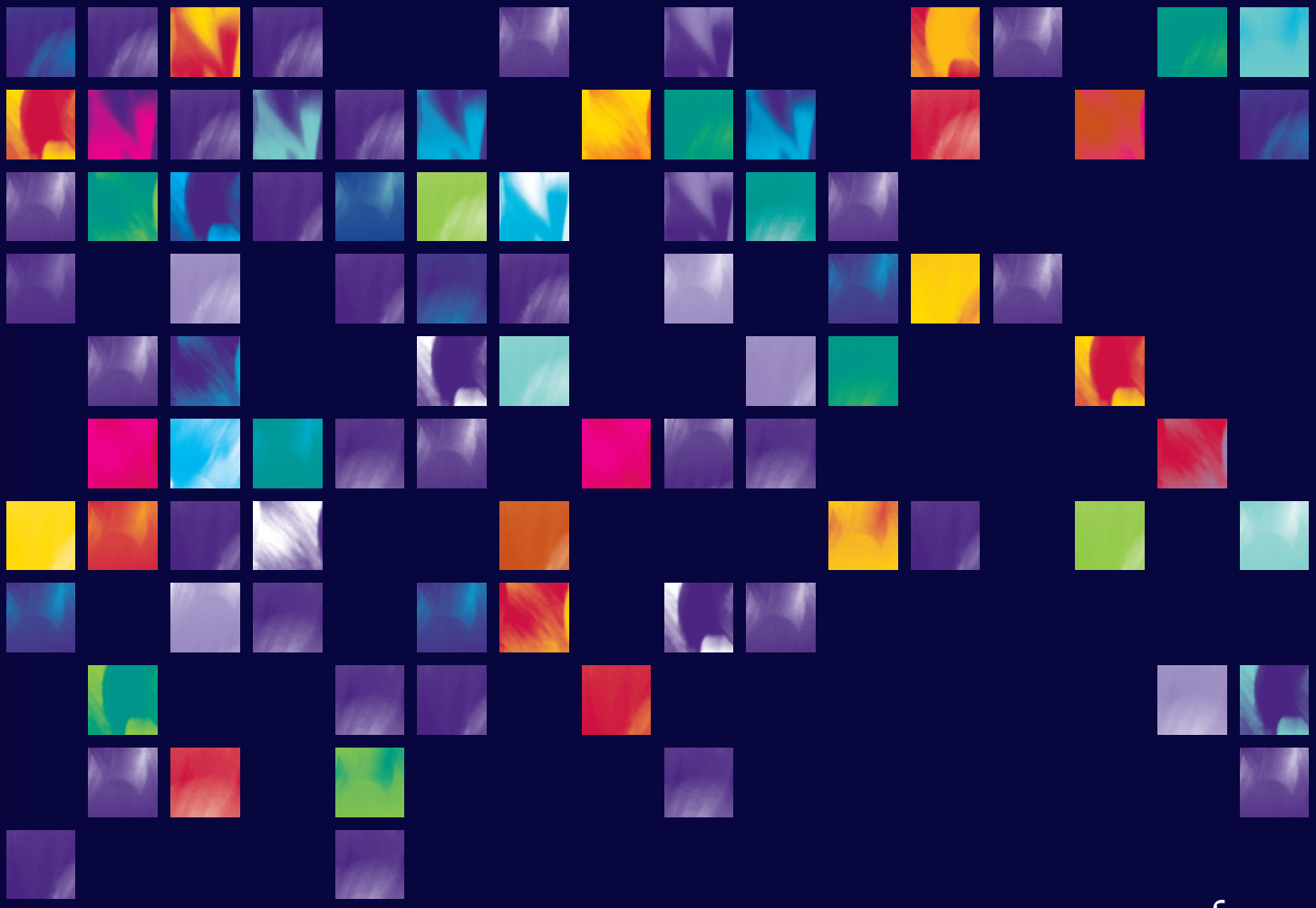
DEATH CASES

A Thematic Report on Liaison in **Death Cases** with Particular Reference to **Organ Retention**



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SCOTTISH EXECUTIVE

Inspectorate of Prosecution in Scotland

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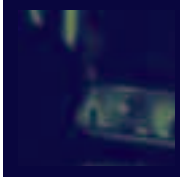
Scottish Executive, Edinburgh 2007



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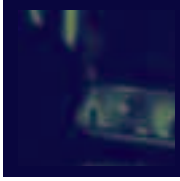


Executive Summary

Chapter 1

Introduction and Methodology

This is the fourth thematic report of the Inspectorate of Prosecution in Scotland.

