Health and Safety Division Thematic Report

April 2013

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Chapter 1

Introduction and Methodology

1. This is the sixteenth thematic report of the Inspectorate of Prosecution in Scotland since the independent post of HM Chief Inspector was created by statute in 2003.

2. The aim of the Inspectorate of Prosecution in Scotland is to make recommendations that will contribute to improvement in the public system of prosecution of crime in Scotland and (where appropriate) improve public knowledge of and confidence in the system.

3. The Inspectorate takes a risk based approach to its work with a focus on outcomes and user perspective, the experience of those using the service being a priority rather than “peer review”. An evidence-based approach is taken to ensure any conclusions/recommendations are well founded.

4. We would like to record our thanks to the many contributors to the report including internal staff members of Crown Office and Procurator Fiscal Service (COPFS), Health and Safety Executive (HSE) officials, Sheriffs, solicitors and others. The conclusions, recommendations etc, however, remain those of the Inspectorate.

Methodology

5. The review was carried out using a number of techniques based on accepted principles of inspection including:-

- Preparation and planning
- Research
- On site visits
- Interviews
- Review of case papers
- Analysis of information
- Report writing

6. All this included:-

- Review of relevant departmental policies
- Review of relevant departmental internal protocols
- Review of relevant departmental external protocols
- Interviews with partners including solicitors and sheriffs
- Review of departmental guidance
- Interviews with COPFS staff

7. In particular case papers relating to 72 cases were examined, being 31% of the total number received by the Health and Safety Division (HSD) of Crown Office since its inception.

Aim

8. The aim of this inspection was to inspect the arrangements, processes and systems employed by COPFS staff (both legal and administrative staff) to investigate and prosecute where appropriate all health and safety cases reported to COPFS. This inspection was carried out in light of the creation of a specialised division with a view to measuring the success of this specialisation.

Objectives

- To assess the quality and timeliness of preparation, investigation and prosecution of cases and any issues arising from these findings.

- To identify good practice and promote same.

- To identify the benefits and disadvantages of specialised practitioners in a specialist field.

- To consider interaction of COPFS with HSE and other such reporting agencies in terms of liaison and to consider reporting of cases and pre-reporting arrangements.

- To consider training of COPFS staff and any training delivered to and by HSE and other reporting agencies.

- To consider how work is recorded, measured and monitored.

- To consider the views and satisfaction of victims and next of kin.

- To consider the views and satisfaction of reporting agencies for health and safety cases such as local authorities, HSE, and the Maritime and Coastguard Agency.

Chapter 2

Leadership

9. The Law Officers have been active in promoting greater specialisation in COPFS. The current Lord Advocate prosecuted the successful case against Transco in 2005 (following the deaths of 4 people) with a fine of £15 million being imposed and was involved in the prosecution of ICL Plastics in 2007 (following the deaths of 9 people).

10. His experience of these cases highlighted a need he felt for specialisation to be brought to health and safety cases leading to the creation of the Health and Safety Division of Crown Office in 2009.

11. This new division was to investigate and prosecute all cases reported to the Procurator Fiscal by the Health and Safety Executive and other agencies. It was to consist of experienced lawyers working in 3 teams, Scotland North, Scotland East and Scotland West. These teams were to work closely with Health and Safety Executive staff in their respective areas.

12. At the time of writing this report the Health and Safety Executive reported an increase of persons killed at work in Scotland from 14 to 20 over a 12 month period. This highlights the need for these cases to be carefully investigated and where necessary prosecuted.

13. In his foreword to the 2009-2012 Crown Office Strategic Plan the then Crown Agent said “We will continue to develop specialist sexual offences teams and we will review our approach to other types of cases of a specialist nature including health and safety cases”. The creation of the specialist Health and Safety Division featured in the published plan stating “lawyers who led the investigation into the ICL Plastics factory explosion in Maryhill in 2004 now head up our Health and Safety Division. Their expertise can be passed onto others to create a well trained specialist team”.

14. The Law Officers have made clear their priorities and strategy for the Crown Office and Procurator Fiscal Service to include “clearer signposting – senior legal staff leading a particular topic such as health and safety cases will be designated as Procurators Fiscal for that particular segment of work to highlight their role to the public and criminal justice partners and ensure clearer understanding of the broad range of Crown Office and Procurator Fiscal Service work”.

15. More recently in the 2012-2015 Strategic Plan the Law Officers listed their priorities for the Crown Office and Procurator Fiscal Service. These included investigation of fatalities with specialist staff from the Scottish Fatalities Investigation Unit (SFIU) and those in the associated Health and Safety Division to continue to bring particular expertise to the investigation of such cases and, where necessary, to ensure the

best possible presentation of the facts in court during Fatal Accident Inquiries (FAIs) or prosecutions.

16. This approach to specialisation is mirrored on the defence side with several large private firms having well established specialist health and safety lawyers engaged in this work. One firm informed us that they had 27 lawyers working in this field (although on a UK-wide basis).

17. There is also a UK Association of Health and Safety Lawyers including Scottish members. The Law Society of Scotland currently has recognised 28 specialisms with lists of accredited members.

18. It was clear to us that health and safety crime has increasingly become a focus of public and political concern. Practitioners across many agencies had already recognised this and all looked forward to the results which would flow from this fresh specialist approach. Accordingly the view of many, from reporting agencies and from defence solicitors practising in this field, was that the creation of HSD was a useful and positive change.

19. The profile of health and safety crime has been raised since HSD was created in 2009. Very few cases proceed to trial and there is now a culture of cases concluding in good pleas with both charges and narratives being agreed in advance between the Crown and defence and the reporting body also being consulted for views during the negotiation process. Sheriffs are given copies of an agreed narrative of events before the plea is tendered, along with financial statements and recent case law, all designed to assist them in their decision making.

20. This is all positive change.

21. An additional positive for the Reporting Agencies is the easy access to advice from the Head of the Unit at the earliest possible stage of investigation. All agencies voiced their positive view of this. However, the volume of time and energy devoted to this stage means that little time is left for supervision of the case load once cases are reported to the unit.

22. The major issue which taxed all those we spoke to was the length of time taken for cases routinely to reach conclusion. This issue should have been tackled by those in charge of the unit. Although staff turnover and possibly resource issues may have led to delays we found other reasons. We felt there should be a better system of initial triage of cases namely;

- early identification of cases which could be dealt with quickly on summary complaint

- early identification of those cases which require minimal additional work before proceeding to court and

- early identification of those cases where pleas should be pressed aggressively rather than awaited passively.

23. Delegation of responsibility to the Principal Deputes in post is required to ensure throughput is not delayed by awaiting decisions from one individual with a large burden of work. In addition to speeding up the existing process this would empower these legal managers and subsequently the deputes within the unit to carry out their duties with ever greater confidence. This would have the effect of retaining staff for longer periods enhancing their knowledge of Health and Safety Law and providing greater job satisfaction for them.

24. Legal managers of this grade elsewhere in COPFS routinely make the decisions about forum, pleas and charges as well as managing teams of lawyers and precognition officers and supervising their precognitions.

Chapter 3

Aims and Structure of Unit

25. The aim of the Health and Safety Division as stated by the Solicitor General when he launched it was to investigate and prosecute all health and safety cases reported to the Procurator Fiscal by the Health and Safety Executive, local authorities and other agencies who report health and safety cases to COPFS. They also investigate and lead evidence in Fatal Accident Inquiries (FAIs) held in all health and safety related deaths which require specialist input.

26. The new Division was set up to provide advice, support and direction from the very earliest stages of investigations.

27. The Health and Safety Division was also to have a greater concentration of expertise, increased specialist input at the start of an investigation and enhanced liaison with stakeholders in this area of investigation and prosecution. The Division was also to work in close consultation with dedicated senior Crown Counsel (CC).

28. Ultimately this is to help to create and maintain safer workplaces and environments across Scotland by identifying unlawful practices that put safety at risk in our communities and bringing to justice those who fail to discharge their obligations under health and safety law.

29. The Health and Safety Division consists of three units as had been envisioned, North, East and West, working closely with HSE, local authorities and other agencies who report Health and Safety cases to COPFS.

Protocols

30. It was agreed that, once HSD was established, all new cases would be reported to the unit. All previously reported summary cases were to remain with the local Procurator Fiscal Offices with advice and assistance from HSD as required. All solemn cases were to be transferred to HSD no matter their stage unless agreed otherwise.

31. We were directed to various protocols relating to Health and Safety. Many of them related to death at work and to protocols for operational work and co-operation and primacy between criminal justice partners in the investigation of such deaths.

32. The Protocols which we were able to find are as follows:

- Work related Deaths protocol which originated in 2008. The signatories being Association of Chief Police Officers in Scotland (ACPOS), British Transport Police (BTP), COPFS and HSE.

- Accompanying Guidance notes from November 2008, updated 14 October 2011.
- Memorandum of Understanding between Air Accidents Investigation Branch (AAIB), Marine Accident Investigation Branch (MAIB), COPFS and ACPOS for the investigation of air and marine accidents and incidents in Scotland, dated 11 January 2008.
- Memorandum of Understanding between HSE, Maritime and Coastguard Agency (MCA) and Marine Investigation Branch (MAIB) dated July 2009 for the health and safety enforcement activities etc at the water margin and offshore.
- ACPOS Manual of Guidance for Senior Investigating Officers on Corporate Manslaughter and Corporate Homicide Act 2007, dated 2012.
- Protocol between COPFS and HSE for submission, processing and monitoring of prosecution reports relating to Health and Safety at Work etc, Act 1974 offences. This protocol is undated but refers to COPFS Areas and specialist deputes within them. It precedes both the formation of HSD in 2009 or the anticipation of it in 2008. We could not find any more recent version.

33. We have been unable to find any written protocol or remit for the Division specifically setting out the parameters upon which their work is based.

34. This has caused difficulties for us in identifying or determining the extent of their role. This gap continues to cause problems for others both internally and externally, for non-HSD deputes, deputes in Scottish Fatalities Investigation Unit (SFIU) and for criminal justice partners. We have seen evidence of cases which have been under discussion for lengthy periods where ownership of the cases within COPFS lacks clarity in the role of HSD. This lack of clarity can cause delay.

35. There is a surprising omission of any reference to HSD internally in COPFS in either the Case Marking Guidelines or in the Knowledge Bank (both internal guidance for staff). These legal sources are available to all staff through the Intranet. Non-HSD deputes would naturally refer to either or both of them as a first port of call for guidance when faced with an unusual or complex type of case to mark. A case involving Health and Safety at Work would generally be considered by most deputes to be unusual and complex. There is reference in both above sources to health and safety offences but neither mention the existence of HSD or suggest that deputes should make enquiries there to determine if the case in question should be passed to HSD to be dealt with there or to seek assistance from this specialist section on a complex area of the law. This has led to at least one case being marked by a non-HSD depute, then prosecuted locally and dealt with in court by way of a plea of guilty. HSD were unaware of the existence of this case until after sentence was passed.

36. Although aware of this problem HSD has not instigated an update to the internal legal guidance to ensure there are pointers to all deputes so this error does not recur.

37. There are protocols in place regarding the manner of investigation of work related deaths but we could find none for any other type of health and safety criminal investigation. More crucially there is currently no protocol or any type of agreement with the former local Deaths Units now SFIU (the national deaths unit). The work of HSD and SFIU crosses over on many occasions, as often deaths do occur at work, and roughly a quarter of the cases dealt with by HSD involve fatalities. Some deaths can be dealt with entirely by SFIU, some by HSD, some by both. There is currently no clarity about which is which. There is a general consensus that all cases are looked at on a "case by case" basis. Deputes find it impossible to predict how cases will be dealt with as there are no guidelines. There is no certainty which cases will be retained by SFIU and which passed to HSD.

