Inspectorate of Prosecution in Scotland

# Thematic Report on Health and Safety Division

Follow-up



August 2015

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#### **Chief Inspector's Foreword**

The thematic review of the Health and Safety Division (HSD) was published by the Inspectorate of Prosecution in Scotland (IPS) in April 2013.

The impetus for the review was two-fold; the increasing profile of health and safety crime and the creation of a specialist division to investigate and prosecute all health and safety offences reported to the Procurator Fiscal, including those that resulted in fatalities.

The establishment of HSD was an early example of specialisation that has been promoted by the Law Officers. Recognising the increased profile of health and safety crimes and the complexity of many health and safety cases, HSD was established to work closely with law enforcement to bring a more strategic approach to the prosecution of health and safety cases and ultimately drive up safety standards in workplaces throughout Scotland through robust investigation and prosecution of those who failed to discharge their health and safety obligations.

Highlighting the increasing complexity of health and safety crimes, the report concluded that:

- the creation of a specialist unit was an appropriate and necessary response;
- cases prepared by HSD were of a high standard;
- there should be earlier consideration of the appropriate forum for all cases;
- the age profile of health and safety cases was of concern.

The review made 38 recommendations designed to improve the efficiency of HSD and reduce the age profile of health and safety cases.

We are encouraged by the substantial progress that has been made in implementing the recommendations and the improved effectiveness of HSD as evidenced by a number of indicators including a significant increase in the throughput of cases and positive feedback from agencies and representatives who have regular contact with HSD.

The thematic review highlighted issues with the reliability, accuracy and consistency of data held by HSD. During the follow-up review, we experienced similar difficulties. To address this concern we have made two new recommendations intended to improve the quality of data held by HSD and support the management and prioritisation of cases.

# Part 1: Introduction and Background

- 1. It is the practice of the IPS to conduct follow-up inspections in order to promote improvement and assess the effectiveness of recommendations and their outcomes.
- 2. This report details the findings of the IPS follow-up inspection of the Health and Safety Division Thematic Report, published in April 2013.
- 3. The first inspection of HSD followed the creation of a specialist division in 2009 to deal with health and safety cases. It comprises of specialist staff working in three geographically located teams in the North, East and West of Scotland, who work closely with the Health and Safety Executive (HSE), Local Authorities (LAs) and other investigating bodies such as the Air Accident Investigation Bureau.
- 4. The remit of the specialist division was to investigate and prosecute all health and safety cases providing advice, support and direction from the earliest stage of the investigation. The aim is to ensure that all health and safety related reports are prepared to the highest possible standard, that policy and practice in the investigation of such cases is applied consistently and that appropriate and timely decisions are taken throughout the life of these cases.
- 5. HSD is also involved in the preparation and conduct of Fatal Accident Inquiries (FAIs) arising from an accident in the course of employment or at a workplace which are deemed to require specialist input.
- 6. The aim of this follow-up review is to assess and report on the progress that has been made against our recommendations.

# Methodology

- Interviews with key personnel;
- Interviews with agencies and legal representatives who have regular contact with HSD;
- Review of guidance, practices, procedures and systems, protocols and policy;
- Review of case papers.

# Part 2: Progress against Recommendations

7. The report made 38 recommendations. We have rated Crown Office and Procurator Fiscal Service's (COPFS) response to each recommendation using the following:

Achieved – COPFS has completed what was required.

**Substantial Progress** – COPFS has made significant advancement in taking forward the recommendation.

**In Progress** – COPFS has taken some action to take forward the recommendation and there is ongoing work aimed at achieving the recommendation.

Not Progressed - COPFS cannot demonstrate any progress.

8. The table below sets out the recommendations and the actions taken by COPFS. We have grouped the recommendations according to the purpose or improvement they were intended to achieve.