This particular thematic report was prompted by the work of the Independent Review Group on Retention of Organs at Post Mortem chaired by Professor Sheila McLean. This in turn led to the passing of the Human Tissue (Scotland) Act 2006.

The Review Group's Phase 3 report (published November 2003) recommended that Crown Office and Procurator Fiscal Service should arrange for an audit of the effectiveness of the arrangements it had put in place.

In the event the remit for this report was wider and included a review of the current arrangements for liaison with next of kin in death cases with particular reference to organ retention.

The report is based on evidence obtained in a number of ways including the use of questionnaires, interviews with relevant staff, consultation with relevant bodies and on site visits. A Reference Group consisting of the relevant criminal justice partners and others met regularly to provide advice and assistance to the Inspectorate team.

Chapter 2

Background Information and Guidance

This chapter looks at the role of the Procurator Fiscal and shows that out of a total number of deaths in Scotland about 25% are reported to the Procurator Fiscal. This contrasts with about 45% of deaths in England reported to the English Coroner.

The guidance available to Procurators Fiscal in the investigation of deaths is considered and the role of Victim Information and Advice.

Chapter 3

Views from Staff

It was intended to get views from service providers (ie staff and others) and separately system users.

In this chapter we analyse the results of a questionnaire sent to all District Fiscals in Scotland. The questionnaire was designed to obtain feedback from staff providing the service on the usefulness of the guidance provided and on day to day experience of using the system.

The question of organ retention was also covered and the various methods used by Procurators Fiscal to communicate with nearest relatives and others in such cases. Three problem cases were highlighted where Procurators Fiscal had not been advised of retention at a post mortem but there was clear evidence that the systems in question had been tightened to prevent the recurrence of this in the future.

The stressful nature of the work in dealing with bereaved persons and next of kin was commented on by several contributors, as was a perceived absence of support such as bereavement training or bereavement counselling. We comment on the current training programme.

Overall feedback from Fiscals was that the new chapter of guidance on dealing with deaths was a big improvement.

In addition to the District Fiscal questionnaires we also examined approximately 400 case papers in relation to deaths throughout Scotland and noted several examples of good practice.

However, we did find that some areas could be strengthened in particular audit trails and the amount of information recorded on the Departmental IT system.

Chapter 4

Feedback from Service Users

We try to take a consumer based approach to inspection work and attempted to get feedback from persons actually using the service.

Following advice from Victim Support Scotland 200 questionnaires were sent out arising from our examination of 400 cases. These were designed to elicit views and feedback from service users on how the system was operating in practice from their perspective.

Overall feedback was positive. It did show underuse of the Departmental leaflets (now under review) although in contrast to that the majority (84%) of persons who replied indicated that they had in fact received all the information they required.

Virtually all respondents indicated that they were treated with courtesy and respect which is of course to be expected but, nevertheless, a satisfying endorsement of the way people had been treated.

In addition to the individuals contacted a number of organisations provided us with their perspective including the Stillbirth and Neonatal Death Society (SANDS). SANDS highlighted the hurt relatives felt where there had been unknown retention.

The organisation Families of Murdered Children (FoMC) also made some comments and welcomed developments such as the creation of Victim Information and Advice in recent years.

Chapter 5

View from Pathologists and Other Medical Personnel

In addition to staff views and the views of persons using the service it was felt important to get the views from pathologists and other medical personnel who were also involved in providing a service in death cases.

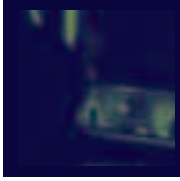
All 4 of the University based Departments of Forensic Pathology (Aberdeen, Dundee, Edinburgh and Glasgow) were contacted as were a host of other pathologists and medical personnel throughout Scotland.

Organ retention and to a lesser extent organ donation were considered in some detail. The overwhelming evidence given to us was that organ retention at Fiscal post mortems was now virtually non-existent. We did receive some feedback that on 3 occasions the system had broken down and Procurators Fiscal had not been advised of retention by the relevant Pathology Department but these had now been tightened up and were unlikely to recur in the future.

The number of hospital post mortems not instructed by the Procurator Fiscal was also reported as having declined (along with organ retention in these) in recent years. Various reasons were given for this including better diagnosis of illness in life.

Generally, so far as the medical input was concerned, liaison with Procurators Fiscal was described as good. In particular pathologists seemed willing to meet with next of kin in difficult cases to explain the circumstances usually in the presence of the Procurator Fiscal. This is a commendable approach.