38. Frequently the police appear to be unaware that a death at work should be reported to HSE for investigation as well as SFIU. If SFIU deputes are unaware of this they neglect to instruct the police to alert HSE to the incident and valuable time is lost. If HSD are made aware of the incident their first action is usually to alert HSE to initiate investigation by these experts. Routinely police simply refer deaths to SFIU. As a result the reporting agency and HSD are unaware of their existence. The area where this is most often incorrectly identified is where a death arises from a fall in a care home.

39. Unfortunately, sometimes, even when HSD do take over cases from SFIU, no-one deals with some aspects of work, each section thinking the other is dealing with it. Even after some years families may still not have the benefit of the final conclusion regarding the cause of death.

40. We did become aware during our inspection process that talks were now ongoing between SFIU and HSD about agreeing a protocol of sorts. However this has not yet, to our knowledge, borne fruit.

RECOMMENDATION 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 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.

RECOMMENDATION 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.

Chapter 4

Processes

41. During the course of our inspection it was drawn to our attention that an internal “Process Review” was carried out during August/September 2012. We discussed the findings with the reviewer and note that those findings echo our own.

42. There are desk instructions for administrative staff, adapted for use in HSD from general instructions, but these relate purely to the processes of preparing and serving indictments and complaints. Much contained in the instructions is irrelevant to the work of HSD. There is no explanation or definition of roles for any staff. This is a basic step which would enable new members of staff to learn their job more quickly and provide clarity for current staff. Because little use is made of SOS (Standard Office System) and FOS (Future Office System) deputes and precognoscers send and receive emails from their own accounts. This correspondence is rarely imported into SOS so is not available for monitoring work or indeed to enable a full handover of case work. Reports are routinely prepared in Word, stored in personal documents and not imported into SOS. This means there is not always an audit trail of what work has been carried out and when or what has been sent for checking, countersigning or for Crown Counsel’s Instructions (CCI) or when. Administrative staff have voiced concerns they are not “kept in the loop” about progress of work by legal staff.

RECOMMENDATION 3

We recommend that full desk instructions are prepared and issued for all administrative posts.

43. Where a death has occurred at work there is a mandatory obligation to hold an FAI. However, where there has been a prosecution and all of the facts relating to the death are covered in it, it would appear to be unnecessary to hold a Fatal Accident Inquiry, if Crown Counsel agree. A new approach is being taken and instruction is being sought at the time the case is reported to Crown Counsel in connection with a plea or prosecution to cover all salient facts in one hearing to avoid the need for an FAI. This system works well suiting both the relatives who do not wish to have a second round of court appearances and also the courts by avoiding overloading. This is a new and welcome development.

44. There does not appear to be any close monitoring of older cases where the prosecution is complete and there had been no such CCI about dispensing with an FAI. There seems to have been sporadic reporting of some cases post disposal seeking instructions to dispense with the FAI. However, there is no system in place to carry out this process or to follow up any request. Some cases sat with the unit for periods of two years before CCI were obtained in relation to FAIs.

Electronic reporting

45. Work should come in by electronic report from outside agencies such as HSE, Local Authorities, Maritime and Coastguard Agency and Office of Rail Regulation (ORR) among others. We have been unable to find a written list of all agencies who report to HSD. In the past there have been problems with some agencies delivering hard copy cases rather than sending them electronically. Maritime and Coastguard Agency is one such agency. During our investigations we were repeatedly informed that many of the smaller Local Authorities or reporting agencies reported very few cases in a year. They did not feel at all confident about how to format the report for the case and send it down the SRA (Specialist Reporting Agency) electronic link. All voiced their opinion that more training for them was required. Many other "outside" reporting agencies reported to us that they went to HSE for such assistance. HSE have a member of staff who sends all of their cases down the link and offered advice and assistance to those other less experienced reporting agencies. Although there had been some initial training when the SRA website was rolled out we regularly heard during out inspection that "refreshers" would be of huge benefit. Local Authorities paid for specific police training at Tulliallan in September 2012 in connection with report writing but the police were unable to provide training in the SRA web as they do not use it. There is some guidance which we found on the Scottish Government website which was of limited use and none on the COPFS website. (Information Systems Division (ISD) told us they thought there was some guidance available but to date we have not seen it). These comments do not only apply to HSD cases but also Department for Work and Pensions and other non-police reporting agencies.

RECOMMENDATION 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.

RECOMMENDATION 5

We recommend that all cases are reported electronically and that HSD decline to accept any not so submitted.

46. About a quarter of cases reported to HSD involve deaths. As a result, multiple reports are received for many individual cases. In a fatality, a "Death Report" would be submitted by the police within days. This would allow arrangements to be made for the post mortem and release of the body. The prosecution report might not come in until years later. The case might be reported by either the Local Authority or HSE and also by the police, so eventually there are three reports for the same case, all having a different reference number. There are also interim reports sent in by HSE every few months which are unnumbered and

not recorded on the system as they do not come in electronically. They pre-date the final report which does come in electronically and is allocated a number. This makes it difficult to keep track of the case on the system since some work may be done under one number and other work under another. There are also documents available hard copy but not on the system. HSD have carried out work relating to the prosecution in some cases within the deaths report. This causes difficulty in monitoring cases and collating the work done. This could be simplified by "rolling up" these cases into one case number in FOS. In non-HSD work this is what happens when multiple cases are reported for prosecution of one accused and all are considered together often resulting in all charges being placed on the one complaint or indictment. If this is not possible for deaths cases, then clear cross references should be placed in each related case to the other associated cases.

RECOMMENDATION 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.

Office code

47. HSD have an office code in FOS but this has not yet been activated. All work is submitted geographically and these cases until identified in some way as being HSD cases are treated as mainstream. This means that when health and safety cases are submitted electronically by agencies the cases are automatically sent to their geographical homes and into a FOS report tray for that place. HSD are not informed by FOS that any new case has come in which requires their attention. Steps have been taken by HSD to identify these cases and ISD currently run a computer programme every night. ISD send an email daily to HSD with this information. If a new case has come in HSD contacts the geographical office (which has become more difficult with the teething troubles in a move to Federation working) and asks them to re-allocate the case into the HSD FOS tray. This whole process relies heavily on manual input and is at risk if there is human error. To attempt to combat this we understand that HSE often inform administrative staff in HSD that they have submitted a report. This also alerts HSD to locate the electronic report. None of these "workarounds" with attendant capacity for missing cases should be necessary. We have discussed this with ISD who know of no reason why the cases cannot come through SRA straight to an office code called HSD. The reporting agency could choose the office as HSD rather than the local office. This would mean cases would come straight to HSD and none would be missed.

RECOMMENDATION 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.

Charge codes

48. There appears to be no complete list of charge codes which relate to the charges which HSD take. This is perhaps expected since there is no recognised written remit for HSD. In order to allow Oracle mentioned above to work the administrative manager and ISD liaise on what charges should be on this list. Both parties have suspicions that this list is not exhaustive and during our inspection we have found two examples of charges which we know HSD do take where the code is not registered as HSD. The most surprising of these is the charge of Corporate Homicide (CH). The other example relates to Work at Height Regulations 2005. Cases involving these charges feature regularly in HSD cases. (No other Division within COPFS is likely ever to deal with these charges.) This omission is a concern. A case involving a breach of this regulation came in to one office report tray in FOS and was not picked up by Oracle since the charge code was not recognised as an HSD one. This meant that HSD were unaware of the existence of the case. The case was marked as a mainstream case in the local office and put into a Sheriff Summary court. HSD only became aware of the case after it had appeared in court.

49. Surprisingly the charge codes have still not since been amended to include this type of charge so there is a very real risk that the same situation could re-occur. It is possible for a case marker who is in a mainstream local office and not in HSD to come across such a case in the local FOS tray since it would go in there automatically. They could mark it since a) there is no protocol available to suggest these cases are to be taken by HSD, b) deputes generally consult the case marking guidelines available on the internal intranet for assistance and technical or legal advice but these guidelines make no reference to the existence of the HSD, c) deputes also frequently consult the Knowledge Bank also available on the internal intranet for assistance and technical or legal advice but the Knowledge Bank makes no reference to the existence of the HSD.

50. Unless the marking depute has personal knowledge of HSD they could remain in ignorance of the fact that such a case MAY or ought to be referred to HSD for investigation or guidance and assistance. HSD is not mentioned in any guidance available to deputes.

RECOMMENDATION 8

We recommend that an exhaustive list of charge codes should be prepared and entered in to FOS to ensure all appropriate cases go to HSD and that that list should be regularly reviewed and updated.

FOS marking

51. The first stage in all mainstream cases is to decide what the charges and forum for the case will be. This decision is immediately recorded in FOS. This record then acts as a trigger for management information and case tracking. In HSD cases are recorded in the FOS system by the administrative manager as soon as they come in to the tray as "defer possible petition". This is not a real and measurable marking. It is intended as a holding marking, usually used while further information is sought. Cases should be re-marked within at most a few months. We found cases in HSD with this marking years later. In fact, in order to keep the records similar to the mainstream system, as soon as a decision is made about forum, the marking should be updated. Since HSD do not place accused on petition the marking should go straight to precognition. These updates bring the cases into line in PROMIS and allow them to be monitored within the National Database via the Management Information Book (MI Book). At every stage FOS and PROMIS should be updated to indicate that the case has been reported to Crown Office, then updated by Crown Office to show that CCI have been given. Thereafter a service record should be entered in PROMIS once an indictment is served. HSD cases do not have all of these entries in the database in every case. On searching the data we have found that they are rarely marked in FOS beyond that initial marking. We assume this is because these cases usually proceed straight to indictment, without first going on petition. Often the accused are companies and they are generally not placed on petition.

RECOMMENDATION 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.

Spreadsheets

52. HSD has developed its own system for monitoring the workload. They have created a system of spreadsheets which are kept on their own shared drive, accessible to all within the unit. Only the administrative manager is authorised to make entries into it. The Division has had to do this as they are unable to use the COPFS database. They are unable to use PROMIS and the National Database which is used by all other departments as they effectively bypass the normal system –

- because they do not mark cases within FOS and there is no system record of their work
- because there is no office charge code which the MI book can use as a filter to obtain this information

53. The manager in the unit who operates these spreadsheets has had no training in the set up, maintenance or use of said spreadsheets. This is an area of learning "as you go" and by asking others both within and outside the service for assistance. Many of the spreadsheets which have been set up have fallen into disuse but when we began our inspection were still there. Spreadsheets rely heavily on there being no human error and there appears to be no way to cross check from the National Database. On our inspection we found examples of human error in that –

- the date of incident in one case had erroneously been noted as the date of birth of the deceased;
- cases which had been closed were still on the "live" spreadsheet;
- cases which had been allocated still featured as unallocated.

54. While the spreadsheet can be a useful tool for staff themselves to see at a glance what cases they have and can be useful for the fair allocation of new work it should not be the only system available to monitor performance, provide statistics, either for monthly returns, provision of information for FOI requests, or any other reason. At the time of inspection the Management Information Book was unable to provide information to HSD for a variety of reasons such as there was an incomplete list of charge codes, no use of Team ID and accordingly no page made ready for HSD. On enquiry with Strategy and Delivery Division (SDD) it has proved to be quite possible to do this and they have now contacted HSD with a view to setting this up to allow them to better monitor and manage their work.

RECOMMENDATION 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.

