

# A Guide to Fatal Accident Inquires for Health and Social Care Staff



# A guide to fatal accident inquires for health and social care staff

This document is a practical guide to Fatal Accident Inquiries (FAIs) for health and social care staff.

It provides an overview of the process, emphasises the need for staff support, outlines what happens in court and provides advice on how staff can prepare and be supported.

Taking part in an FAI can be stressful. Staff can find their actions questioned and challenged in an environment that can feel alien and sometimes hostile. Making sure all staff understand what is involved in advance will not only reduce anxiety, but also help staff and organisations prepare and learn from the experience.

This document does not include legal advice – this should be obtained from the legal profession or professional defence union.



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# 1. Overview of an FAI

An FAI is a legal process, unique to Scotland, that seeks to establish the circumstances of an unexpected, unexplained, suspicious, or sudden death. It also considers several factors such as the place, date, and time of death as well as the cause of death. The FAI procedure is governed by the <a href="Inquiries into Fatal Accidents and Sudden Deaths etc.">Inquiries into Fatal Accidents and Sudden Deaths etc.</a> (Scotland) Act 2016.

The purpose of an FAI is to determine how the death occurred and identify any measures that may have prevented that death and may prevent future deaths in similar circumstances. Specifically, an FAI seeks to identify what lessons can be learned to avoid a repeat of errors, omissions, or system failures that caused or contributed to the death. Thus, the aim of an FAI is not to apportion blame or to establish civil or criminal liability. That remains for the civil or criminal courts or indeed any disciplinary or regulatory processes which may also follow.

The decision whether to hold an FAI is considered by the procurator fiscal and will be taken by Crown Counsel acting on behalf of the Lord Advocate. The Scottish Fatalities Investigation Unit (SFIU) is a specialist team in the Crown Office and Procurator Fiscal Service (COPFS) responsible for investigating deaths. SFIU investigates all sudden, suspicious, accidental, and unexplained deaths. Contact details of SFIU hubs are available here.

COPFS also has several other specialist death investigation teams who may be responsible for conducting FAIs - the Health and Safety Investigation Unit (HSIU), COVID Deaths Investigation Team (CDIT) and the Custody Deaths Unit (CDU).

FAIs are not usually held until a decision has been taken on whether there should be criminal proceedings. The same rules apply to FAIs investigating a single death as to those investigating a major incident where a number of deaths have occurred.

Once the circumstances of the death have been investigated, they may either give rise to a mandatory or a discretionary FAI as outlined below.

In England and Wales, a similar process is carried out through an inquest under the coroner's system.



# 1. Overview of an FAI

An FAI may be either mandatory or discretionary depending on the circumstances of the death.

#### **Mandatory FAIs:**

<u>Section 2 of the 2016 Act</u> sets out the circumstances where a mandatory inquiry is required 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
- or where the person who has died was, at the time of his death, in legal custody
- or where the death is of a child required to be kept or detained in secure accommodation

<u>Section 6 of the 2016 Act</u> sets out new provisions that an FAI can be held into a death abroad. Whilst a number of investigations have been conducted, as of 2023 no such FAI has yet taken place.

<u>Section 7 of the 2016 Act</u> also sets out information about FAIs being held into service deaths abroad. Mandatory FAIs will tend to relate to prison deaths, suicides and indeed natural deaths or deaths in police custody and those in the course of employment.

#### **Discretionary FAIs:**

<u>Section 4 of the 2016 Act</u> sets out the requirements for discretionary inquiries. These are held into the circumstances of a 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 and that the Lord Advocate decides that it is in the public interest to hold an FAI.

Discretionary FAIs will relate to all sorts of circumstances – e.g. those that are medical and road traffic accident deaths. A good source of recent FAI reports can be found on the Scottish Courts and Tribunals Service **website**.

Table 1 2019 – 2023 Breakdown of concluded FAIs (i.e. cases where the evidence has concluded) between mandatory and discretionary FAIs<sup>1</sup>.