Some concern was expressed about the role of the Procurator Fiscal at the scene of suspicious



deaths and at the subsequent post mortem. In addition the number of Forensic Pathologists was described to us as being very small for Scotland (about 8 persons) and it was suggested that it would be useful for a forum to exist to enable Forensic Pathologists and others to discuss matters of mutual interest and we make a recommendation to that effect.

The question of organ donation also arose in the course of our investigations and we received feedback to the effect that organ donation was rarely feasible in the types of deaths which are the subject of reports to Procurators Fiscal but we did come across several examples where this had taken place and there was no evidence that Fiscals were in any way obstructing donation of organs in cases dealt with by them.

Chapter 6

Post Mortems, Organ Retention and Donation

In Chapter 6 we look more closely at post mortems and organ retention and donation.

The total number of Fiscal post mortems in Scotland is analysed and it appears that post mortems are instructed by Procurators Fiscal in about 50% of cases reported to them. Curiously this is very similar to the rate in England instructed by Coroners.

The instructions to Procurators Fiscal in the sensitive area of organ retention are examined and the difficult question of disposal where retention has had to take place.

Over the period January to November 2006 21 Procurator Fiscal Offices were visited by the Inspectorate team with a particular focus on organ retention. It was found that organs had been retained on 22 occasions and we analysed the type of organ and its ultimate disposal. In this context retention included even short-term retention (ie where the organ is returned to the body prior to the body's release) to show the kind of retention that was necessary and what in practice was happening.

In addition, 3 cases of organ donation were examined and another case was brought to our attention, a recent large-scale donation in Glasgow.

Following on from the work of the Independent Review Group on retention of organs we contacted all the NHS Boards across Scotland in an attempt to update the information supplied to that Committee.

The figures obtained demonstrate that the number of hospital post mortems not instructed by the Procurator Fiscal has declined in recent years (and also organs retained at such). However the number of Fiscal post mortems has remained relatively steady which would indicate that recent problems with the holding of post mortems and organ retention has not inhibited Fiscals from carrying out proper investigation in such deaths. However, it has to be stressed that even in Fiscal post mortems retention is now a very rare event indeed.

Chapter 7

Road Deaths

Although there are many categories of deaths, road deaths stood out as an area of particular concern with constant references in the media.

We analyse the number of road deaths in Scotland and compare that to the number of homicides (there are 3 times as many road deaths on average as there are homicides). This

we feel is an interesting point as the effect of a road death for nearest relatives, next of kin, etc. can be every bit as traumatic as a homicide. These are sudden, violent deaths with huge emotional and financial consequences.

We examine the background law and look at the offence of causing death by dangerous driving (Section 1 of the Road Traffic Act 1988) and the lesser offence of careless driving (Section 3 of the Act). We attempt to analyse the relevant law and note that it is very difficult for prosecutors to explain to nearest relatives etc what the law actually means.

We met with several nearest relatives who had suffered such losses most of whom were referred to us by SCID (Scotland's Campaign against Irresponsible Drivers).

We anticipate the coming into force of the new Road Safety Act 2006 which creates the offence of causing death by careless driving.

We comment on the Crown policy of taking cases of causing death by dangerous driving only in the High Court although analysis of sentences passed showed average lengths which were below the maximum which could be imposed by the High Court. These are averages and there were, of course, many sentences imposed within the High Court range.

We repeat concern expressed to us about the age when a licence can be obtained and the high mortality rate among the young. This, of course, is a matter for others but of interest in passing.

We also note calls for Fatal Accident Inquiries (FAIs) to be instructed by the Lord Advocate in all road deaths or at least in all road deaths where there is an element of careless driving.

We are of the opinion that it would not be correct or advisable for Fatal Accident Inquiries to be instructed in all road deaths and that the present discretionary system is more in line with the philosophy of the Fatal Accidents and Sudden Deaths Inquiries (Scotland) Act 1976.

We did receive strong representations, however, regarding cases being either dropped or pleas being accepted to lesser offences quite often at a late stage. Although these cases are extremely small in number they do have a high impact especially in the media. We accordingly make a recommendation that a reduced charge should not be accepted unless there has been a change in circumstances and not without the circumstances being explained to the nearest relative, etc.

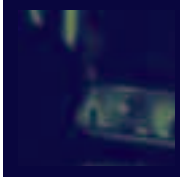
Chapter 8

Diversity Issues

Crown Office and Procurator Fiscal Service on its Intranet has a range of diversity guidance for staff and we examine what is available and are of the opinion that it is extremely comprehensive and useful.