RECOMMENDATION 11

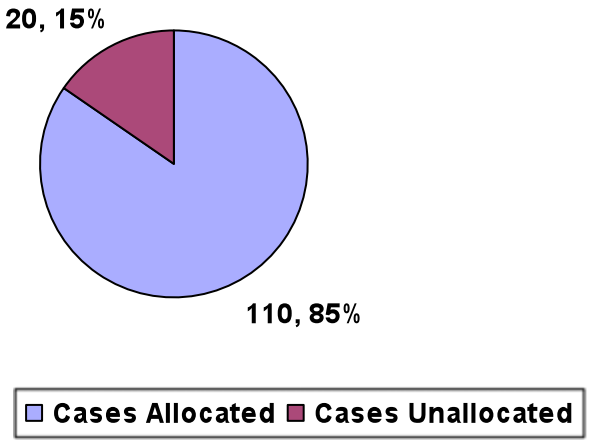
We recommend training for the administrative manager to allow more effective set up and work with spreadsheets, if spreadsheets are still to be used for internal use.

55. Meantime any information about data which HSD seek either for internal use or to answer any external questions has to be sought manually and counted from their spreadsheets. They are uncertain of the accuracy of these spreadsheets and the information contained therein. On the shared drive are 5 spreadsheets but most are historical and are currently completely or partly defunct. Old cases are removed from the "Main spreadsheet" and placed on a "closed cases

spreadsheet" so do not appear in the "Main spreadsheet". We were told that in reality only the "Main spreadsheet" is in use.

56. The HSD 'Main' spreadsheet (as at 04/07/12) provided details of 130 cases of which 110 cases had been allocated (26 involving fatalities) and 20 unallocated (5 involving fatalities). This spreadsheet does not provide details of the current position of the case. It was noted that 4 of the cases on the spreadsheet were yet to be reported.

57. **HSD main spreadsheet at 4 July 2012[1]:**



58. If use of spreadsheets is to be continued one system should be used for all to provide consistency.

59. HSD also use a document called the 'Case Load' Document. Each depute or precognoscer is asked to complete information about their cases. The HSD 'Case Load' document is used to keep a note of progress and update the Solicitor General at regular meetings (roughly every 6 weeks). At 30 August 2012 this document had progress reports relating to 76 cases. There were no updates from 3 members of staff, 2 of whom were leaving/had left the unit. One would expect to see updates for all cases that have been allocated even if there has been no progress since last report. There is a clear flaw in the total accuracy of this document as it is left to individual members of staff to complete information if they are available. If the members of staff are not available or simply fail to complete the document then no information is provided.

60. It was noted that 8 cases referred to in the 'Case Load' document were not recorded on the 'Main' HSD spreadsheet. On checking further it was found that all 8 were recorded on the HSD 'Deaths' spreadsheet and a further check of the 'Closed Cases' revealed that 6 of them were

[1] There is also a spreadsheet called "ongoing investigations not yet reported". This details cases that are being worked on but no report has yet been received. Other (not yet reported) cases are actually on the "Main" spreadsheet and noted with *not yet reported* beside it.

closed but waiting instructions re FAIs. The other two were still ongoing. The 'Main' spreadsheet is the first point of reference and from which information is collected and provided. All ongoing cases should be recorded on this spreadsheet if its use is to continue.

61. The 'Case Load' document also showed that 5 of the 20 cases recorded as unallocated in the 'Main' spreadsheet have been worked on. Four of these cases involved fatalities. Therefore, looking at the spreadsheet, it appears that cases have been unallocated when in fact some initial work has been carried out.

62. Further, it can be seen from comparing the spreadsheets with the 'Case Load' document, 3 cases were marked as allocated to someone other than the person who had been working on them. One case is not recorded on the spreadsheets at all, another is a defence appeal where the case has been moved to the HSD 'closed' spreadsheet but has no note of an appeal on it (the case is still active on PROMIS) and lastly one is closed but still on the 'Main' spreadsheet.

Conclusions on data:

63. Our findings show that the HSD 'Main' spreadsheet is not completely up to date and does not record every case. Given that the 'Main' spreadsheet is the first point of reference for HSD cases efforts should be made to ensure that all cases are recorded there and that it is updated regularly so that accurate and up to date information can be given. It may also be useful to add other columns to show the current position of cases. HSD staff indicated that they were not confident that the spreadsheet is accurate and that information passed on is correct.

64. The 'Case Load' document does not provide progress reports for all cases. This document is a useful tool to monitor progress (or lack thereof) and for local management of cases and staff. It would also be useful for new staff who are re-allocated work as it would provide brief notes on what has been happening with the case. The format of the "case load" document currently does not record date of receipt of report. It would be useful to provide management with this information for each of the cases so they can see at a glance the age profile of cases and how long they are taking to process.

RECOMMENDATION 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.

Disclosure

65. Disclosure of statements and productions is done at a very early stage. It appears in the main that as soon as a case is reported electronically a request is sent for hard copy of the file and all documents. Most, but not all, statements seem to come electronically. No documentary productions are sent electronically. Hard copy is requested and received very quickly. At the start of our inspection, due to reduced administrative resources, all case papers were coming to Glasgow for disclosure. A depute unconnected with the case looks at these and redacts it all hard copy. Administrative staff then copy this on to a pen drive. The pen drive is then delivered to a COPFS office near to the defence solicitor for them to collect. This is carried out very speedily and the defence have as full disclosure as possible before any work is actually carried out by HSD on the case. This was highlighted by defence solicitors as being a very positive development. This is done to allow earliest possible discussions about pleas and is entirely commendable. Some comments have been made by deputes that they would prefer to carry out their own disclosure to allow them to see the case at the earliest possible stage rather than have an unconnected third party involved. If cases were allocated immediately this would be possible. However, any change contemplated should not slow down the disclosure process which is working well.

66. The hard copy papers remain in Glasgow until allocated. At the time of inspection 20 cases remained unallocated, some from November 2011. Cases are allocated to deputes across all three areas. Following allocation the Principal Depute with line management responsibility for that depute prepares an allocation note. The hard copy papers are sent to the appropriate Principal Depute then onwards to the allocated depute. A letter is sent to the defence solicitor at the time of disclosure. It contains a list of the documents enclosed and should be signed for on receipt. A copy of the list sent is kept in the electronic case record. This is the only record of what has been disclosed. In all other mainstream areas within COPFS all documentary productions are either sent electronically or scanned and imported into SOS or FOS. Disclosure is then carried out electronically recording what was disclosed, to whom and when, as defence agents have their own passwords to allow them access to the website. It means nothing can be lost or misplaced. There is an automatic computerised record of all disclosure made with dates and times of download of this information by the defence. This record can be printed off and used as proof of disclosure. From our discussions with reporting agencies all informed us that they themselves scan all documents into their own data systems to retain copies for their own use before submitting the hard (original) copy to COPFS and it would be simple for them to submit this electronically to COPFS. If this were done it would mean that HSD administrative staff would not themselves have to scan and copy every document on to a pen drive but simply put it on to the web for agents to

access. As well as saving time this would be a more secure system also providing a record of disclosure.

67. We have discussed this with ISD and SDD who indicate that it is perfectly possible for HSD administrative staff to scan documents into the electronic case directory and thereafter disclose using the secure website. They also believe that if the reporting agencies send scanned versions down the SRA link then these scanned versions can be disclosed via the secure website. SDD plan to discuss this with HSD to move this forward.

68. When the police send statements and documents for any solemn case they also send a completed disclosure schedule which is treated as a living document by both them as they send additional material and COPFS to record decisions made about what disclosure is to be made, then what disclosure is made and when. It accordingly contains a complete record of all material in the possession of the reporting agency and COPFS and allows both to refer to it and to ensure all disclosure obligations are met. Neither HSE nor the Local Authorities do this and no disclosure schedule is prepared or contained within any case directory for any HSD case. Since most cases within HSD are resolved by a plea and indeed disclosure is carried out at the very earliest opportunity this issue has not yet been raised in court. However, it is a potential problem. It appears that, when COPFS were holding discussions about the whole issue of disclosure with the police, other reporting agencies were not included or even informed immediately afterwards and it is only recently that they are being made aware of their obligations. During our inspection deputes, local authority officers and representatives of HSE all voiced their concerns over this. They also indicated that proposed timescales for reporting agencies to comply with these new arrangements were impossible to meet. Training will be required for reporting officers and a programme should be agreed for commencement as soon as possible so that disclosure obligations can be met and demonstrated.

RECOMMENDATION 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.

RECOMMENDATION 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.

Precognition

69. HSD routinely precognosce witnesses when the case is allocated. According to Crown Office policy mainstream units no longer do so routinely. Instead they carry out “purpose driven precognition”. HSD staff at interview were clear that this precognition process is essential in order to prosecute this complex area of the law and that reports from the specialist agencies are not enough upon which to base decisions. HSD have no power to direct HSE to carry out further enquiries having to rely instead on co-operation. This is different to the situation with the police where there is power to direct. The precognition process however adds considerably to the time taken to reach a conclusion with cases reported to the unit and ways should be considered to reduce time spent on this including finding other ways to obtain information. Clearly it is essential HSD specialists are in full possession of the facts and if initial statements do not provide it then precognition has to continue as it enables pleas to be obtained in cases. Perhaps further training of specialist reporting agencies would lead to reports and statements meeting the needs of HSD, minimising the requirement for precognition, bringing HSD more into line with mainstream units and speeding up the prosecution process.

RECOMMENDATION 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.

Indictment

70. An indictment intended for trial includes all the charges, lists of witnesses and lists of productions. Only witnesses and items listed can be used at the trial. This court document, therefore, needs to be prepared to a very high standard. This is a very resource intensive procedure for COPFS.

71. On the other hand, where an accused has indicated an intention to plead guilty to agreed charges, a very short indictment (called s76) is prepared without the lists of witnesses etc. This is much less resource intensive as the case does not have to be prepared for trial.

72. The approach of HSD is to pursue an agreed plea. During our inspection we found only 4 cases out of 81 had been prepared for trial.

73. We are told there is delay in obtaining court time. Clearly this is less of an issue for summary work or for pleas. It is only in the event of a jury trial or Fatal Accident Inquiry which may take a few weeks, that there is a problem. Liaison with the Sheriff Clerks is essential to prevent delays.

Chapter 5

Management, Monitoring and Targets

Age Profile of Cases

74. During our inspection we consulted widely with (among others) agents acting for accused, agents acting for families of victims, reporting agencies and sheriffs. All expressed concerns about the age profile of cases and about their perceptions of delay in dealing with the cases from receipt of the report to getting the cases into court. We saw letters from next of kin and from MSPs and solicitors on their behalf making enquiry into the progress of cases. They also intimated concern over the length of time it took for decisions to be reached about whether there was to be a prosecution, an FAI, both or neither. They also expressed concern about how long it actually took for a conclusion of same. One such case was concluded 4 years after the incident, despite concern having been expressed before the case was transferred to HSD. Another case only came to conclusion over 5 years after the incident (concern having been expressed in the press about the delay). A further case took 5 years before a decision was made that no proceedings were to be taken. One is still being investigated 2½ years after the incident and has also received adverse press coverage.

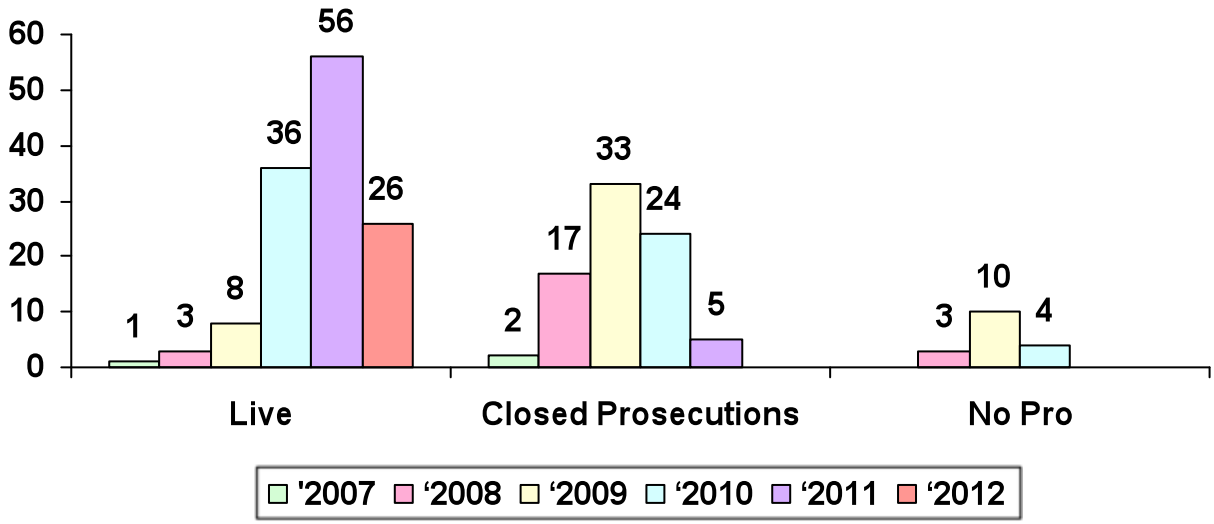
75. We accept some of these cases can be complex and time consuming.