Reporting Year	Number of concluded FAIs	Mandatory FAIs	Discretionary FAIs	FAIs for multiple deceased where both mandatory and discretonary
2019/2020	57	55	1	1
2020/2021	58	55	3	0
2021/2022	42	38	4	0
2022/2023	51	41	10	0

<sup>5</sup> 

# 1. Overview of an FAI

#### 1.2 Timing of an FAI

The gap between the decision to hold an FAI and the date when the FAI commences can be a long one - it is likely to be at least several months but can be several years. In most inquiries, the sheriff will ask for a 'preliminary hearing' before the FAI begins. The preliminary hearing is a chance for the sheriff to find out who will be taking part in the FAI and what the issues are for the inquiry to consider. Witnesses do not attend these preliminary hearings.

#### 1.3 Who attends an FAI

The sheriff presiding over the FAI, the procurator fiscal depute (who is responsible for conducting the FAI), legal representatives of the parties appearing at the FAI, and fellow health and social care professionals. The families of the deceased will often attend the inquiry, and FAIs may also involve members of the public as witnesses.

It is likely that the media will also be in attendance, if not in person they will likely report on the determination, which is the conclusion to the FAI once it is published.

#### 1.4 Location of an FAI

<u>Section 12 of the 2016 Act</u> sets out where FAIs may be held, which is generally in sheriff court buildings.

However, an FAI may be held in another appropriate building (e.g., within a hospital). The geographical location of an FAI may be flexible to accommodate the location of witnesses and availability of premises.

Since the Covid 19 pandemic, it has been possible to conduct FAIs online. That remains an option post-pandemic.

#### 1.5 Family liaison charter

<u>Section 8 of the 2016 Act</u> sets out that the Lord Advocate must prepare a family liaison charter. This is a document setting out how the procurator fiscal will liaise with the family of a person in relation to whose death an inquiry may or is to be held. In particular, the charter must set out:

- information to be made available to the family
- + timescales for the giving of the information

#### 1.6 Decision not to hold an FAI

<u>Section 9 of the 2016 Act</u> sets out the circumstances of where, if it is decided that an inquiry is not to be held into the death of a person, the Lord Advocate must give reasons in writing if requested to specific family members, partners or nearest known relative(s).

## 2. Before an FAI

#### 2.1 Recognising the need for staff support

Whilst preparing for, and giving evidence at an FAI, health and social care staff may need assistance professionally, pastorally, and emotionally. There are many different types of support available, and it is important to have access to these. At an organisation level, information regarding a central point of contact should be made available to staff to coordinate this.

Employing organisations may offer access to spiritual care / chaplaincy services and may also offer access to a dedicated counselling service. These services can provide an opportunity for staff to talk through their concerns in a safe and confidential environment alongside trained, impartial and understanding listeners.

As a colleague of someone involved in an FAI, it is good to take the time to check up on their wellbeing to help make them feel valued, at a time when they are likely to be feeling increasingly vulnerable or insecure.

It is also important to remember that support can be found within personal networks of friends and family. They are likely to be concerned and keeping them informed of the progress of the FAI may help address their anxiety.

#### 2.2 Dealing with traumatic experiences

It is quite common for staff who have been exposed to stressful or traumatic incidents to develop a range of reactions and post-trauma symptoms, some of which may be distressing and disabling. Both in the short and longer term, the individual's wellbeing and performance may be severely affected. An FAI can be one of these traumatic incidents, especially if an individual is a central figure to the investigation.

The nature of the investigation may cause feelings of personal blame. Health and social care staff who may come under intense scrutiny might experience feelings of guilt, anxiety and shame which can take their psychological toll. It should be remembered that FAIs are factfinding and inquisitorial and not held to find fault or to place blame with an individual.