As we carry out office inspections in tandem with thematic reports the opportunity was taken when carrying out 34 such inspections to examine individual case papers relating to deaths where any racial or cultural issues might be involved.

We report on about 18 such deaths and the overall conclusion is that such deaths are treated in a sensitive and considerate fashion by Procurators Fiscal while bearing in mind the need to carry out a proper investigation. We make the point that we received no complaints in this regard from any of the people who responded to our various requests for information.



Chapter 9

Conclusions and Recommendations

In Chapter 9 we review the previous chapters and make 9 specific recommendations.

We anticipate the possible roll out of the Victim Statement Scheme in Scotland which has already been piloted and which may provide the opportunity for next of kin to have a voice at subsequent court hearings.

In general, subject to the various factors that we comment on throughout the report, we found that overall, deaths were investigated properly and in a sensitive fashion. We mention the need for training (already under consideration by the Department) and strongly recommend that the training programme be rolled out as soon as possible to help raise awareness and facilitate the provision of a good service.

Joseph T O'Donnell
Chief Inspector
Inspectorate of Prosecution in Scotland

February 2007

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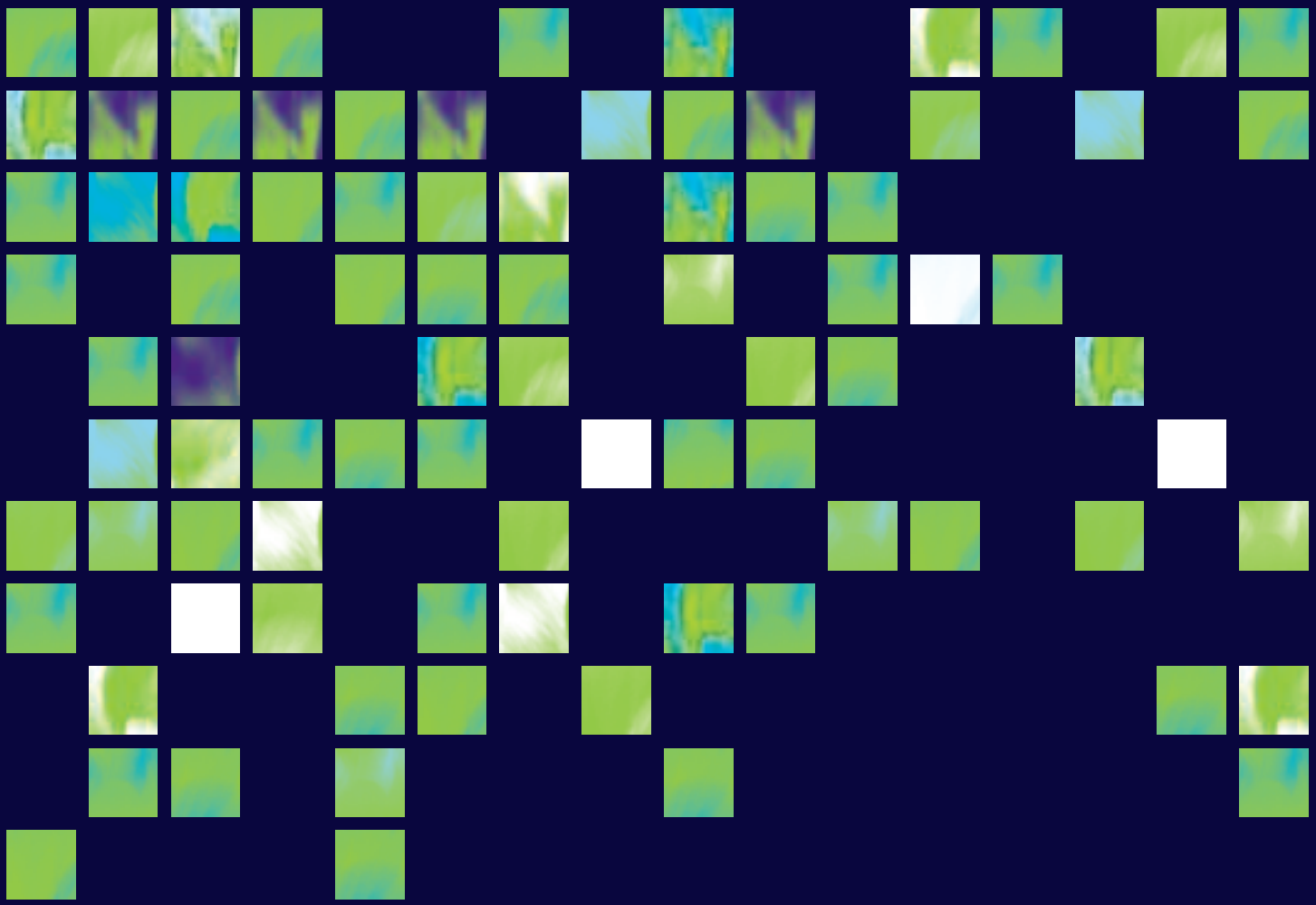
CHAPTER 1