76. The table below shows the status of cases since the Health and Safety Division was unofficially set up in October 2008 before being formally launched in July 2009. The figures have been extracted from HSD spreadsheets at 4 July 2012 and are based on year of receipt of the report. It is based on number of cases rather than number of accused. If cases have more than one accused with disposal dates in different years, the latter date has been used.

77. The Division took on old cases from the Areas including some from 2007. We wonder whether adequate consideration was given to the resource implications to appropriately deal with these old and very complex cases, some of which are still within HSD now.

78. As stated above, we were unable to obtain any data from any other source such as the national database. It has to be borne in mind that the spreadsheets have already been demonstrated to be inaccurate and out of date. There are ongoing investigations which are not recorded here as they are registered “not yet reported”.

79. **Profile of Cases 2007 - 4 July 2012 based on date of receipt:**



80. The above chart shows that the Health and Safety Division had (at 4 July 2012) a total of 130 live cases and 98 closed cases. 37% (or 48) of live cases were received before 2011 one of which was received in 2007, 3 in 2008, 8 in 2009 and 36 in 2010.

81. Of the 98 closed cases 17 (or 17%) were marked no proceedings or no further proceedings.

82. For the remaining 81 closed cases the choice of court forum was split as follows:

- 21 or 26% were dealt with on summary complaint
- 60 or 74% were dealt with on indictment (of these 60 cases 56 were agreed pleas and only 4 were prepared and proceeded to trial)

83. Reporting agencies for health and safety cases such as HSE, Local Authorities, BTP, Maritime and Coastguard Agency and ORR take long periods to report cases, often over 2 years. These agencies accept in the main that it would be helpful if HSD drove them to report more quickly. Although HSD, mostly through the Head of the Unit, is involved in the very early stages of investigation it might be helpful if the cases were then allocated at an early stage to the precognoscer. This would allow the precognoscer to be more involved in driving the investigation to an earlier conclusion. Alternatively the Head of Unit requires to drive the reporting agency to earlier report. It is clear that at the beginning of the investigation it is often not known if a crime has been committed and this accounts for some of the time taken to report the case to HSD. With more direction from HSD during this lengthy phase this process could be accelerated. There are numerous decisions to be made at this stage. These include matters such as –

- from whom to take statements

- the format of these interviews
- questions around compulsion and legal representation at interview
- decisions about what agency takes the lead. This can be time consuming especially where a Corporate Homicide charge may apply.
- requesting documents and information from companies who could ultimately be the accused
- when to seek this information by warrant

84. These are all time consuming matters but have a direct consequence on the outcome of the investigation. It would be beneficial if it were driven along more quickly. All reporting agencies are more than satisfied with the service provided meantime in the area of initial investigation. They have almost unfettered access to the Head of the Unit but it does appear from our investigation that enquiries are allowed to drift for long periods after that initial stage. It may be that this could be speeded up if there was even more, but differently focussed, involvement from HSD. Currently only the Head of the Unit is involved at the very initial investigative stage. This area of work is already very time consuming. If the Head of Unit took responsibility for ensuring reports were received by HSD at least within a year (which is the understanding of HSE) along with providing additional training and support for reporting agencies, day to day responsibility for decisions in processing cases would then primarily be delegated to Principal Deputes (PDs). In all other units PDs already have that responsibility. All work following receipt of the reports could be delegated to PDs, closely supervising precognoscers. The PDs would then have the responsibility of ensuring precognitions were concluded timeously under the general management of the Head of the Unit. This would allow a freer and speedier flow of work. An early decision identifying summary cases and those which require to be treated as Corporate Homicide is essential, even though this can be difficult.

85. Currently we have found that even when cases are reported to HSD they remain unallocated to a precognoscer for some months.

86. No doubt this delay was in part due to the frequent changeover of staff. Thereafter even when the case was allocated no early report target was given. We also found that as cases were re-allocated and went through several deputes who came and went from the unit no real effort was made to place new reporting targets on the cases and cases were not flagged up as priority.

87. We have also seen instances of cases where reports have been prepared by deputes but not sent for Crown Counsel's Instructions (CCI) for months. We saw a case where the death occurred some 5 years before any report went to Crown Office. This case came from HSE recommending that no proceedings should be taken. Although it was already 2 years old before it came into the new unit it did not appear to be treated with any urgency. Despite receiving frequent requests from the next of kin and their solicitors for progress reports,

and escalating demands to know if any priority had been given to this investigation, a report was not prepared for CCI until 52 months after the death. The report seeking CCI did not go to CC until another 8 months had passed. This delay is unexplained and of concern. Instructions agreeing with the recommendation not to proceed were given by Crown Counsel on the same day as sought. Meantime a "protective" civil action had to be raised on behalf of the next of kin to preserve their position within the civil time bar of three years. This action was sisted for about 18 months then later abandoned due to lack of essential documents and evidence upon which to base their case. The evidence was unavailable to representatives for the next of kin having been seized by reporting agencies, then passed to HSD. HSD were still holding this while considering whether there would be any criminal action or an FAI. The next of kin were only met and told formally of the decision 2 months after CCI were received and asked for their views on an FAI.

88. There is no further evidence of another report seeking CC's instructions re an FAI but the accused were informed after another two months that no further court action would be taken.

89. We also found another example in which CCI were received to proceed and some months later this instruction had not been carried out. In one case CCI were received to proceed by sheriff and jury and this was not acted upon for 7 months.

90. Initially cases were reported to Crown Counsel for decisions on prosecution but the question of FAI was not addressed until after the case had been concluded. We found examples where this was not done for years. This policy has now changed and instructions are sought simultaneously for prosecution and FAI.

91. We also note that in 6 cases prosecutions could not continue as the accused company had ceased trading, leaving no-one to prosecute. If cases were dealt with more speedily and could reach a conclusion more quickly the risk of this happening would reduce.

RECOMMENDATION 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.

RECOMMENDATION 17

We recommend that Crown Counsel's Instructions are acted upon within an agreed short timescale.

Targets

92. Cases appear to be routinely years in the preparation. Cases are reported to HSD years after the incident, then are investigated further by HSD for years with witnesses being precognosced by HSD. The default procedure for cases, whether or not they involve fatalities, appears to be indictment. Ordinary solemn cases in mainstream units usually start life on petition. This initiates a time bar of one year within which a trial must be commenced. HSD cases are never placed on petition as the accused are primarily companies and cannot be placed on petition so this target never kicks in. The cases dealt with in HSD accordingly do not have this one year procedural time bar and in addition health and safety legislation does not impose legal time bars.

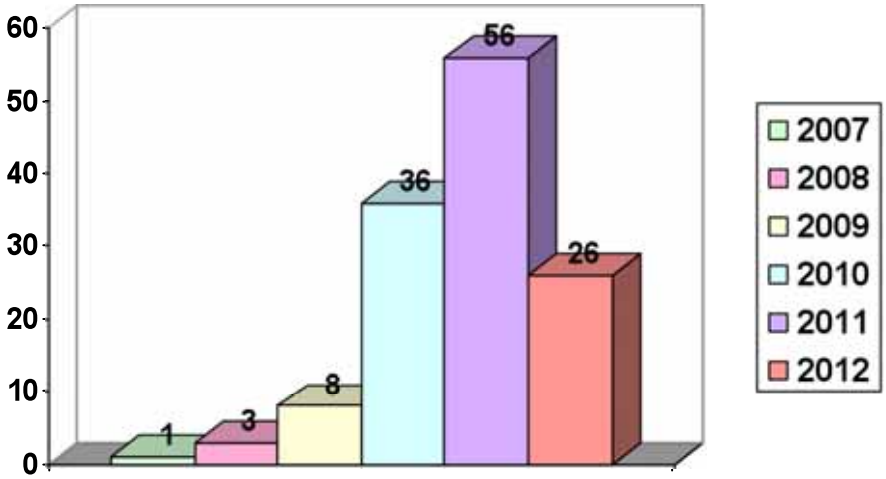
93. There are therefore no discernible targets within HSD.

94. HSD rely entirely on manual monitoring. Because they do not mark cases in FOS the statistics do not feature in the national database and so they are not automatically flagged up by MID. There is no apparent sense of urgency to meet either a legal time bar within which the case must be raised or a procedural legal time bar once the case has been commenced in court. The age profile of these cases is accordingly significant. We are told that most cases are given a target for reporting when an original allocation note is prepared and we have seen some during our inspection. However, as the cases routinely pass through several hands during the precognition process, by the time they get to the second or third person the cases will already have overshot the reporting target and do not seem to be given new ones. No further target is given to the case. It is all too easy for the case to drift and for time to pass.

95. As the cases can be complex it would not be realistic to anticipate that a “one size fits all” target would suit and that every case would be ready to proceed to court within a year of the investigation but some cases are less complex than others. It should be possible to have a realistic estimate of anticipated time scales at the start of each case, on a case by case basis. As the unit has been in existence for some 3 years staff should have more experience of the specialist work and be better able to gauge the appropriate timescales. On looking at the spreadsheets kept by HSD for their own use the age profile of their cases is of concern to us. The table below shows the age profile of cases currently being precognosced in the unit.

Age Profile of Cases on HSD Spreadsheet:

96. This spreadsheet shows the current state of work in hand as at 4 July 2012. The year shown relates to the year the report was received and **NOT** the date of the incident, which is often one or two years earlier.

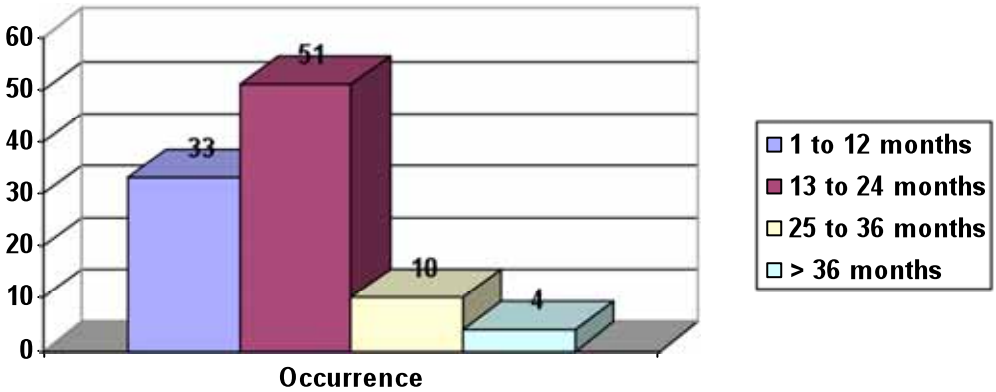


97. It can be seen that there are large numbers of cases which were reported to the HSD 2 years ago and which have not yet reached conclusion and there are 12 cases of over 3 years. Crown Counsel would welcome the idea of internal targets as a means to prevent long periods of delay, to prioritise work and as a management tool.

