Healthcare Improvement Scotland | Inspections and reviews To drive improvement

CROWN OFFICE & PROCURATOR FISCAL SERVICE
SCOTLAND'S PROSECUTION SERVICE

care inspectorate

National hub for reviewing and learning from the deaths of children and young people

Consideration of parallel or other review processes and investigatory proceedings

1. The National Hub aims to ensure that the death of every child in Scotland is subject to a quality review. Within and across NHS boards, local authorities and partnerships, various processes are already in place to review child deaths, with each having a distinct purpose (see national guidance Appendix 1). In some cases, reviews will be subject to separate statutory guidance, with prescribed timescales and reporting channels to adhere to. Most child death reviews will align to one of these existing review processes; however, there may be times when the circumstances of a child's death may merit consideration of more than one type of review. Wherever possible, a **single review** of the child's death should be conducted to minimise any associated stress or anxiety of bereaved family members or the staff who cared for or supported the child. It will therefore be important that organisations and relevant partnerships such as the child/public protection committees, consider and agree together the most appropriate approach to follow to minimise any potential duplication or overlap. This may require consideration of a 'blended' approach to a review whereby those with a legitimate interest in differing review processes work together to plan their approach, optimise and share learning in real time. Consideration should also be given to which organisation/partnership should complete the core review dataset.

2. While no one process is inherently more important than others, and therefore expected to automatically take precedence, where there are ongoing criminal proceedings or a Fatal Accident Inquiry (FAI) in contemplation, the Crown Office and Procurator Fiscal Service (COPFS) will always have primacy. In these cases, to establish what status your review should have relative to other formal investigations, early and ongoing dialogue must take place with Police Scotland, COPFS or others to determine how far and how fast a review process can proceed. This should ensure that parallel processes are pre-planned and that any changes in status of a child's death are shared. Issues to consider should include:

    - how to link processes
    - how to avoid witness contamination
    - how to avoid duplicate information being collected
    - whether to postpone a review (if a parallel process is running), and wait for the determination of the parallel proceedings

3. Where a case is subject to police investigation or court proceedings, these should not inhibit the setting up of a review nor delay immediate remedial action being taken to improve services. It is important that the purpose of the review process, which is to support professional and organisational learning, is understood and remains the focus.

4. National guidance to support child protection committees and adult protection committees undertaking a learning review[1] [2] provides helpful direction for those involved in reviews when parallel processes may be necessary. Both sets of guidance set out key principles that will apply to all circumstances where there are ongoing criminal proceedings or the likelihood of a FAI. A national protocol for the Police Service of Scotland, COPFS and Child Protection Committees (included as Appendix 2 within the national guidance) provides a framework for conducting learning reviews when criminal prosecutions, FAIs or investigations with a view that such proceedings are running in parallel; and for the sharing and exchange of relevant information generated by each process.

5. Once a decision has been made to hold a child death review, communication can be made with COPFS through the Scottish Fatalities Investigation Units (SFIU) in the East, West or North of Scotland. The chair of the review (or named designate) should be the single point of contact for all communication with SFIU.

   SFIUWest@copfs.gov.uk
   G Division – Glasgow
   U Division – Ayrshire
   Q Division – Lanarkshire
   L, K and V Division – Argyll & Clyde, Dumfries and Galloway

   SFIUEast@copfs.gov.uk
   E Division - Edinburgh
   C Division - Forth Valley
   P Division - Fife
   J Division - Lothian
   J Division - Borders

   SFIUNorth@copfs.gov.uk
   A Division – Grampian, Aberdeen, Aberdeenshire and Moray
   N Division – Highland and Islands
   D Division – Tayside (Perthshire, Angus and Dundee areas)

[1] Scottish Government 2021. National Guidance for Child Protection Committees undertaking a Learning Review

[2] Scottish Government 2022. National Guidance for Adult Protection Committees undertaking learning reviews.

6. **The role of the Crown Office and Procurator Fiscal Service (COPFS)**

As the head of the systems of criminal prosecution and investigation of deaths in Scotland, the Lord Advocate has responsibility for the investigation of all sudden, suspicious and unexplained deaths. This includes the sudden, suspicious and unexplained deaths of children. The purpose of the investigation of a child death is to eliminate the risk of undetected homicide, to identify preventable dangers to life and to the health and safety of children, to allay public anxiety, to restore public confidence, to assist in the maintenance of accurate statistics and to secure and preserve evidence. A child death investigation may result in a prosecution and/ or a Fatal Accident Inquiry in terms of the Inquiries into Fatal Accidents and Sudden Deaths etc (Sc) Act 2016, although not every investigation will result in any court proceedings.

