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Fatal Accident Inquiries: raising awareness of their role in relation to the medical profession in Scotland

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INTRODUCTION

Fatal Accident Inquiries (FAIs) are unique to Scotland. FAIs provide the legal mechanism where judicial investigation of deaths occurring in Scotland is involved. For the medical profession, a few of the FAIs instructed annually will focus on the role of the actual delivery of the medical treatment and care in relation to the death.

This paper considers generally the nature and role of FAIs by reference to these medical-type FAIs. It aims to promote a greater understanding of such FAIs and the medical profession's role in such inquiries which, in turn, may enhance how medical practitioners deal with communications with deceased relatives following such a death. It is directed primarily at doctors practising in Scotland who have qualified in other jurisdictions with no experience of Scottish procedures relating to investigations into deaths/FAIs. It should also be of interest to other medical practitioners both in Scotland and elsewhere.

Part 1 outlines the historical background and context of FAIs. Part 2 discusses the legislation governing when a FAI will be held, the procedure, types, location and the role of FAIs including consideration of the significance of the determination issued by the sheriff. FAIs are only one specific type of procedure that may result from a death. Other procedures, disciplinary and civil or criminal, may also follow. In concluding, FAIs provide a transparent and public mechanism for inquiring into deaths whereby the State complies with its obligations under the European Convention on Human Rights Article 2 Right to life:

- Everyone's right to life shall be protected by law. No one shall be deprived of his life intentionally save in the execution of a sentence of a court following his conviction of a crime for which this penalty is provided by law.

FAIs provide a means of undertaking a robust examination into circumstances of a death by seeking to 'avoid the same happening to anyone else'. Although their outcome may not always satisfy, what can be said is that there is an opportunity provided for all involved to learn lessons from what has happened.

This paper does not seek to provide legal advice. It is from the legal profession and the medical defence unions that detailed advice can and should be obtained. One such helpful document is *Essential Guide to the Fatal Accident Inquiry*.[1]

PART 1: CONTEXT AND BACKGROUND OF FAIS

Context

Many doctors who practise medicine in Scotland never appear at a FAI. Some doctors, such as pathologists and those involved in Accident and Emergency, will be very familiar with the role of giving evidence at FAIs. Any death must be followed by certification of the death by a medical practitioner. A number of deaths, for various reasons, will require a post-mortem. When a FAI is instructed in relation to a specific death, various doctors are likely to have been involved at different stages and will be cited for court.

Certain doctors will merely be speaking on routine medical procedures, such as admission and blood tests, where evidence provided will be of a relatively routine and non-contentious nature. Some doctors, however, will be providing substantial evidence about their medical examination, diagnosis and decision-making processes, where such issues are now, with the benefit of hindsight, under detailed scrutiny. For doctors who have been clinically involved in the circumstances of a death that results in a FAI, the citation to appear as a witness at a sheriff court will doubtless arrive as an unwelcome (and potentially concerning) interruption to their everyday professional life.

FAIs may also involve members of the public (including the relatives), the legal profession (responsible for conducting the FAI and representing the parties appearing before the FAI), fellow medical professionals (involved in providing expert opinion evidence) and the sheriff presiding over the FAI whose responsibility it is to publish the determination. The determination is the

formal finding issued at the conclusion of the FAI setting out core information about the time, place and cause of death. Mostly these details are agreed, though the inclusion of a hospital- borne infection, as a contributing factor to a death, may well have been previously resisted. The determination can seek to make recommendations, if relevant, on the circumstances of the death if the sheriff is satisfied with the evidence (based on the civil standard of proof, namely the balance of probabilities).

If cited, the doctor will already be familiar with the case. The sudden death is likely to have arisen in a complex case (and therefore be both distressing and memorable). It may have already featured in a critical case review. The doctor may well have been precognosed by the police and/or a member of staff within the Crown Office and Procurator Fiscal Service (COPFS) as to the facts, background and their role in relation to the death.