98. We also looked at the average time it took for a case to be dealt with.

99. By reviewing the HSD spreadsheets relating to all closed cases the following results were found. These include cases marked 'no proceedings' and 'no further proceedings' and are all cases dealt with by HSD since 2009:

100. **Time in months from receipt to disposal for all closed cases:**



101. As at 4 July 2012 a total of 98[2] cases had been closed by HSD. The above chart shows that 33 cases were dealt with between 1 and 12 months of receipt; 51 between 13 and 24 months; 10 between 25 and 36 months and 4 took more than 36 months to disposal.

[2] 81 closed prosecutions and 17 no proceedings or no further proceedings

102. It was noted that the time in months from receipt to disposal/verdict of a case ranged from 1 to 42 months with an average of 17 months.

103. Cases received within the unit when it was created, which had already been in local offices, do not appear to have been “fast-tracked”, even though they were older cases. We saw one case where the death occurred in October 2006, the report was received by COPFS locally in August 2008 and transferred to HSD when it was set up in March 2009. Disclosure was made to the defence in April 2009, CCI were received to proceed by sheriff and jury in September 2009 but the case did not get into court until February 2010 when it was resolved by plea.

104. We note as stated above that cases are usually at least a year and often more than 2 years old before any report is received in HSD. When this is added to the average of 17 months to reach a conclusion the triennium (a 3 year time bar) for civil cases has expired before cases reach conclusion. This delay seriously impacts on the ability of families of victims to appropriately seek redress from the accused company. HSE routinely refuse to provide any documentation or information to solicitors acting for the family until a conclusion is reached in the criminal case. At that stage they do hand over all documentation. Although civil proceedings can be raised and suspended it is often difficult for the family and their representatives to identify the correct body against which to raise their action if they are unable to obtain information from HSE until AFTER conclusion of the criminal case. By that time they may easily have exceeded the three year mark and cannot then raise proceedings.

RECOMMENDATION 18

We recommend that targets are imposed on reporting agencies to ensure cases are reported within much shorter timescales than at present.

RECOMMENDATION 19

We recommend that internal targets are put in place to avoid cases becoming too old for meaningful prosecution. This would have a beneficial effect on ensuing civil cases. 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.

RECOMMENDATION 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.

RECOMMENDATION 21

We recommend that HSD hold regular management meetings to ensure cases are progressed as quickly as possible.

RECOMMENDATION 22

We recommend that more cases are indicted into court for trial rather than waiting for the defence to agree a plea.

Management/monitoring

105. Because cases are not marked within FOS and are not always recorded in PROMIS (the two national databases), the cases cannot be monitored within the national database and therefore any monitoring of work has to be done manually. This involves Principal Deputes being personally aware of all ongoing work their team members have on their desk. Since HSD is a small unit this is possible to an extent but is not recommended as a good system. It also means that nationally (including the Management Board and Law Officers) there may be an incomplete picture of what work exists in the unit. Presumably in an effort to keep track of this we saw use of the "case load document" for overall monitoring and reporting to the Solicitor General. Again, this document was only as good as the information entered into it and was not fail-safe if cases were omitted for any reason.

106. Reports, letters emails and documents are not routinely kept in the electronic case records. They can not therefore be seen by anyone either managing the work or following on from someone who has left the unit. All documents should be imported into the electronic case record.

107. We found that almost every member of staff had created their own (different) way of recording their work or that of staff for whom they had responsibilities. This information was not communal or shared in any way. The best records we found to be created and maintained were those of VIA (see Chapter 6). The minute sheets there were comprehensive but often contained only information passed verbally to the VIA Officer by the precognoscer and were not 100% accurate for dates and so on.

108. We have found that even when cases are precognosced and sent to Crown Office for Crown Counsel's Instructions this is not always recorded in PROMIS. Administrative staff were aware of this problem and had in the past asked precognoscers to keep them "in the loop" when reports were sent from personal accounts. This was in an effort to keep better records. There is accordingly no record in the system to show the stage of the cases and this can cause difficulty in providing accurate information to next of kin on the actual state of the case.

109. As stated above, we found that cases were unallocated for months. No doubt this delay was due to the frequent change over of staff but thereafter even when the case was allocated no early report target was given and we found that as cases went through several deputes who came and went from the unit no real effort was made to place new reporting targets on the cases and cases were not flagged up as priority. We also found that although some cases were less complex they were not hurried through the process to an easy speedy conclusion. They simply joined the queue along with more complex cases.

110. Although many of the cases are complex and “one off” cases some are not following more routine types of accident. They do not require the same level of legal input either to regulate the investigation or to consider the law in depth in relation to the breach. Templates for some of these more routine types of case would help speed up the process such as work at height cases. This would allow a Precognition Officer (PO) to work to a format with minimal supervision, turning cases out more quickly where appropriate. A PO requires a high level of supervision as they are not able to have meaningful meetings with agents to agree pleas, draft charges and narratives but could do this type of work, freeing up deputes to carry out more of the legal work. Job descriptions for POs and Principal Deputes would be of benefit here in clarifying responsibilities.

111. In cases where Corporate Homicide is under consideration we found two areas of bottleneck. Firstly in determining whether it is a corporate homicide as this determines whether the HSE/Local Authority or police have primacy in investigating, taking witness statements, etc. Delay in a decision here means that the investigation comes to a stop as neither knows who is to conduct the interviews and then how they are carried out. The second bottleneck is once the case is reported as a possible Corporate Homicide (CH). It appears that it would be helpful to have an early decision about whether that charge is likely or not and CCI should be sought. Since no such case has yet been prosecuted there is a level of uncertainty amongst the precognoscers about how to tackle it. It would be of benefit if the precognoscer could be told initially if it is unlikely to be a Corporate Homicide as they could immediately precognosce as normal. If it is to be a CH then a different approach may be necessary but clear monitoring and management of the case would be required by the PDs and the Head of Unit.

112. It also appeared to us that the PDs do not have full autonomy for countersigning cases as all key decisions seem to have to be made by the Head of Unit including forum, draft charges, pleas and any agreed narrative. This is not an efficient way of working and fails to make full use of the PD grade. In every other unit deputes of this grade make these key decisions. It also causes a bottleneck for work as the Head of Unit is more than fully occupied with the early stages of investigation of new cases and working closely with HSE. There is insufficient time

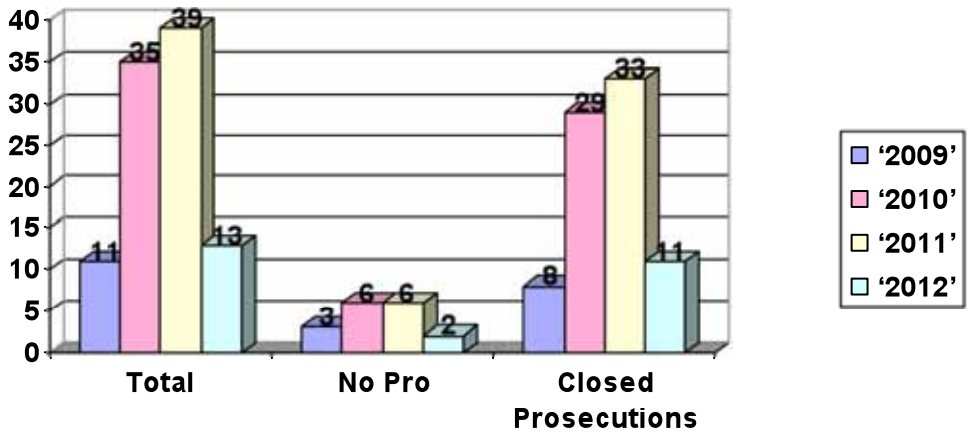
for one person to deal with the initial stages in addition to the latter stages. We have seen that this delays decisions as well as disenfranchising perfectly able PDs who should be supervising the precognition process.

113. We found an instance where a plea and narrative had been agreed by the defence and CC had instructed this plea was acceptable. However on the day before the case was pre-arranged to call in court it was decided the narrative was not acceptable. Although the case was due to call in court next day it did not, and before the case could be prosecuted, the company went into liquidation months later and could not then be prosecuted.

114. We found inexplicable delays where deputes had worked on cases and prepared reports for CCI but the only electronic record of the case shows it being sent to Crown Office up to a year later.

115. We looked at the level of work coming out of the unit since 2009 and the volume of work going in and have concerns that the work within the unit to be processed is rising. The input is greater than the output. It has to be borne in mind that HSD took on a large number of "legacy" cases which by definition were the most complex of cases. Some of them were already very old before they came to HSD.

116. **Cases closed years 2009 – 2012 (4 July 2012)[3]:**



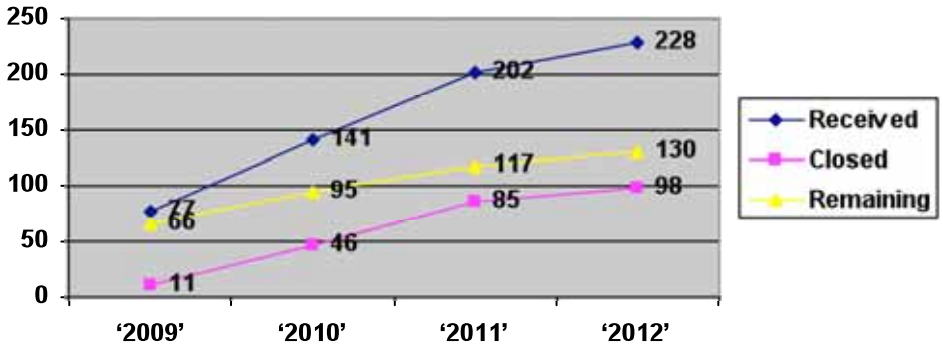
117. The above table shows a total of 11 cases were closed in 2009; 35 in 2010; 39 in 2011 and 13 in 2012 (up to 4 July 2012) totalling 98.

118. This compares with input over the same periods of 77 in 2009 (this includes cases from 2007 & 2008); 64 in 2010; 61 in 2011 and 26 in

[3] Figures are based on number of cases and not number of accused. If however the case has multiple accused with different verdict dates in different years, we have chosen the latter disposal date.

2012 (up to 4 July 2012) totalling 228 cases which can be shown as follows:

119. **Cumulative numbers of cases received since 2009 compared with cumulative number of cases closed since 2009 to 2012 (at 4 July 2012):**



120. The above chart shows that 57% (130 from 228) of cases received during the whole period are still live. Based on average annual output over the period of 29 cases it can be said that it could take 4½ years to clear the current case load.

RECOMMENDATION 23

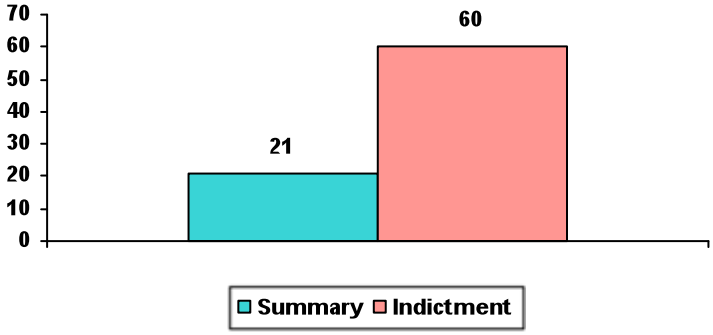
We recommend that all mail and documents created within HSD are stored in the electronic record of the case.

RECOMMENDATION 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.