# Role of Health and Safety Division (HSD)

- 1 We recommend that a written remit of HSD work is prepared and promoted throughout COPFS by being made available through the "intranet" and also to the reporting agencies. This should clarify which cases will be dealt with by HSD, which are dealt with by the Scottish Fatalities Investigation Unit (SFIU), which are to remain within the Federations for prosecution and how agreement about these issues are to be dealt with in "borderline cases". In particular this protocol should agree the division of duties in relation to deaths so all tasks are covered.
- 2 We recommend that the case marking guidelines, the Knowledge Bank and any other reference or guidance should be amended to direct appropriate cases to HSD. This should be clearly cross-referenced to the remit recommended above. Instruction and guidance about how these cases should be marked should also be included.
- 9. The aim of these recommendations was to provide greater clarity on the role and remit of HSD and ensure that health and safety cases were appropriately signposted to specialist prosecutors. The thematic report highlighted a lack of clarity between the Scottish Fatalities Investigation Unit (SFIU) and HSD on which team was to take ownership of cases involving fatalities and the potential of delay due to such confusion.

# **Action Taken**

- The remit and an organisational chart of HSD have been published on the COPFS intranet;
- HSD has become a division within SFIU. A protocol governing the allocation of cases between the two specialist units has been

introduced, resulting in an improved and more effective working relationship;

• The case marking instructions have been updated to direct all health and safety offences to HSD for investigation.

#### Outcome



# Specialist Reporting Agencies (SRAs)

4	We recommend that more training and guidance be provided to specialist agencies on how to send reports via the Specialist Reporting Agency (SRA) website to COPFS.
5	We recommend that all cases are reported electronically and that HSD decline to accept any not so submitted.
13	We recommend reporting agencies submit all documents such as statements and productions electronically into the case directory to allow disclosure on the website, using the Disclosure Manual Client (secure disclosure website) as do all other mainstream units.
14	We recommend that full discussions take place with all reporting agencies as soon as possible to allow a training programme on disclosure schedules to be arranged as a priority.
15	We recommend further training of specialist agencies to ensure their reports and statements meet the needs of the prosecutors and to minimise the need for precognition. This would speed up the preparation process and bring the HSD more into line with all mainstream units.
18	We recommend that targets are imposed on reporting agencies to ensure cases are reported within much shorter timescales than at present.

10. The purpose of this group of recommendations was to promote and foster good working relationships with specialist reporting agencies, to streamline the processes for reporting cases and reduce unnecessary double handling of work.

# **Action Taken**

- All SRAs now submit their reports electronically to COPFS through a dedicated web link;
- There are regular liaison meetings between SRAs, HSD and Local Authorities. There is also improved communication with legal representatives of accused persons; In 2014 the Head of HSD received favourable feedback following a meeting of the Health and Safety

Lawyers Association at which he stressed the importance of early discussion of cases including plea negotiation and agreed narratives and emphasised his intention to progress criminal proceedings more quickly in cases where there was no meaningful discussion;

- There have been a number of collaborative training events, including:
  - Training hosted by HSE on report writing and evidence gathering;
  - Training for SRAs on how to submit additional charges and accused persons and supplementary reports;
- The LAs have set up a network of "Health and Safety champions" to cascade their expertise and share best practice;
- There is ongoing discussion between HSD and SRAs to provide additional training or support where necessary;
- On being allocated a case, the identity of the case investigator is intimated to the reporting agency to facilitate early discussion;
- There has been an improvement in the submission times of reports involving fatalities from HSE and more proactive dialogue on submission times between HSD and HSE.

# Matters Outstanding

#### **Recommendation 13**

 In many cases, the extensive size of the file and formatting issues between the SRAs and the COPFS IT system has prevented the electronic submission of all statements and productions. COPFS has identified a technical fix that will enable any size of file to be submitted electronically<sup>1</sup> and is working on resolving outstanding formatting issues. The electronic submission of all documents and productions will enable disclosure to be made electronically providing efficiency savings for HSD.

# **Recommendation 14**

 Feedback from SRAs indicates that training on the provision of disclosure schedules is still required.