The FAI process for doctors, both before and in court, can be stressful and such inquiries, inevitably, place medical professionals under the spotlight. It is not suggested that a FAI should not be held when the circumstances merit it or should be avoided. However, the medical profession does have a role in educating itself about FAIs and being familiar with the types of deaths arising from medical mishap or subject to complaint that might result in a FAI. The relatives of the deceased will make a request for a FAI to be heard, not necessarily fully appreciating the purpose of a FAI but based on perceived poor communications (and understanding) with medical professionals from the outset. That stresses the importance of the initial communication with and the disclosure of information to the deceased's relatives immediately after death.

BACKGROUND

Investigating the cause of that death is, of course, of immediate interest to the next of kin. The public interest in deaths is much wider.[2] Criminal and civil justice require certification as to the cause of death, be it in criminal law to permit murders to be detected or in civil law to allow the administration of the deceased's estate. Both the English and Scottish legal systems make investigations into sudden, suspicious, accidental, unexpected and unexplained deaths as well as any death that is reported to them. The operation of an efficient death investigation system is the legal responsibility of the COPFS in Scotland and the Inquest and Coroner system in England and Wales.

Historically, in Scotland, administrative procedures existed where the procurator fiscal investigated, in private, all accidental or industrial deaths. That 'was thought preferable to [the English system]' with 'the vulgarities, the exposure, and the endless repetition of the Coroner's inquest' ((1893) 5 Jur. Rev. 266-267 quoted by Robert S Shields in *The opposition of lawyers to the introduction of fatal accident inquiries* 2014 SLT 179).

Legislation was first enacted with the Fatal Accidents Inquiry (Scotland) Act 1895 that set out the procurator fiscal's responsibilities in dealing with the investigation and initiation of such inquiries. His role came from his public interest duty to prosecute and exclude criminality:

> There being no coroner in Scotland it is the duty of the Sheriff and his PF [procurator fiscal] in cases where there is reason to suspect that any individual has met his death by violence or from any other natural causes, immediately to have the body examined by medical men and to take a precognition regarding the circumstances of the case.[3]

PART 2: LEGISLATION, PROCEDURE, TYPES, LOCATION AND ROLE OF A FAI

Legislation

The procedure governing inquiries currently being held is governed by the Fatal Accidents and Sudden Deaths Inquiry (Scotland) Act 1976. Recognising that Act is now 40 years old, the Minister for Community Safety and Legal Affairs, Paul Wheelhouse, brought forward the Inquiries into Fatal Accident and Sudden Deaths etc. (Scotland) Act 2016 indicating that:

> [The 2016 Act] will strengthen Fatal Accident Inquiry legislation and bring it into the 21st century, ensuring that inquiries are effective, efficient and fair…

The changes included in the 2016 Act adopt a number of the recommendations made by Lord Cullen in the *Report of findings of Review of Fatal Accident Inquiry Legislation* published in November 2009.[4] Much of the 2016 Act has still to come into force.

Procedure

Before a FAI can be held, there must be a death. A death that culminates in a FAI will have been a 'reportable death'; namely one that must be reported to the local Procurator Fiscal where the categories are wide, including, for example, deaths arising from suicide, accident, drowning, due to violent, suspicious or unexplained causes, related to abortion or attempted abortion and where the cause remains unknown.

The deaths relevant to the FAIs being discussed, occur as a result of a medical mishap and any death where a complaint is received which suggests that medical treatment or the absence of treatment may have contributed to the death.[5] Once such a death is reported, an investigation will be conducted by the COPFS, now by their specialist unit launched on 8 March 2011, known as the Scottish Fatalities Investigation Unit,[6] which provides expertise and specialist advice for all procurator fiscals.

To put the number of FAIs being held annually into perspective, according to Scottish Government statistics, over 11,000 deaths in Scotland are reported to the Procurator Fiscal. It states, on average, about 50–60 deaths per year will be the subject of a FAI. That does seem an unusually high number of FAIs. From September 2015 to September 2016, only 25 FAI determinations were published on the Scottish Courts website.[7] Determinations are normally all published although the website does indicate that:

> not all judgments are published. Only where there is a significant point of law or particular public interest will the details be published.

As will be seen from later discussion, that perhaps runs somewhat contrary to the ethos and public interest in holding FAIs.

Types

FAIs can be either mandatory or discretionary depending on the circumstances of the death.

