?

Members *indicated agreement.*

The Convener: Thank you.

Meeting closed at 12:21.

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