#### Outcome

Substantial Progress

<sup>&</sup>lt;sup>1</sup> To be implemented in the current financial year.

# Management of Cases

6	We recommend that, where criminal cases are reported by multiple agencies, all reports for the incident should be rolled up in FOS to allow a single case reference number to be used and all case documents to be found within the one case reference in FOS, SOS and PROMIS.
7	We recommend that HSD use their existing FOS report tray and office code. This would allow cases identified as being for HSD to automatically flow.
8	We recommend that an exhaustive list of charge codes should be prepared and entered into FOS to ensure all appropriate cases go to HSD and that that list should be regularly reviewed and updated.
9	We recommend that, as soon as forum is decided upon, the case should be re-marked in FOS to bring it under the umbrella of MI Book and to allow central and local monitoring of all work in HSD. Every stage of the life of the case should be recorded within the database.
10	We recommend that use of spreadsheets as sole records ceases and that use is made of existing national systems (PROMIS) to record, monitor and manage the work. A decision should be made about which spreadsheets are to be used for internal purposes and all others should be deleted from the shared drive to avoid confusion. Thereafter that remaining spreadsheet should be kept up-to-date and accurate.
12	We recommend that if the 'Case Load' document is to be retained it must contain ALL relevant cases, updated at regular intervals for it to be really meaningful. The case load document should be available for all and be on the shared drive.
16	We recommend that at all stages the system should be fully updated to allow fruitful interrogation of the system by any enquirer and also to allow Management Information Division (MID) to provide automatic information about the stage and state of case preparation with a view to flagging up any potential problems in time to prevent delays and risks to reputation re old cases.
23	We recommend that all mail and documents created within HSD are stored in the electronic record of the case.
26	We recommend that work is allocated geographically wherever possible.
29	We recommend that original hard copy papers should not routinely be sent from office to office.
35	We recommend that a B/U (bring up) system is used by all managers in HSD to monitor the progress of cases.

11. The purpose of this group of recommendations was to improve case management and working practices through better recording and monitoring of the workload. Central to improving efficiency was HSD fully utilising the COPFS electronic case management system.

# **Action Taken**

- Criminal reports relating to the same incident are being associated and "rolled-up" into one case. Criminal cases are now cross-referenced to the associated death report;
- All cases are now submitted electronically by SRAs directly to HSD, identifiable by the prefix 'HS';
- The most frequent health and safety offences have been added to the COPFS electronic case management system - known as FOS - enabling HSD to work on such cases within the system. New health and safety offences are added to FOS as they are identified;
- HSD staff, following training, are conversant with the operation of FOS;
- The COPFS case tracking system, PROMIS, is updated for every case. The forum is inputted when the case is allocated for preparation, enabling more effective monitoring, through PROMIS or the Management Information (MI) Book. In the MI Book, HSD has a dedicated section (or dashboard) containing all live health and safety cases, enabling such cases to be easily identified and monitored;
- HSD now operates a single spreadsheet, accessible to all staff in HSD, with each case linked to a minute sheet, designed to provide up-to-date information on the case;
- Correspondence and documents created within HSD are stored in the electronic record of the case;
- There is HSD staff in each of the three geographical areas, enabling HSD prosecutors to deal with cases across Scotland. Wherever possible, work is allocated geographically. This provides more accessible contact with SRAs and witnesses. This has been facilitated by electronic reporting of cases which has obviated the need to send hard copy papers between offices;
- Regular meetings take place between HSD and SFIU which has facilitated early decision-making on who deals with fatalities at work, liaises with the nearest relatives, interacts with reporting agencies and provides clarity on the appropriate point of contact.