Mandatory inquiries are held either under:

- Section 1(1) (a) (i) of the 1976 Act where it appears that the death has resulted from an accident occurring in Scotland while the person who has died, being an employee, was in the course of his employment or, being an employer or self-employed person, was engaged in his occupation as such.

The Lockerbie FAI was an example of a mandatory inquiry, despite the obvious criminal act in bringing down the plane, since the aircrew were employees of the airline, Pan American

or under:

- Section 1 (1) (a) (ii) the person who has died was, at the time of his death, in legal custody

Suicides, as well as prisoners dying of natural causes, are included under this category. The death of Sheku Bayoh who died while under police detention in Kirkcaldy will comprise a mandatory FAI in due course.

The COPFS has no discretion as to holding an inquiry even if there appear to be no lessons to be learnt from the death. Sheriff concern has been expressed in relation to 'the emotional trauma [that holding a FAI] caused to families of a deceased person'.[8]

Discretionary inquiries are held under:

- Section 1(1)(b) where it appears to the Lord Advocate to be expedient in the public interest that an inquiry under this Act should be held into the circumstances of the death on the ground that it was sudden, suspicious or unexplained, or has occurred in circumstances such as to give rise to serious public concern.

FAIs into medical deaths will be instructed under this discretionary category. Just because the death is reported does not mean the Lord Advocate will consider it is expedient, in the public interest or gives rise to serious public concern for a FAI to be held. How these factors are assessed is discussed under the role of the FAI.

Note that the distinction between the types of FAIs is to continue under the 2016 Act though the range of deaths in which a mandatory FAI must be held will be widened. It will include deaths of children in secure accommodation and deaths under police arrest regardless of location (section 2 of the 2016 Act). Deaths of Scots abroad will now be included. Previously, FAIs could only be held into deaths arising in Scotland. This is in contrast to England where the death of Princess Diana in Paris was the subject of a long running inquest in London.

Location

A doctor who is cited to a FAI may wonder at the location of the FAI. Traditionally, all FAIs were held at the sheriff court with the closest connection to where the death occurred. That is not necessarily as straightforward as it sounds.

Consider if there was a climbing accident on Ben Nevis. Medical treatment was administered locally. Specialist treatment followed at the Queen Elizabeth University Hospital, Glasgow. The patient died. The FAI would probably be held in Glasgow Sheriff Court. However, if the issues focused on the climbing aspects and/or the initial medical treatment at Fort William, for practical purposes such as the location of witnesses or relatives, it might be more expedient to hold the FAI in Fort William.

Sheriff courts may not always present the best venue for holding inquiries because they can be impractical; for example, the Lockerbie inquiry was held at the Crichton Royal Hospital, Dumfries. That was no doubt on account of the number of witnesses being heard and to accommodate and ensure appropriate facilities for the public (including relatives and press who were attending). Pressure on the courts' scheduling and space today, creates delay in holding FAIs if they must be held in the local court. Arrangements enabling FAI venues to be changed were previously piecemeal. Section 12 of the 2016 Act (in force September 2016) provides much needed flexibility over location.

ROLE OF THE FAI

What does public interest mean when considering if a FAI should be held into a medical death? By posing the following questions, some clarity is obtained.

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Are issues of patient safety involved?

The primary purpose of a FAI is to promote safety in the public interest by having public inquiries into deaths [Lord Advocate, Petitioner 2007 S.L.T. 849]. They are therefore described as 'expense neutral', as the public purse bears the costs incurred by the procurator fiscal in representing the public. Were cost to be a consideration in holding a FAI, one might venture to suppose that few would ever be instructed in the public interest. In 1991, the Lockerbie Inquiry ran for 61 days and cost £3m. Inevitably, FAIs involving medical issues will require the attendance of a number of expert witnesses and reports. Consequently, they are not cheap or short in duration, given the complexity and nature of the medical evidence. Indeed, the FAI into the death of Sharman Weir involved six UK expert consultants in the pre-eclampsia field and ran for 43 days.[9]

What are the families' views?

The families' views on the holding of a FAI will be considered by the COPFS but are not paramount to the decision which is made at the discretion of the Lord Advocate [paragraph 29 *Emms v Lord Advocate [2011] CSIH* 7].