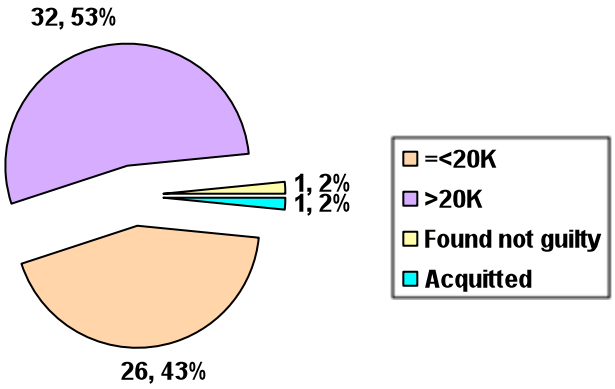
Forum of Closed Cases at 4 July 2012:

121. This chart excludes 'no proceedings' cases. From inception of the unit, 21 cases (26%) were dealt with on summary charge with the remaining 60 cases (74%) placed on indictment:



122. The chart below shows that 43% (or 26) of the 60 cases that proceeded on indictment resulted in fines that can be awarded in a summary court (£20,000 or less). Given that the general policy is for proceedings to take an "outcome based" approach it can be argued that perhaps for these 26 cases summary procedure may have been a more appropriate forum given the final results. 53% (or 32) of the 60 cases resulted in fines appropriate to the forum in which it was processed and one case was found not guilty with one other resulting in an acquittal.

123. **Results of cases placed on indictment are as follows:**



RECOMMENDATION 25

We recommend that early consideration is given to placing cases wherever appropriate on summary complaint and fixing court dates for them as priority.

Geographic Allocation and Management of Work

124. It is clear from the way the unit was originally presented by the Lord Advocate that a great deal of importance was attached to the geographical links between the individuals in the unit and the Reporting Agencies. One of the theories and best practice is that the precognition work should ideally be done by the same depute who then prosecutes the case in court. Obviously ideally it should allow for that depute to know the court and all connected personnel and to be able to live at home during the life of the court case. Typically the cases last for some three weeks.

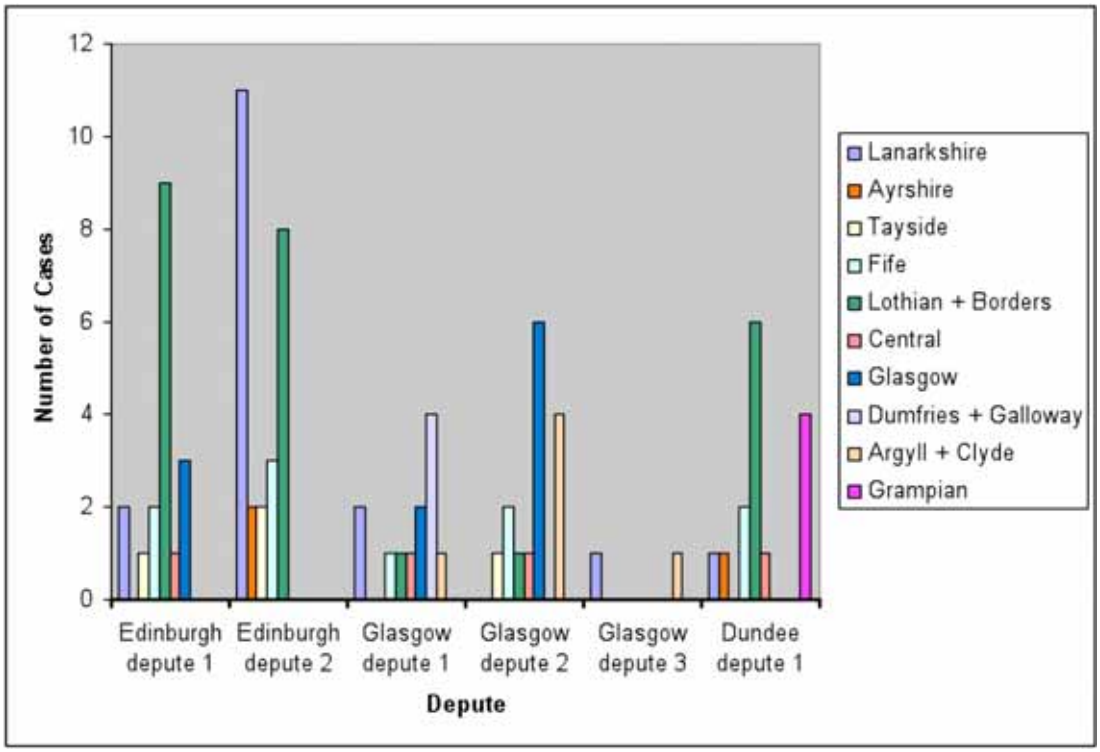
125. This sensible ideal appears to have been mirrored in the allocation of work at the birth of HSD but due to the frequent high turn over of staff and the necessity to re-allocate work this has not been followed through.

126. On looking at the spread of work currently allocated we have found that there is no longer any close geographical connection between the incident, with all its associated witnesses and reporting agency, and the depute within the unit. A depute based in Edinburgh is as likely to be prosecuting cases in Dumfries as they are in Lothian and Borders or

Central while the depute based in Dundee is as likely to be prosecuting in Lothian and Borders as in Fife or Grampian. Indeed we are aware that an Edinburgh-based depute was specifically allocated a three week trial in Glasgow with all the associated displacement issues involved for the duration of the trial. On looking at the case load of an Edinburgh depute it can be seen it includes a case in Kilmarnock another in Hamilton along with 2 in Tayside, 3 in Fife and 1 in Ayrshire. Trials in any of those will involve upheaval and a "familiarisation" time for each different court. While it is clearly difficult to re-allocate work appropriately this spread of work is inefficient.

127. It also appears to militate against the idea of having three bases for HSD to be attached to local HSE, witnesses and courts.

128. **Work Allocated Geographically to Deputes:**



129. The spread of work and the geographical set up of staff also adversely affects the monitoring of the work.

130. The PD for the West is based in Glasgow and has line management responsibility for deputes and a Precognition Officer (PO) in Glasgow which works well.

131. There is no PD for the East. The PD for the North is based in Elgin and has line management responsibilities for one depute based in Dundee and two deputes based in Edinburgh along with a Fiscal Officer based in Aberdeen. This is all far from ideal. Contact is by phone and email but of necessity involves discussion about particular cases without

access to papers. Although, as we have mentioned, the original report is now sent electronically and is on the system only some statements and no documentary productions are contained in the electronic case. No mail or emails are imported in to electronic case papers. It appears that in any discussion involving this remote PD of a case during its life the case may not be seen again by the PD unless he comes to Edinburgh and he is relying on memory of the case at allocation or notes made by him then.

132. We were told that the PDs do meet and discuss allocation of work on an irregular basis since one is based in Elgin and the other two in Glasgow. However, it appears that when work is allocated, allocation notes are prepared by the PD with line management responsibility for the depute. This must involve case papers travelling round the country. For at least a year (2011 to 2012), due to reduced administrative resources, all administrative work for HSD was carried out in Glasgow. There is no administrative support in Edinburgh. This means that if a case is allocated to a depute in Edinburgh the case may be in Glasgow for administrative work and for allocation discussions, then be sent to Elgin for the PD to prepare an allocation note before being sent to Edinburgh for the depute to work on. For the PD to countersign the case it appears the case may again be physically transported to him before returning to Glasgow for administration purposes.

RECOMMENDATION 26

We recommend that work is allocated geographically wherever possible.

Chapter 6

Staffing/Training

133. The unit is overseen by a Legal Manager. At the moment it is part of SFIU but during our inspection there were discussions about it becoming part of Serious and Organised Crime Division (SOCD).

134. A Victim Information and Advice (VIA) Officer based in Glasgow is attached to the whole unit.

135. The North is staffed by a Principal Depute, a Senior Depute and a Fiscal Officer.

136. The East is staffed by a Senior Depute and a Depute and is overseen by the Principal Depute for the North.

137. The West is staffed by a part time Principal Depute, two Senior Deputes, a Precognition Officer, an administrative manager and two Fiscal Officers. Temporarily another Senior Depute is attached to deal with one particular large case. A new Principal Depute has been appointed to oversee another large case and, during our inspection, two additional deputes were seconded to deal with that case.

138. When the HSD was set up, there was an administrative manager based in Glasgow, with two Fiscal Officers (FO) there, one FO in Edinburgh and one in Aberdeen. Later it was decided that Edinburgh did not require an FO.

Dedicated Crown Counsel

139. Crown Counsel are very satisfied with the standard of work coming from HSD.

140. When HSD was set up it was clear that the intention was to have dedicated Crown Counsel attached. Experience would be built up in this sphere at Crown Counsel level as well as in HSD itself. All HSD cases would go to this person to be read and advice could be sought from him/her during the investigation of a case when required, rather than simply at the end. This is a commendable idea, providing a known point of contact for legal advice for HSD. It also provided a means for a single person to make all decisions about a case through its life and avoid double handling.

141. The reality however is somewhat different. The first case likely to proceed in the High Court was actually allocated to someone other than the dedicated Crown Counsel. That AD however has been responsible for the case throughout its life. In fact, since the inception of HSD, no case has ever been prosecuted in the High Court so Crown

Counsel have no practical experience of prosecuting a health and safety case.

142. During our investigation we found that one person was nominated as dedicated Crown Counsel for health and safety but was involved at all times with other criminal cases. He is regularly involved in murder trials lasting for weeks during which no HSD work can be done. HSD work appears to be in addition to all other mainstream work. Effectively HSD cases allocated to him can often sit for long periods unattended, adding to delays in reaching any conclusion. It also appeared that when cases arrive some are much easier and quicker to deal with than others but this is not apparent until the case is read. It would be easier if Crown Counsel and the person arranging the rota knew from the start if the case was one which could be dealt with quickly or one which required time. During discussion it appeared Crown Counsel are very open to having internal imposed targets as a means of managing work to enable the rota for Crown Counsel to better release him for HSD work. It appears that more effort is required to release him for HSD work when required. Another option which found merit was in having two dedicated Crown Counsel at all times. This would mean a better opportunity for work to be dealt with more quickly, would mean counsel could discuss more complex pieces of work with each other and would also mean an overlap. Crown Counsel are only in post for short periods and could be appointed on a “staggered” basis so that new entrants would have the benefit of the experience of one in post for a period.

RECOMMENDATION 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.

RECOMMENDATION 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.

143. Staff turnover of deputes is a problem for this unit. This view was reflected in comments by both reporting agencies and defence solicitors. It appears that adverts for vacancies often have few or no applicants and often deputes are prepared to join the unit only on the basis of obtaining temporary promotion. Deputes we spoke to who have been involved in health and safety work indicated that they did enjoy the work itself. Many members of staff have received praise from criminal justice partners for their dedication to the investigation of cases.

144. Staffing in general has been an issue for the HSD. It has taken time for the numbers of administrative staff to be defined. In 2011-2012 there was no administrative resource in Aberdeen and reduced administrative resource in Glasgow, leaving the Band C and one FO covering for them all. The Glasgow FO was only replaced in August 2012. During this time all disclosure for HSD was being done in Glasgow. Only some cases at that time were electronic. Productions in particular are still not sent electronically from the agencies, and statements are only sometimes sent electronically. This means that disclosure is carried out on hard copy cases, redacted and copied onto a pen drive. To carry this out, hard copy cases were being sent from the office of origin (Edinburgh or Aberdeen) to Glasgow to be copied on to pen drive, then the pen drive and the papers sent back to the office of origin. Since there are no copies of the cases this incurred a real risk of loss in transit.

145. HSD has its own dedicated VIA member of staff. At first we thought this was excessive for the relatively small number of cases dealt with by the unit, particularly when compared to the SFIU, which has a much larger number of cases but does not have its own dedicated VIA person but as discussed below we found that the VIA Officer played a very important role. When there was a shortage of FOs within HSD it would have been helpful for the VIA person to assist in this area of work but lack of training in this area prevented this and it was considered to be too time consuming to take time out to train her. Accordingly she was unable to assist. There are plans now to train both her and the new FO upon her arrival to ensure assistance could be obtained from this area when required in future. In addition the Band C Manager was then carrying out administrative tasks to support the staff and had no time to carry out Band C work.