# **Matters Outstanding**

# Recommendations 9, 16 and 35

12. To monitor the progress of health and safety cases more effectively, the review advocated electronic reporting and recording and streamlining the use of spreadsheets. While these recommendations have been implemented, we found a number of data integrity issues, including the duplication and omission of cases. This presented difficulty in reconciling the data on the MI Book with the manually recorded data and obtaining reliable statistics on cases received by

HSD and their progression. To improve the quality of data held by HSD we recommend that HSD should implement a monthly reconciliation between all cases recorded on the HSD spreadsheet and the MI Book.

#### **Recommendation 1**

HSD should implement a monthly reconciliation between all cases recorded on the HSD spreadsheet and the MI Book.

#### Outcome

**Substantial Progress** 

#### **Case Progression**

17	We recommend that Crown Counsel's Instructions (CCI) are acted upon within an agreed short timescale.
19	We recommend that internal targets are put in place to avoid cases becoming too old for meaningful prosecution. It may be that individual targets could be attached to each case, based on complexity, to allow for a realistic preparation time. A target should also be extended to cases as they are reported for CCI.
20	We recommend that wherever possible information required for processing a civil claim is passed to representatives of victims and next of kin as soon as possible to allow them to raise a civil action within the three year civil time bar.
21	We recommend that HSD hold regular management meetings to ensure cases are progressed as quickly as possible.
22	We recommend that more cases are indicted into court for trial rather than waiting for the defence to agree a plea.
25	We recommend that early consideration is given to placing cases wherever appropriate on summary complaint and fixing court dates for them as priority.
27	We recommend that when cases are sent to Crown Office there should be an accompanying letter or email indicating the complexity of the decision for Crown Counsel and giving a target or an indication of urgency. This information should be recorded both within HSD and Crown Office as part of an audit trail and as an aid to monitor progress of and manage work.

- 28 We recommend that two Crown Counsel should be appointed on a "staggered" basis to prevent lengthy periods where no Crown Counsel is available due to other work commitments.
- 34 We recommend that all complaints and compliments should be recorded in Respond, to monitor how HSD is performing.
- 13. These recommendations were designed to accelerate the progression of cases and measure performance.

# **Action Taken**

- Internal Key Performance Indicators (KPIs) have recently been introduced;
- In cases where there are associated civil proceedings, HSD provides contact details of witnesses to legal representatives of nearest relatives to facilitate the civil action. The improved timescales for the throughput of cases has increased the number of cases being concluded within the triennium enabling any associated civil case to be dealt with unfettered by criminal proceedings;
- Two members of Crown Counsel have been appointed to deal with health and safety cases. From a review of files, we found that instructions issued by Crown Counsel are being actioned upon their receipt and that there is constructive and regular contact and communication between HSD and Crown Counsel;
- Early identification of forum by legal managers has been prioritised. Cases considered suitable for solemn proceedings and capable of being resolved are actively pursued with legal representatives. In cases where negotiations have become protracted, HSD has proceeded to commence court proceedings, often prompting more proactive discussion with legal representatives acting on behalf of accused persons;
- Chart 1<sup>2</sup> provides a breakdown of the disposal of health and safety cases over a three year period. Of note is the increase in the number of cases dealt with by summary proceedings over the last three years;

<sup>&</sup>lt;sup>2</sup> Source – HSD spreadsheets as at 10 June 2015.

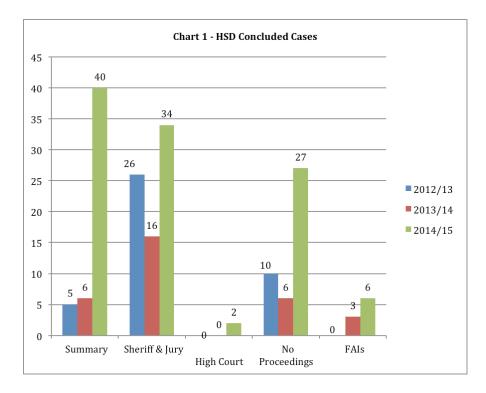
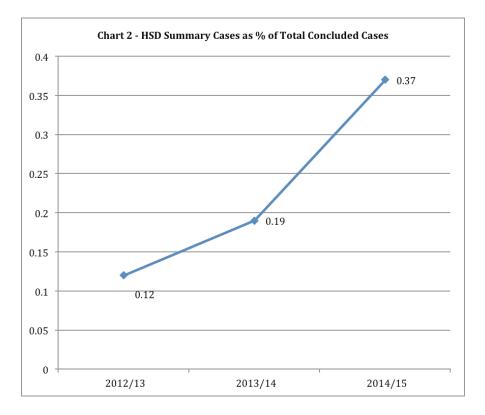