Families will have had the outcome of the investigation into the death explained to them, including the experts' opinion, specifically addressing any issues worthy of exploring in the context of a FAI. The COPFS has provided useful information about procedures in its Family Charter: Charter to Bereaved Relatives: Access to Information and Liaison with the Procurator Fiscal in the implementation of section 8 of the 2016 Act.[10]

Families need to understand the role of a FAI. At the FAI's conclusion, usually at a later date, a written determination must be issued by the sheriff. The framework of which is set out under section 6(1) of the 1976 Act where, in every FAI, the sheriff must state that the following circumstances have been established to his satisfaction as to (a) where and when the death and any accident resulting in the death took place and (b) the cause or causes of such death and any accident resulting in the death (sometimes referred to as 'formal findings').

The sheriff may go on to make further findings if he is satisfied on the evidence presented under section 6(1) of the 1976 Act that there were (c) reasonable precautions, if any, whereby the death and any accident resulting in the death might have been avoided, (d) defects, if any, in any system of working which contributed to the death or any accident resulting in the death and (e) any other facts which are relevant to the circumstances of the death (sometimes referred to as 'discretionary findings' since the sheriff may not make such findings). Anecdotally, it is suggested only one third of all FAIs result in such discretionary findings being made.

The families' concerns are inevitably motivated by them wanting answers as to why the death occurred. The FAI into Alison Hume's non-medical death in a mineshaft in 2008 illustrates the effects that a determination in a FAI can have. Health and safety rules had delayed her rescue for six hours, which were held as factors 'accelerating' her death. New safety measures, including line rescue training, are now in place. Community Safety Minister, Roseanna Cunningham, indicated following that FAI 'lessons have been, and will continue to be, learned from the tragic event'.[11]

When the Lord Advocate makes a decision not to hold a FAI, that decision can be very upsetting for the family. That may tend to be based on an unrealistic understanding and expectation of what the FAI is about and can achieve. Sheriffs have made a number of comments about the role of medical FAIs:

The interests of a particular family does not necessarily coincide with the public interest Sheriff Principal Sir Stephen ST Young Bt QC in the Inquiry into the circumstances of the death of Mrs Eileen Peterson at Lerwick (10 July 2006) stressed the need to balance the various interests between the family and the medical staff. Medical professionals whose actions were under scrutiny needed to continue working and caring for patients. This subjected them to 'the strain inevitably associated with the prospect of having to give evidence at a [FAI] and perhaps being made the subject of any public criticism at the end…'[12]

Medical deaths must be viewed in context The case of *Emms* involved an unsuccessful judicial review by the deceased's mother of the Lord Advocate's refusal to hold a FAI. She had claimed that there had been 'possible' systemic failure by hospital employees which had caused or contributed to his death.

Her 49-year-old son had a complicated medical history. On arrival in hospital, he was admitted to hospital and fed artificially. A percutaneous endoscopic gastrostomy was inserted. He died the following week. All investigations by the pathologist, the internal Trust review and the independent consultant gastroenterologist, concluded that there had been no problem with the care provided to the patient, clinical decision making or the percutaneous endoscopic gastrostomy insertion. The Lord Advocate considered that nothing further would be achieved in holding a FAI.

Doctors are not in:

> the business of killing people. Sometimes things go wrong…because hospitals are institutions staffed by human beings, however well trained and competent the staff may be. If such mistakes are made, the person, or persons, responsible may be sued in a civil litigation. But such occurrences, however

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> understandably distressing they may be to the relatives of the persons who die as a result, do not raise questions of public concern unless something has apparently gone quite seriously wrong, which is indicative of not just a one-off situation, or a single example of error of judgment, or carelessness, but is of such a nature that gives concern that the system and procedures in operation at the hospital were so deficient that there may have been a number of deaths attributable to them or, that if these deficiencies are not addressed, there may be more deaths in the future. (*Emms* (paragraph [27] pp 453)

The family has a right to know why their relative has died, to be informed of the conclusion of any investigations and to be provided with access to the medical records. The independence of the COPFS' investigation in this regard cannot be over-stressed. Any concerns expressed by the family justifying the public interest in holding a FAI must be founded on the basis of relevant evidence and not conjecture. In considering the facts and circumstances of each case, possible allegations of medical negligence may well arise. That potential action lies in a different forum but of its own, does not justify a FAI. The public interest in FAIs is wider, aimed at systemic failures or personal negligence but, crucially, where changes were not made, other deaths might follow.