RECOMMENDATION 29

We recommend that original hard copy papers should not routinely be sent from office to office.

RECOMMENDATION 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.

146. Since HSD was set up in March 2009 the turnover of legal staff has been continuous. Recently in 2012 Edinburgh lost one depute who was only replaced some 4 months later. Two of the Senior Deputes in Glasgow left. Only one has been fully replaced. This has left huge gaps in the resourcing of the unit. Many cases have had to be passed on to as many as three different deputes or POs and one case we found had been in the hands of 7 people. Only some of the cases which had been allocated to the Edinburgh Depute and one of the Glasgow Senior Deputes have been re-allocated (as at November). This obviously

slows down the whole preparation and investigation process. If the outgoing person leaves long before the replacement arrives there can be no meaningful handover of information about the case. Most of the correspondence is carried out through personal accounts. It relies upon the outgoing person printing off pages for the benefit of the new person. The outgoing person is not in a position to pass on to defence solicitors the name of the next contact. The new precognoscer is largely unsighted on the finer nuances of the case. As a result some cases have fallen into the trap of not being worked on for years. The age profile of work in the unit is a matter of concern as discussed above. Multiple handling does not assist in the speedy conclusion of cases.

147. The work is clearly specialised and it takes a considerable period of time for deputes to become “experts” in this field. It is anticipated by the Head of Division that deputes should remain in the unit for a few years to attain expertise with no need to leave if the work suits them. The work clearly does not suit all deputes, particularly as very few cases proceed to trial. Deputes may be concerned at becoming “de-skilled” or simply do not enjoy working with one or two cases for years to the exclusion of everything else. Others feel that their confidence has been affected by their experience within the unit as they are given little or no authority.

148. Many deputes have indicated they feel that their time and experience within this specialist unit does not enhance their career prospects, might not be worth doing and that their experience as specialist deputes is not valued by COPFS. In any event, for whatever reason, many deputes have left the unit after a very short period, having started work on a few cases without bringing them to a conclusion. Their replacement then has to start again. Thus time is wasted on many occasions.

149. We consider that efficiencies could be made in the management of this unit and accordingly could not at this stage make any comment about whether additional resources are required.

RECOMMENDATION 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.

RECOMMENDATION 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.

RECOMMENDATION 33

We recommend that consideration be given to creating a "reserve list" to minimise delays in recruiting.

Role of Victim Information and Advice (VIA)

150. VIA play a significant role in dealing with distressed next of kin or victims especially those who are aggrieved by the delays in achieving closure in their cases. The VIA Officer is often the only constant throughout the life of cases. She provides support to the next of kin through the investigation and any court process. The VIA Officer in HSD manages their concerns and anger over the issue of delay very ably. She keeps very close regular contact with them, advising them where she can of the current state of the case and manages their expectations.

151. In examining individual cases we have perused VIA minute sheets. They contain very careful notes of each telephone call and action taken. They are often the sole electronic record of the person to whom cases have been allocated and when. They use the electronic B/U ('bring up') system to keep on top of each case. Each telephone call or email sent and received is accounted for. A record is made noting concerns, what information was passed on to the next of kin and what steps were taken by VIA to press the precognoscer and/or manager to reach speedier conclusions in the cases. It is clear that many uncomfortable conversations have been fielded by VIA with these relatives in what are extremely sensitive and anxious circumstances. VIA appear to have the only B/U system in HSD for looking at cases on a monthly basis and appear often to draw cases to the attention of the manager or precognoscer.

152. VIA also keep an "anniversary" list, noting significant dates, such as the date of incident or death and what would have been birthdays for deceased. VIA advise the precognoscers of these dates and ensure they or VIA try to make or avoid contact on these significant dates, whichever is most appreciated by the individual next of kin. This is another way of keeping next of kin informed of progress or lack of progress. More use should be made of this B/U system by managers to monitor progress and to drive cases to a conclusion.

153. There have been no formal complaints registered in RESPOND (the COPFS system for recording complaints etc) about the delay in concluding cases. It is clear that because of the regular contact maintained by both VIA and the individual precognoscers good relationships are fostered and maintained. Any complaints are voiced during this contact and addressed. Complaints do not therefore escalate into more formal letters. Many members of staff have indicated that they are surprised that so far next of kin have accepted these explanations without taking the matter further. It is clear that

many “informal” complaints have been made but are not recorded. It is also clear that many letters of thanks or expressions of gratitude have been received, in particular by VIA. These have not been recorded either.

RECOMMENDATION 34

We recommend that all complaints and compliments should be recorded in Respond, to monitor how HSD is performing.

RECOMMENDATION 35

We recommend that a B/U (bring up) system is used by all managers in HSD to monitor the progress of cases.

Training

154. At the inception of the HSD some training on specific topics such as Asbestos Regulations was delivered by HSE to HSD team members in 2009/2010. While this was of some interest deputes have expressed the need for more specific legal training. They indicate this would be of more value to all but particularly to new members of the team.

155. Defence solicitors specialise in this field from an early stage in their career, seeing themselves as true experts. They express the view in the main that it is impossible to be a health and safety expert if the lawyer only works in this field for a year or two. They indicate they are (and appear to be) better resourced as “experts” than the Crown. We agree with this view.

156. A library of case law and styles for charges and narratives has been built up in HSD and is available for use within the unit. This is of very great benefit to all, not just new team members, and was commended by all deputes.

157. Since the unit was set up to house specialists specific training should be provided to legal staff upon joining the unit. Generally upon arrival deputes are simply presented with a copy of the Health and Safety at Work Act and copies of narratives and indictments which have been successfully used in closed cases. While it is clearly of benefit for new deputes to read these documents, some additional personal, pertinent and informal guidance would be more useful in bringing them up to speed as “experts” in this very specialised field of work. Where new team members are lucky enough to be located near experienced team members there appears to be great benefit in shared knowledge and “mentoring”. There does not seem to be any structure within the unit for providing either formal or informal training on health and safety law to new members of staff. A large amount of training appears to be “on the job” training. It appears there is an intention to begin some more formalised training. It would be helpful to have a “pack” of useful policy,

guidance and the law for all new entrants, updated as and when changes to the law and practice occur.

158. An “in-house” training day was held in June 2012. The dedicated Health and Safety Counsel also participated. Training was informal and centred round deputes discussing recent court experiences, sharing information about problems which had arisen during these trials and how they had been dealt with. It is clear all found this particularly helpful. This was all the more relevant as only 3 deputes in the unit have ever conducted a health and safety trial. It is a matter of note and some concern that only deputes have conducted trials so far with no PDs or above ever having done so. Crown Counsel also has never carried out a health and safety prosecution. This has led to a lack of shared trial experience and also a lack of relevant Scottish case law. The only recently tested decisions are from English cases and it is unclear how the Scottish courts will deal with these decisions. There has now been a further training session in October which coincided with new team members arriving.

159. All deputes agree it takes a long time to become familiar with health and safety law. There is general agreement that it takes at least 18 months before new team members have developed confidence and enough knowledge to deal with cases effectively. Some training in the law, delivered informally by sessions such as occurred in June 2012, at the start of every secondment would be of assistance in reducing the time taken to achieve a level of expertise. This along with court experience would be of benefit to developing expertise. To this end it might be helpful if HSD kept **ALL** health and safety FAIs. The straightforward ones go to SFIU. Experience in dealing with “experts” and leading technical evidence in court would be helpful to deputes within HSD. It would also benefit them to maintain their jury court practice by prosecuting occasional jury trials. This would of course have resourcing implications for the unit.

RECOMMENDATION 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.

RECOMMENDATION 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.

Team briefings

160. HSD was set up in March 2009. Prior to our inspection there had only been one team briefing. Due to the geographical location of the unit some members of the unit have to attend via Video Conferencing (VC). The first team briefing recorded was on 10 February 2010.

161. Unfortunately, due to technical difficulties with Video Conferencing equipment, team members from Edinburgh were unable to be present or take part. At that time, it was noted that it was intended to have regular briefings, every 6 weeks. An agenda was prepared for the next meeting on 7 April 2010 but it does not appear to have taken place and no other briefing took place until 23 August 2012, during the period of our review. On this occasion, members of staff from Aberdeen, Elgin and Edinburgh were able to attend via VC. Again it was noted that meetings should be held every 6 to 8 weeks with the next scheduled for September 2012. We note that there have since also been briefings with minutes in October and November.

162. Some team members are very isolated, effectively working alone within a local office, meeting with other team members on an infrequent basis. While the work can be carried out in this way it would appear to be even more important to generate and maintain team identity by having regular team briefings. It is apparent that there is regular daily contact between all offices by telephone and email but some team members would benefit from more regular contact with their colleagues.

RECOMMENDATION 38

It is recommended that regular team briefings are held and minutes noted and recorded on the shared drive.

Chapter 7

Criminal Justice Partners

163. While the vast majority of cases are reported by HSE we found from the spreadsheets that out of 228 cases received since 2009, 45 (or 20%) were non-HSE.

164. British Transport Police (BTP) indicated they had a good relationship with HSD and had built up trust on both sides. As a direct result of the creation of HSD and having a permanent point of contact they reported there was better consistency of approach by COPFS, more accessibility to decision makers, (namely Head of Unit) and they could thus obtain instant decisions. They could see benefits since HSD was set up. They would welcome HSD enforcing more time constraints on them for submitting cases as they believed this would speed up the time taken by BTP to report.

165. The Office of Rail Regulation (ORR) agreed that following the creation of HSD there was better decision making and more accessibility to head of HSD. Once the case was allocated they enjoyed good contact with the precognoscer. They were particularly satisfied with the level of consultation about pleas being negotiated and the agreed narratives. One of their main aims in a prosecution was to obtain publicity for the breach, to educate the industry and avoid repetition of the accidents. By having a more co-ordinated approach to any plea being tendered in court they were able to marshall their publicity relations unit to ensure they obtained maximum appropriate publicity. They indicated, however, that before HSD there had been more discussion with the local Procurator Fiscal as soon as the case was reported and any difficulty was communicated immediately so any further work could be done by ORR at the earliest opportunity. Now there tended to be delay before any discussion took place which meant additional work was carried out a long time later. This mirrored our findings about delay in allocation of cases. This was not beneficial either to the Reporting Officer or to the case. The vast majority of their cases involved fatalities and were dealt with on indictment.

166. Local Authorities echoed the improvement of liaison about individual cases since HSD came into being and applauded also the consultation about pleas. In their view this enabled them to organise the media as above. The reporting officer could attend court to see and hear what was said. This was in itself a useful training tool since so few officers were ever asked to give evidence. It gave a sense of job satisfaction. Whilst they currently accepted liaison on a case by case basis they sought more general formal liaison and training. A benefit was that they now knew who was dealing with health and safety cases in contrast with non-health and safety cases reported by them (such as environmental health cases). They reported that all deputes were

approachable on an individual basis and that the trend was for cases to be concluded by plea rather than go to trial.

167. HSE were supportive of the service provided by HSD, stating it was a much improved service, particularly at the initial investigation stage. Having a known point of contact and consistency in decision making was an improvement from individual local Fiscals with different levels of skill and knowledge of health and safety. They also appreciated being consulted about pleas for the same reasons given by others. It also helped them to understand why some pleas were accepted and not others so was educational for them.

168. HSE also commented that improved media handling was a real benefit of the set up with HSD. It also seemed to HSE that there was a better understanding generally among deputes in SFIU and in the police about when HSE should be involved. In the past they were often not informed until too late about an incident but their view is that this is now much better regulated.

169. They also indicated that liaison with the police in potential corporate homicide cases was now much improved due to liaison with HSD.