 Chart 2<sup>3</sup> shows the increase in summary concluded cases as a percentage of total concluded cases. 92% of these cases were resolved with pleas being tendered, avoiding unnecessary court proceedings for nearest relatives and victims;



<sup>&</sup>lt;sup>3</sup> Source – HSD spreadsheets as at 10 June 2015.

- All complaints are recorded and overseen by the Head of HSD who disseminates any learning outcomes to his team;
- There are regular meetings between the Head of HSD and senior management in COPFS to discuss the progress of high profile cases.

#### **Matters Outstanding**

#### **Recommendation 19**

As the KPIs were only introduced in September 2014, it is too early to evaluate their success. The imposition of targets should introduce more focus on managing caseload and in time reduce the age profile of cases. Compliance with the KPIs should be subject to regular scrutiny and monitoring.

#### **Recommendation 20**

The extent and content of information that can be provided to those representing nearest relatives and other interested parties, pending the conclusion of criminal or fatal accident proceedings, is currently under consideration.

#### **Recommendation 21**

While there are regular management meetings within HSD and between HSD and senior members of COPFS, the focus of discussion centres on legal issues and high profile cases. Management information on case workload and age profile of cases is not regularly discussed.

With the introduction of KPIs and to assist with the prioritisation of HSD case load, we recommend that management information, to facilitate the effective progress of health and safety cases, should be a standard item on the agenda at management meetings. This should include up-to-date information on the current workload and age profile of cases.

#### **Recommendation 2**

Management information, to facilitate the effective progress of health and safety cases, should be a standard item on the agenda at management meetings. This should include up-to-date information on the current workload and age profile of cases.

# Outcome

Substantial Progress

# Training and Staffing

3	We recommend that full desk instructions are prepared and issued for all administrative posts.
11	We recommend training for the administrative manager to allow more effective set up and work with spreadsheets, if spreadsheets are still to be used for internal use.
24	We recommend that in order to avoid a bottleneck Principal Deputes are given more autonomy to make decisions about forum, charges and agreed narratives and acceptable pleas leaving the Head of Unit freer to train reporting agencies, improve reports and concentrate on the initial stages of investigation with HSE and the other reporting agencies.
30	We recommend that the level of staffing of Fiscal Officers should not be allowed to fall from the agreed level of three for any period in excess of four weeks without cover from some other source.
31	We recommend that there should be an agreed complement of Legal and Precognition staff. Where staff members do leave the unit they should be replaced within an agreed short period with a minimum agreed handover, to allow work to carry on more fluently than at present, thus avoiding delays.
32	We recommend that there should always be an agreed period for legal and precognition staff to remain within the unit. There should perhaps be a short trial period to allow the staff to determine whether the work will suit them.
33	We recommend that consideration be given to creating a "reserve list" to minimise delays in recruiting.
36	We recommend more formal and informal training in health and safety law for staff on a regular basis, particularly for new members of staff. A prepared pack would be very useful.
37	We recommend training for those with an interest in joining the unit in the future. This would build up a bank of staff to cover quickly when team members leave. It would also provide a bank of knowledge when large cases are reported and additional support and resources are required.
38	It is recommended that regular team briefings are held and minutes noted and recorded on the shared drive.