FAIS are not a general inquiry into procedures, irregularities, acts, or omissions of an organisation Sheriff DJ Leslie confirmed that the scope of a FAI is an exercise in finding the facts that contributed or caused of the death.[13] The sheriff's determination stated (a) that Gordon Greig…died at the Vale of Leven Hospital, Alexandria, on 2 March 2007 at 20:45 hours and (b) that the cause of death was haemopericardium due to acute myocardial infarction due to coronary artery thrombosis. No discretionary findings were made under paragraphs (c), (d) or (e).

The death was only investigated at the instigation of the deceased's wife. The patient had died at the Vale of Leven Hospital (where his death was recorded). That death was not linked to his earlier presentation at the Royal Alexandra Hospital, Paisley, six days previously whose treatment formed the basis of the inquiry. Making the link between an admission at the Royal Alexandra Hospital and the death might be significant in the advancement of medical education. However, it was not a matter for the FAI, which was concerned only with circumstances whereby Mr Greig's death might have been avoided.

There is a perception by the families is that no stone should be left unturned FAIs are neither criminal nor civil proceedings (described as being in a class of their own (*sui generis*)). They are inquisitorial in nature and not adversarial. Representation for parties such as the family interested in a FAI is optional. In any event, the deceased's relatives will be the first witness at the FAI to allow them to set out their concerns. They can then take their place in court to hear the remainder of the inquiry. The concerns spoken may or may not be warranted.

There is no power in a FAI to apportion blame This is well known (*Black v Scott Lithgow* 1990 S.L.T. 612 at pp 615). Sheriff Derek CW Pyle, at the inquiry into the circumstances of the death of Michael Dodds at Dundee (11 August 2009),[14] recognised that FAIs had limitations. Their purpose was not to find fault but elicit facts. '[Later] litigation [can be pursued] where the normal rules apply of advance notice in writing of each party's case and control of the manner evidence is presented to the court'. The deceased's family may well be disappointed 'that blame has not been apportioned'.

FAIs have distinct roles; they are not designed to be an encompassing inquiry into a death nor offer panaceas to the relatives. FAIs explore the facts at issue in determining if the death could have been avoided. Better awareness for all concerned in the process/procedure of FAIs would engender and promote their more efficient use.

CONCLUSION

Doctors should be aware of the role of medical-type FAIs. Not every medical death will result in a FAI; potentially, any medical death could, as the categories of death involved in a FAI are open-ended. Medical FAIs will be dominated by public sector and the NHS, though the private health service is not exempt from such inquiries.[15]

FAIs are independent of all interested parties and held in the public interest. FAIs are quite different in procedure from an inquest; for instance, there is no jury or verdict. Doctors may fear that evidence given at a FAI could incriminate, resulting in disciplinary or negligence action. A FAI will not prevent such proceedings but should be seen as a quite separate and distinct process.

FAIs 'are armed with the benefit of hindsight, the evidence led at the Inquiry and the Determination of the Inquiry, [that] may be persuaded to take steps to prevent any recurrence of such a death in the future'. (Sheriff Reith: Inquiry into the circumstances of the death of Sharman Weir, supra).

The determination should be publicly available for all to see, but any recommendations currently made by the sheriff are not legally binding. Until section 28 of the 2016 Act comes into force, there are no monitoring or follow up requirements to ensure that individuals or organisations explain how they have implemented any recommendations issued by a sheriff after an FAI, or why none have been implemented.

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There is naturally considerable public interest in FAIs; for example, the Glasgow Bin Lorry case. With the monitoring of recommendations in future, this will enable more public scrutiny with an audit to see if recommendations have been implemented, if required. More opportunities will be provided to learn and give effect to lessons learnt through the FAI mechanism.

What must be remembered at all times is that the death was a bereavement to someone. Sympathy and condolence for the loss, irrespective of the nature of the death, must remain at the forefront of the FAI while meeting the public interest in inquiring into the issues surrounding that death.

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