More information can be obtained from the appropriate defence body or union. There are also links to resources in <u>Section 5</u> regarding Psychological First Aid (PFA), and Trauma Informed Justice that may be helpful.

## 2. Before an FAI

#### 2.3 Internal organisational investigation

There may also be an internal review carried out by the NHS or Local Authority organisation into the circumstances of any death which give cause for concern. An FAI is about fact-finding and isn't an adversarial process so there aren't the same restrictions as there would be in a criminal trial.

However, the same principles apply as per a criminal trial that there shouldn't be discussions with witnesses which involve trying to change or restrict the evidence that they are going to give.

#### 2.4 Precognition

<u>Section 10 of the 2016 Act</u> sets out certain circumstances where the procurator fiscal may cite a person to attend for precognition in connection with an investigation. Precognitions are important as they provide the basis on which the procurator fiscal will ascertain the relevant background information.

Where a witness who is cited for precognition fails to attend without reasonable 'excuse', or refuses to give information within their 'knowledge', an application to the sheriff can be made to require them to attend. Failure to comply with the order of attendance is a criminal offence.

Solicitors acting for parties represented at the inquiry may also ask witnesses for precognitions in advance of the hearing. Unlike a request from a procurator fiscal, it is not obligatory to provide a precognition to other solicitors, but it is generally sensible to cooperate if requested.

#### 2.5 Preliminary hearing

Section 16 of the 2016 Act requires that at least one preliminary hearing is to be held unless this requirement is dispensed with by the sheriff. Preliminary hearings are used to consider the scope of the FAI, to identify which issues are in dispute, and to consider the information likely to be presented. Any number of preliminary hearings in relation to an FAI may be held. Witnesses do not attend these hearings.



# 3. During an FAI

#### 3.1 Providing evidence

The sheriff can determine the way evidence is to be provided, e.g., by:

- + oral presentation or written statement
- + the production of documents
- live link video recording

In FAIs, evidence that has not been corroborated and hearsay evidence are both admissible. The standard for facts to be proven is on the balance of probabilities.

Section 20 of the 2016 Act contains the important provision that examination of a person at an FAI does not prevent criminal proceedings being taken against that person. However, a person giving evidence at an FAI is not require to answer a question tending to show that the person is guilty of an offence. If you are concerned about this, you should seek legal advice or contact a professional defence organisation.



# 3. During an FAI

#### 3.2 Answering questions

Any clinical practice or care records will have been lodged with the court as they will have been requested in advance of the case.

A witness should however highlight if they are aware that there are other notes or records which are not available at the FAI, but may assist in being able to answer questions asked, or understand the circumstances surrounding the death. It would then be for the parties to the FAI and the sheriff to decide whether that material should be obtained.

Witnesses will need to familiarise themselves with the files and records in relation to the incident and consider what decisions were taken, when and why. Consideration should also be given to any factors which may have had a bearing on the death and how to respond to questions about these.

To the extent that it is within their knowledge, witnesses will be expected to give evidence on the seven points listed in **s4.1** (**below**). The questioning is led by the procurator fiscal, who represents the public interest. Questions can then follow from any other party represented at the FAI which may include:

- + A lawyer representing the deceased's family (if they have chosen to appoint legal representatives)
- Lawyers representing the NHS/healthcare or social care organisation

+ The legal representatives of any individuals or other organisations who have chosen to be represented in their own right

Listen carefully to the questions and take time to consider responses. Water is usually on the stand so take a drink during pauses or if needing a moment to consider the answer to be given.

Do not feel pressured to give a "yes" or "no" response. Where points cannot be remembered or are unknown, say so – do not try to guess. If a question has multiple parts, break down the answer. If there is uncertainty about a question, ask for it to be repeated.

Generally, there will be questions on the witness's identity, qualifications and experience, and place of work, before going into the specific circumstances surrounding the death.