14. The objective of this group of recommendations was to promote and enhance the expertise and specialism of the unit.

# Action Taken

- Standardised administrative procedures have been introduced enabling more flexibility in obtaining assistance;
- Administrative managers have received training on electronic systems and spreadsheets;
- Administrative staff have been reallocated, with at least one member of administrative staff in each geographical hub. Incorporating HSD into SFIU has also facilitated the sharing of administrative resources;
- There has been continuity of an agreed complement of legal staff since the thematic review which has enabled greater ownership of cases. The previous difficulties in attracting staff have receded alleviating the requirement to maintain a reserve list or to prescribe minimum periods for staff to remain in post;
- With increased stability of staff in HSD, the legal managers have acquired greater expertise and have assumed a more proactive role in identifying and progressing summary cases and agreeing pleas and narratives in solemn cases;
- HSD has prepared a bespoke legal database of materials which is utilised by current team members and as a training tool for new members;
- There are regular training events. Events with a focus on practical issues, such as a forthcoming training day devoted to leading evidence from and cross examining an expert witness, have been favourably received by HSD;
- Debriefs are held following every trial to ensure that knowledge gained is shared and emerging trends and problems are identified and discussed;
- Training on the MI Book for all managers is to be rolled out imminently;
- Team briefings are being held and the minutes circulated and published.

# Outcome

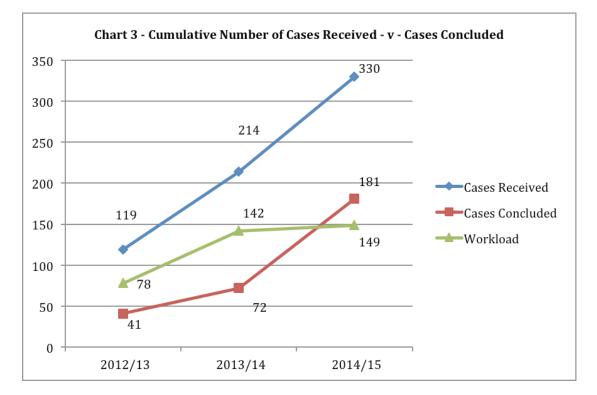
# Achieved

# Overview

# Case Workload

15. Since the thematic review there has been a significant increase in the number of cases reported to HSD, which peaked in 2012/13 with 119 new cases being received. There has not, however, been a corresponding increase in the HSD case workload as shown in

Chart 3.<sup>4</sup> This is due to an increase in the number of cases being concluded and in particular a 151% increase between 2013/14 and 2014/15.



There are a number of factors that have contributed to the increase in productivity:

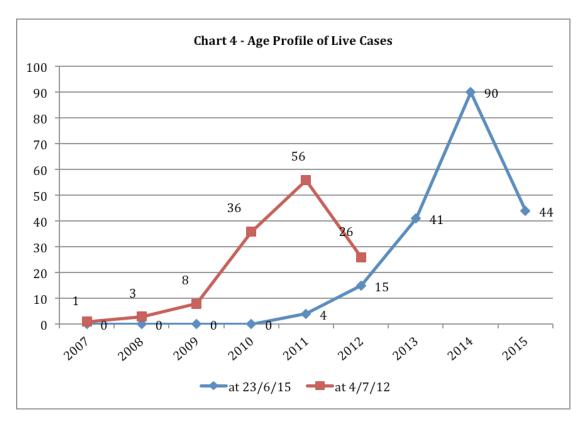
- Early triage of cases by legal managers to determine the appropriate forum;
- Continuity of staff in HSD and enhanced experience;
- An improved working relationship and greater clarity of roles between SFIU and HSD;
- Improved communication and working relationships between HSD, LAs and the SRAs, including more joint training;
- The provision of electronic reporting.

Efforts to improve communication between the SRAs and HSD have undoubtedly led to improved efficiencies, more fruitful working relationships and an overall improved service.

<sup>&</sup>lt;sup>4</sup> Source – HSD spreadsheets as at 10 June 2015. The year relates to when the report was received by HSD.