170. HSE expressed concern not to have been involved in discussions about disclosure for as long as the police had been. They did not think they would be able to comply with the new requirements within the timescale first suggested. They did think they should have been advised even if not involved as soon as discussions began with police to allow them to have a chance to get ready with disclosure schedules.

171. Many agencies praised individual members of HSD for their work and dedication.

172. All agencies expressed frustration about the length of time it took for any case to be prosecuted after they had reported it. It appeared to many that cases went into a “black hole” after they reached HSD. Many mentioned the inevitable “bottleneck” where all decisions were funnelled through one individual and thought staffing must be an issue causing delay. Many thought that in some cases summary procedure was the appropriate forum and indictment should not always be the default position as this procedure took much longer. There was general agreement that some cases did not merit indictment penalties and while they had been keen for the serious nature of health and safety offences to be highlighted in this way they would sacrifice this publicity to achieve speedier resolution.

173. Some cases were relatively straightforward but it was thought these were held up in a “queuing system” only proceeding as fast as the most complex, slowest case. There were questions about whether some could be short-circuited for example by template or style.

174. Most also felt that the added layers when corporate homicide was a consideration led to huge delays. This was because the police took primacy until it was decided Corporate Homicide was not an issue. Initially the case might be considered jointly, then by the police, then handed over to the other reporting agency. During the initial phase there might be discussions about how interviews would be conducted, by whom and whether this was to be with assistance from the other agency or not. There was a general belief that the protocol for dealing with Corporate Homicide was too cumbersome.

175. All agreed that HSD had done a good job in obtaining pleas in cases. This resulted in great savings of their time as witnesses in court. The down side was no case law developed and investigators did not obtain experience in giving evidence. Experts were not tested in court either.

176. We saw a wide spread of solicitors working in the field of health and safety. Some represented the companies who were subsequently accused, some represented insurance companies who were paying for a defence for the accused and for any civil claim. Some represented the families of victims in the criminal and civil case. Surprisingly most agreed upon the main points. All applauded the set up of the specialist division. All agreed it was of benefit for the Crown to have their own experts in the field with whom they could have early, meaningful discussions. All agreed that a known point of contact, namely the Head of Unit was a huge benefit. As with the reporting agencies many commented positively on the approachability and dedication of individual members of staff.

177. There was also very positive feedback about early disclosure. Delay was the universal problem for them. Many have been quoted in the press in relation to complaints about the delay in specific cases and the effect this has on associated civil claims.

178. Many felt they and their clients were reliant on the conclusion of FAIs before they could process civil claims. They voiced concerns that they were unable to obtain vital information from the reporting agencies until conclusion of HSD work. Given that the triennium applies here they were at a real disadvantage when criminal proceedings and/or FAIs were taking over three years to conclude. Solicitors acting for accused companies were all keen to emphasise that they and their clients did not want delay. Many reported that their clients were horrified by the events which had caused injury or worse to employees of theirs and from a human point of view wanted to be punished. They also wanted to draw a line under the incident. Others were also concerned about the reputation of their companies and wanted to pay any fine with the minimum of fuss along with any compensation due as soon as possible. All agreed, however, that delay in dealing with the case allowed companies to rectify whatever error or failure had caused the incident.

179. The strongly held views of deputes within the unit was that a major reason for delay was that defence solicitors required time to obtain instructions from their clients. Solicitors, however, indicated that they had no difficulty in obtaining instructions from either individuals or from a board of directors and they saw delays in the Crown accepting tentative pleas, sending draft charges and narratives for negotiation and agreement, then obtaining final agreement or Crown Counsel's instructions once agreed by parties.

180. Solicitors did question whether the noticeable turnover of staff contributed to the problem of delays and questioned also whether that affected the development of expertise within the unit.

181. Most solicitors accepted that pleas of guilty were inevitable in this area of law as the legislation provided little "wriggle room" for the defence but many indicated that the insistence of proceeding on indictment in the majority of cases prevented or delayed pleas. No-one questioned the merit of indictment in cases of fatality.

182. Another issue of contention was that following a long process of agreeing charges and narratives (after the court appearance) there was an insistence by HSD to issue a press statement. This was never agreed. They were concerned that it could damage reputations which had been a major consideration in the agreement. In fact since solicitors were unable to predict what might be said on this occasion it was now a sticking point in agreeing pleas. The same did not apply to press releases by HSE and reporting agencies who were keen to promote good health and safety practice. Those to whom we spoke could not see the relevance or benefit of the Crown statement. HSD did not agree that their press statements were a problem. We examined all HSD press statements and compared them with the agreed narratives. We did not find any inconsistencies between them.

183. All expressed concern at the additional time and complications caused by the protocol in the investigation of fatalities. The system can involve double handling.

184. Solicitors acting for families expressed concern that HSE and other reporting agencies would not provide any information to them during an investigation and they were also unable to speak to witnesses in the case until a conclusion was reached by the Crown in relation to the criminal case. This endangered their civil claim which has a three year time bar unlike the criminal case which has none. They could raise a case where they knew who to raise it against, then have it sisted until conclusion of the criminal case. They were, however, unable to do so if they were unaware of who to raise the action against. This obviously prejudiced their clients who were invariably the family of a victim. If the Crown case were to be disposed of more quickly it would not interfere with their civil action ultimately resulting in compensation being paid to families more quickly.

185. Sheriffs we spoke to appreciated receiving the agreed narrative in advance of the plea along with financial information. They were also positive about the pleas. They did, however, express disquiet about the delays in cases coming to court. In one case, where there was an agreed plea, in open court the sheriff demanded an explanation for the delay. He was not entirely satisfied with the explanations. In another case where there had been a debate the defence sought leave to appeal which was opposed by the Crown on the basis it would delay the case. The sheriff was of the view that the Crown had been responsible for delay and indicated that the Crown should not have opposed the motion. Other sheriffs also had concerns. During our investigation delay and age of cases was mentioned by all.

Liaison with Criminal Justice Partners

186. Findings during our investigations were mixed. HSE and ORR are content with quarterly formal liaison meetings with HSD. They are also positive about the unlimited access they have to HSD Head of Unit. They are also content with regular liaison meetings between HSE, ORR, HSD and the police in relation to Corporate Homicide cases. However, none of the other reporting agencies appear to have any formal liaison with HSD. The Local Authorities were very vocal in their view that some formal liaison, perhaps once a year, would be of huge benefit to them and indirectly to HSD as they think this would go some way towards improving the quality of their reports.

Training of reporting agencies

187. There did not appear to be much training provided to reporting agencies other than on a case by case basis. While that may be effective with reporting officers with larger case loads who report cases on a regular basis it is not effective for those who rarely report. HSE were satisfied they had had some training from the Head of HSD and a member of staff on one or two topics, including Corporate Homicide, but appeared to be content to provide their own nationwide training. Given that HSD routinely feel the need to precognosce witnesses this suggests that more training of HSE is required, to permit more minimal precognition by HSD and to save time.

188. Local Authority representatives to whom we spoke, however, expressed anxiety about lack of training. They have made attempts to involve HSD in delivering training to them but this has not borne fruit. Although there are numerous Local Authorities (32), they are all pulled together under the umbrella of Royal Environmental Health Officers of Scotland (REHIS). This body does deliver training to its members with occasional input from HSE officers. During our investigation we attended a training session organised by this body. On this occasion they had sought input from HSD who had been unable to assist. There was, however, someone from HSE to deliver training to them at that same event.

189. There were concerns voiced from REHIS that they were “overlooked” by HSD. They indicated they had recently received comments about contents of their reports and looming issues, such as disclosure, second hand from HSE. They did not feel they should be receiving such messages indirectly, preferring to have first hand contact with HSD.

190. Members of REHIS had taken up an offer by the police to deliver a half day course on report writing, delivered at Tulliallan Police College during August 2012. Such was the level of interest that the course was delivered both morning and afternoon that day. Unfortunately, although the COPFS representative gave a well received presentation, it was not as pertinent as one delivered by HSD itself. This demonstrates the perception of Environmental Health Officers of their need for training and their willingness to be trained. This course was a “one off” offered by Tulliallan trainers who had free capacity and there is no guarantee that it will be repeated. While this course covered “report writing” in general terms it did not cover health and safety cases, nor did it cover their other area of concern, sending reports down the electronic link.

191. The Office of Rail Regulation were positive about their relationship with HSD and HSD were satisfied with reports from this body.

Chapter 8

Conclusions

192. The work which is produced at the end of the process by HSD is of very high quality. This was the view of Crown Counsel, reporting agencies and solicitors.

193. The presumption appears to be for cases to proceed on indictment. It is questionable whether this is appropriate given that the maximum sentence for summary is £20,000. Not all breaches are so serious they merit solemn procedure and not all companies are able to pay fines in excess of £20,000. It should be quicker to proceed on summary although we came across some cases which did not call in court on summary complaint for at least a year.

194. Conversely, one case which was marked without delay, on summary complaint, was in court only 5 weeks after the report was received and received a £2,000 fine following an immediate plea of guilty. This case bypassed HSD but was dealt with efficiently by the local office none the less. Cases dealt with in the unit take much longer. One example involved a straightforward case, but while the case was received in May 2009 was not ready for court on indictment as a plea until August 2010. Other cases which have been disposed of on indictment have taken on average, as indicated above, over 17 months to reach conclusion.

195. Time would be saved by better and quicker filtering of cases into summary procedure as this procedure is less formal, allowing quicker resolution of pleas and quicker entry into the court system. Perhaps pleas would be obtained more quickly as during our investigation we frequently heard that forum caused delay as it was a sticking point for reaching agreement about pleas.

196. Very few cases proceed to trial. Most commence by an agreed plea on indictment with an agreed narrative or plead guilty at first diet with an agreed narrative. It can be seen from the spreadsheets that as at 4 July 2012, of 60 closed cases placed on indictment, 55 or 92% were dealt with by agreed plea. Crown Counsel's Instructions are sought at the same time the case is reported to ensure the full facts are covered and no FAI will later be instructed following any prosecution. This quality of preparation avoids extensive and expensive court time, avoids unnecessary FAIs and means the defence know exactly what will be said. The defence can tailor their plea in mitigation and the sheriff usually has a copy of the narrative BEFORE the plea is tendered also giving him time to consider the full facts for sentence. However, we did receive (as narrated above) adverse comments by solicitors about the press release by HSD AFTER conviction.

197. It appears from the profile of cases within the unit that this process of agreeing the Crown narrative is time consuming. The defence are given disclosure as soon as the case comes in, even before any Crown prosecution work is done. This is very good practice. Meetings are regularly held with the defence from the outset to find what can be agreed and what plea can be hammered out but this seems to slow down the case coming in to court. It should be possible to push the defence to agree pleas and narratives more quickly. This would lead to fresher cases rather than cases being years old before they come into court. If cases were pushed through more quickly more cases could be dealt with, including the very complex ones.

198. We have a concern that the ongoing age profile of cases is an issue. Figures show the backlog is increasing.

199. The risk to the reputation of the HSD in the event of delays is high given the age profile of the cases.

200. Rather than wait to agree a plea in all cases we think some cases should be indicted into court (as is the norm in other mainstream criminal work). This would be a speedier process. To date only 4 cases have been taken to trial.

201. The overarching conclusion is that the creation of the Health and Safety Division was an appropriate response to growing specialisation in this field. The cases which are concluded are well prepared and presented but the concern is the time taken to conclude them. With the benefit of hindsight the new unit was somewhat put at an immediate disadvantage by agreeing to take over serious previous cases from Procurator Fiscal Offices, in many cases these were already elderly with little work done on them.

ISBN: 978-1-78256-495-9 (web only)

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St Andrew's House
Edinburgh
EH1 3DG

Produced for the Scottish Government by APS Group Scotland
DPPAS14137 (04/13)

Published by the Scottish Government, April 2013