Evidence is normally given standing up; if there is a need to sit, the bar officer should be asked to inform the sheriff. Be calm, courteous, and honest and remain objective. Speak clearly and concisely, focus on the question at hand, and be ready to confirm your evidence from notes taken at the time. Try to keep answers concise, avoiding 'rambling' or talking for too long after the issue has been sufficiently covered.

#### Tips for answering questions

#### Do:

- + prepare in advance and be fully familiar with the facts / issues in the case
- + take a senior manager or colleague with you (this cannot be someone else involved in the FAI unless they have already given evidence themselves)
- + arrive in good time for your case, you may require to go through metal detectors/security when entering the building
- + switch off your mobile phone before entering the courtroom and keep it switched off throughout the proceedings
- + ask if you can sit down if this would be helpful to you
- + stick to the facts and be clear in what you say do not make assumptions about what other people did or did not do
- where medical terms are used follow these with a layman's explanation of the term so that all those present and unfamiliar with the term will be able to understand
- + be polite and courteous to the sheriff, other court users and court officials
- + give detailed and relevant answers

- be ready and willing to expand and explain your answers if requested
- + be ready and willing to see the argument in opposing views but be firm and clear about your own evidence
- be prepared for delays, take a snack and some bottled water as you may be waiting some time
- + ask to take a break if needed



#### Tips for answering questions (cont.)

#### Don't:

- expect to be able to work whilst waiting. It is not always possible to get an internet connection and sensitive information cannot be viewed if in a room with others. For the same reason, private calls might not be achievable as sometimes several witnesses will be waiting in the same room
- + be arrogant, impatient, patronising, rude, or argumentative
- + react emotionally
- + be too suggestible or allow yourself to be easily led by a line of questioning
- + appear uncertain
- + smoke, eat or drink in court
- + make audio or video recordings or take photographs in the courtroom unless you have the court's authority to do so



# 3. During an FAI

<u>Section 21 of the 2016 Act</u> provides that the FAI should be conducted in public (although it may be held in private at the discretion of the sheriff). Public notice must be given of the fact that an FAI is to be held (e.g., via the Scottish Courts and Tribunals Service, newspapers, social media).

As it is a public event, be prepared to see journalists and for them to be present in court. Media interest should be managed at organisational level, and it is best to avoid being drawn into making comment at any time to journalists about the circumstances of the FAI.

Media reports are selective, and coverage can be biased. It is best to avoid reading or listening to media reports, if possible, as it can be stressful and frustrating. Media reporting may even result in individuals feeling they are being blamed unfairly for circumstances relating to the death. If this happens, seek support and advice from employers, defence body or union, as well as family and friends.



## 4. After an FAI

#### 4.1 The Sheriff's determination

As soon as possible after the conclusion of the evidence and submissions in an inquiry, the sheriff's determination will be made available and published on the <u>Scottish Courts and Tribunals Service website</u>.

A copy of the sheriff's written determination is usually given to the main parties involved in the inquiry, including the deceased's family, in advance of it being made public. This is a courtesy to help those involved consider the findings and prepare any reaction, such as potential statements to the media.

<u>Section 26 of the 2016 Act</u> explains the determination which includes detail such as:

- + when and where the death occurred
- + when and where any accident resulting in the death occurred
- + the cause or causes of the death
- + the cause or causes of any accident resulting in the death
- + any precautions which
  - could reasonably have been taken
  - had they been taken, might realistically have resulted in the death, or any accident resulting in the death, being avoided

- + any defects in any system of working which contributed to the death or any accident resulting in the death
- + any other facts which are relevant to the circumstances of the death

Importantly, the process is a fact-finding one, not a fault-finding one. Although the determination may include criticism of parties from which a basis for alleging fault may be inferred, it cannot be founded upon in any judicial proceedings of any nature - either civil or criminal.