# Age Profile

The age profile of HSD cases was highlighted as a concern in the thematic review. Chart 4<sup>5</sup> compares the age profile at the time of the thematic review with the current age profile.



- 16. There are a number of factors that impact on the age profile of cases including the volume of health and safety cases, the increasing complexity of cases of this nature and in some cases difficulties in obtaining relevant information from investigating agencies or expert witnesses. Against this background, HSD has made significant efforts to progress older cases, although there remain a number of cases that were reported more than two years ago. The introduction of KPIs and the provision and monitoring of more robust management information should drive further prioritisation of these cases.
- 17. The modernisation of HSD through the introduction of electronic reporting, improved working relationships between HSD, the reporting agencies and HSE, investing in a wide-ranging training programme and proactively triaging cases on receipt have addressed many of the issues identified in the thematic report and enhanced the effectiveness of HSD. The electronic submission of all documents and productions enabling disclosure to be made electronically will provide further efficiencies for HSD.

<sup>&</sup>lt;sup>5</sup> Source – HSD spreadsheets.

# **Glossary of Terms**

#### Bring Up (B/U)

Term applied to an administrative process of ensuring case files are followed up for review on a specific date.

#### Crown Counsel

The Law Officers (Lord Advocate and Solicitor General) and Advocates Deputes.

#### Crown Office and Procurator Fiscal Service (COPFS)

The independent public prosecution service in Scotland. It is responsible for the investigation and prosecution of crime in Scotland. It is also responsible for the investigation of sudden, unexplained or suspicious deaths and the investigation of allegations of criminal conduct against police officers.

#### **Disclosure schedules**

A document providing details of the statements and documents that may be used in a criminal trial which must be disclosed to the representatives of the accused.

#### Fatal Accident Inquiry (FAI)

A court hearing presided over by a Sheriff which publicly enquires into the circumstances of some sudden, unexplained or suspicious deaths. A FAI must take place when someone dies in custody or a death is caused by an accident at work.

#### **Fiscal Officers**

Administrative officers within COPFS.

#### Forum

The level at which the case is to be prosecuted with more serious offences (solemn proceedings) being heard by a jury and less serious offences (summary proceedings) heard by a single judge.

#### **FOS Office code**

A reference number identifying the office or unit responsible for dealing with the case.

#### Health and Safety Lawyers Association

Association for solicitors who act for accused persons in health and safety prosecutions.

#### Health and Safety Executive (HSE)

Great Britain's independent regulator for work-related health and safety and illness.

#### Indicted

Service of the document (an indictment) on the accused setting out the charges he/she faces in solemn proceedings.

#### Key Performance Indicators (KPIs)

Type of performance measurement.

#### Law Officers

The Lord Advocate and the Solicitor General for Scotland.

#### Management Information Book (MI Book)

Management information in a readable format.

#### Narrative

The facts of the crime read out by the prosecutor to the presiding judge when a plea of guilty is tendered by the accused.

#### **Principal Deputes**

Legal managers.

#### PROMIS

(Acronym for **Pro**secutors **M**anagement Information **S**ystem) COPFS computer-based case-tracking and management system.

#### Respond

COPFS database for recording complaints and compliments.

#### Rolled up

Process of conjoining all charges and cases for an accused person into a single case.

#### Scottish Fatalities Investigation Unit (SFIU)

A national specialist unit responsible for investigating all sudden, suspicious, accidental and unexplained deaths in Scotland.

#### Solemn proceedings

Prosecution of serious criminal cases before a judge and jury in the High Court or Sheriff Court.

#### SOS

(Acronym for Standard Office System) COPFS case database.

#### Specialist Reporting Agency

A body (other than police) which reports crimes to COPFS, including the Health and Safety Executive (HSE) and Local Authorities.

#### Summary proceedings

Prosecutions held in the Sheriff or Justice of the Peace Court before a judge without a jury.

#### Triennium

A three year time limit to commence civil proceedings.

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