A Fatal Accident Inquiry (FAI) is a type of court hearing in Scotland held in public which enquires into the circumstances of a death. It is presided over by a Sheriff in the Sheriff Court. It is mandatory if the death is as a result of an accident whilst at work or if the death happened whilst in legal custody. FAIs can also be held at the discretion of the Lord Advocate where the circumstances give rise to serious public concern.

The form of the investigation will vary on a case-by-case basis. All investigations require to be independent, effective, reasonably prompt, open to a sufficient element of public scrutiny and one in which the next- of- kin are involved to an appropriate extent. COPFS must consider that every child has the right to life and, to the maximum extent possible, the survival and development of the child should be ensured. Some of the significant factors that COPFS take into account in child deaths investigations are:

- whether there are steps that could reasonably have been taken, and had they been taken, might realistically have resulted in the death, or any accident resulting in the death, being avoided; and
- any defects in any system of working which contributed to the death or any accident resulting in the death.

It is also important for COPFS to have information on any remedial action that has been taken in response to the death and any action plan arising. A robust, timely review of any death will assist in informing COPFS when deciding to make representations to the Lord Advocate as to whether a discretionary FAI should be considered. COPFS may, in certain circumstances, instruct independent experts to review the case overall and consider any review and action plan.

7. Healthcare Improvement Scotland has agreed with COPFS to share the learning points from particular reviews into deaths more widely across NHS Scotland, in order to facilitate national learning and improvement. This process can be of considerable assistance where, for example, an NHS Significant Adverse Event Review (SAER) or Crown-instructed expert report, identifies systemic failures in systems or processes.

By sharing details of those failings as well as any changes to processes by way of a Learning Summary, COPFS can be reassured that that learning has been made known to all the NHS boards in Scotland rather than just the one where the death occurred. In previous cases, this has allowed COPFS to provide confirmation to Crown Counsel (senior legal advocates acting for the Crown) that the changes intended to prevent future similar deaths have been disseminated throughout Scotland and to recommend that no discretionary FAI is required to be instructed to highlight those issues as a result.

8. If COPFS have any cases where the publication of a Learning Summary may be suitable, they are to email his.adverseevents@nhs.scot with brief details of the circumstances. HIS will then discuss with COPFS whether a Summary would be appropriate and, if so, request further information to enable a Summary to be drafted.

The importance, therefore, of a review which thoroughly examines the circumstances surrounding the death and identifies any lessons to be learned to prevent similar deaths could obviate the need for a Fatal Accident Inquiry at a later date. The focus of these reviews is entirely on learning and neither the review nor a FAI seeks to apportion blame to any individual.

Due to the review potentially having a bearing on whether a FAI is held (at the Lord Advocate's discretion) and to maintain that degree of independence, COPFS would not be involved directly in review meetings due to the potential conflict should the death result in a prosecution and/or a Fatal Accident Inquiry.

As reassurance, however, COPFS ask a Victim Information and Advice Officer (VIA) Officer to engage with nearest bereaved relatives of deceased children usually a few weeks after death to explain their role in investigating the death, possible outcomes and thereafter keep families advised of progress every 6 weeks, if they so wish. These VIA Officers can be contacted by those involved in reviews using the same email addresses above.

Once the review is shared with SFIU, it allows for such things as instruction of an expert view in respect of matters which may inform the need for a FAI. The objective of a Fatal Accident Inquiry can be found under s26 of the Inquiries into Fatal Accidents and Sudden Deaths etc (Sc) Act 2016 (Appendix 1).

Acknowledgements
This guidance was informed by:

- National Guidance for child protection committees undertaking learning reviews (2021)
- National Guidance for adult protection committees undertaking learning reviews (2022)
- National Hub Guidance – when a child or young person dies (2021)

Appendix 1: s26 of the Inquiries into Fatal Accidents and Sudden Deaths etc (Sc) Act 2016.

Section (1) As soon as possible after the conclusion of the evidence and submissions in an inquiry, the sheriff must make a determination setting out—

(a) in relation to the death to which the inquiry relates, the sheriff's findings as to the circumstances mentioned in subsection (2), and

(b) such recommendations (if any) as to any of the matters mentioned in subsection (4) as the sheriff considers appropriate.

(2) The circumstances referred to in subsection (1)(a) are—

(a) when and where the death occurred,

(b) when and where any accident resulting in the death occurred,

(c) the cause or causes of the death,

(d) the cause or causes of any accident resulting in the death,

(e) any precautions which—

> (i) could reasonably have been taken, and
>
> (ii) had they been taken, might realistically have resulted in the death, or any accident resulting in the death, being avoided,

(f) any defects in any system of working which contributed to the death or any accident resulting in the death,

(g) any other facts which are relevant to the circumstances of the death]