## 4. After an FAI

#### 4.2 Sheriff's recommendations

Section 26 of the 2016 Act indicates that the sheriff may also make recommendations if they feel it is appropriate. A recommendation may (but need not be) addressed to (a) a participant in the inquiry or (b) a body or organisation. Recommendations may focus on:

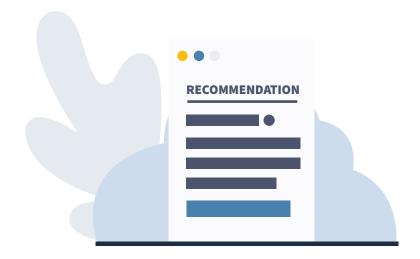
- + the taking of reasonable precautions,
- + the making of improvements to any system of working,
- + the introduction of a system of working,
- + taking of any other steps which might realistically prevent other deaths in similar circumstances.

The purpose of making recommendations is to reflect the lessons learnt and to prevent deaths arising in similar circumstances in the future. Recommendations can be made to organisations or individuals. If the sheriff makes a recommendation, then a formal response needs to be prepared by a body or organisation, within eight weeks, detailing an action plan to prevent recurrences. However, a response only needs to be provided by an individual person if they were a participant in the Inquiry see section 28 (1) of the 2016 Act.

#### 4.3 Further inquiry proceedings

<u>Sections 30 to 34 of the 2016 Act</u> stipulate that in certain circumstances, where an inquiry into the death of a person has ended, further inquiry proceedings may be held in relation to the death where there is new evidence in relation to the circumstances of the death, and the Lord Advocate:

- + considers that it is highly likely that a finding or recommendation set out in the determination would have been materially different if the evidence had been brought forward at the inquiry, and
- + decides that it is in the public interest for further inquiry proceedings to be held in relation to the circumstances of the death.



### 5. Resources

#### 5.1 Staff support and wellbeing

National Wellbeing Hub Home - National Wellbeing Hub

NHS Education for Scotland Psychological First Aid

NHS Education for Scotland Staff Wellbeing - <a href="https://learn.nes.nhs.">https://learn.nes.nhs.</a> scot/37897

NHS Education for Scotland (2023) Trauma Informed Justice: A Knowledge and Skills Framework for Working with Victims and Witnesses.

#### 5.2 FAI legislative and process information

Crown Office and Procurator Fiscal Service: Information for Bereaved Relatives <a href="https://www.copfs.gov.uk/investigating-deaths/deaths">https://www.copfs.gov.uk/investigating-deaths/deaths</a>

2016 FAI legislation <u>Inquiries into Fatal Accidents and Sudden Deaths</u> etc. (Scotland) Act 2016 (legislation.gov.uk)

Scottish Fatalities Investigation Unit: <u>Contact us about a death investigation</u>.

#### **5.3 Suggested further reading**

Mawdsley G (2023) Sudden Deaths and Fatal Accident Inquiries in Scotland: Law, Policy and Practice. Bloomsbury Publishing.

Mawdsley G (2016) Fatal Accident Inquiries: raising awareness of their role in relation to the medical profession in Scotland. J R Coll Physicians Edinb; 46: 254–9.



### APPENDIX FAI Summary checklist

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he inquiry

#### **APPENDIX FAI Summary checklist**

# Media handling checklist

- + Understand that there are likely to be journalists present. Ask someone to support you if you attend court
- + Avoid making any comment to the press
- + Ask your organisation to manage the media interest
- + Try not to read or listen to any coverage during the FAI
- + Seek legal advice if you or your organisation is misrepresented

#### After the outcome

You / Your organisation will:

- Facilitate / engage with psychological first aid / support
- Take the time to read through the determination
- Consider and discuss any recommendations
- Prepare a response plan to prevent future similar accidents

This resource may be made available, in full or summary form, in alternative formats and community languages. Please contact us on **0131 636 3200** or email **altformats@nes.scot.nhs.uk** to discuss how we best meet your requirements.

For more information: www.sad.scot.nhs.uk or contact supportarounddeath@nes.scot.nhs.uk



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