Introduction and Methodology



This is the fourth thematic report of the Inspectorate of Prosecution in Scotland. The Inspectorate of Prosecution in Scotland was created in 2003 with the task of inspecting the Crown Office and Procurator Fiscal Service. It carries out this function by a series of office inspections and thematic reports usually in conjunction with criminal justice service partners and others with an interest in the topic of report. All reports are published on our website to be found at www.scotland.gov.uk/topics.justice/ipis/intro.

The aim of the Inspectorate of Prosecution in Scotland is to make recommendations that will result in clear and measurable improvements in the Crown Office and Procurator Fiscal Service thus making the Crown Office and Procurator Fiscal Service more accountable and enhancing public confidence. There are 11 separate "Fiscal" areas in Scotland presided over by an Area Procurator Fiscal. These areas are sub-divided into districts presided over by a District Procurator Fiscal. The Crown Office is the Departmental Headquarters and the Civil Service Head of the Department is the Crown Agent and Chief Executive. The Ministerial Head is the Lord Advocate assisted by the Solicitor General known collectively as the Law Officers. The Law Officers are assisted by Crown Counsel who among other things consider reports submitted by Procurators Fiscal.

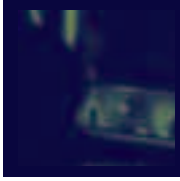
The Inspectorate of Prosecution in Scotland takes a risk-based approach to its work and follows the 10 principles of inspection promulgated by Central Government in 2003. In particular the **purpose of improvement** is followed, the aim being to improve service delivery and there is a focus on **outcomes** and **user perspective** whereby the experience of those using the service is a priority rather than "peer review". An **evidence-based** approach is taken to ensure any conclusions/recommendations are well founded.

To assist in the preparation of this report a Reference Group was created consisting of persons and organisations with expertise in the field. The Reference Group met between March and December 2006 and the membership is contained in Annex 1.

I would like to record my gratitude to the members of the Reference Group for the support and advice they gave to the Inspectorate team and without whose assistance this report would not have been possible. The conclusions, recommendations etc remain, however, those of the Inspectorate.

This particular thematic report was prompted by the work of the Independent Review Group on Retention of Organs at Post Mortem chaired by Professor Sheila McLean. This Group was established in September 2000 to review matters arising from the retention of organs at post mortem and led to the passing of the Human Tissue (Scotland) Act 2006. The Act came into force in September 2006 and replaced for Scotland the provisions of the Human Tissue Act 1961 which dealt with transplantation and post mortem examinations. The new legislation introduces the concept of "authorisation" and embodies the principle that people can expect their wishes expressed in life about what should happen to their bodies after death to be fulfilled.

The Review Group's Phase 3 Report (published in November 2003) included a chapter (3) on issues relating to post mortem examinations instructed by the Procurator Fiscal. Paragraph 108 of that report spoke of the need for communication with those closest to the deceased to be every bit as sensitive in Fiscal cases as in hospital (post mortem) cases and



went on to recommend that the Crown Office and Procurator Fiscal Service should arrange for an audit of the effectiveness of the arrangements it had put in place. The Report stressed that the views of families as users of the service must be canvassed. We consider this in greater detail in Chapter 4.

In the event the remit for this report was wider and was agreed as "a review of the current arrangements for liaison with next of kin in death cases with particular reference to organ retention".

A number of issues were identified including:

- The provision of information, advice and support to next of kin
- Diversity issues
- Organ retention – in particular an examination of policy and working practice regarding organ retention.

Methodology

The review was carried out using a number of techniques (and with a view to the 10 principles of inspection) including:

- Preparation and planning
- Research
- On site visits (namely Procurator Fiscal Offices)
- Interviews
- Questionnaires
- Review of case papers (deaths)
- Analysis of information
- Report writing

This included:

- Review of relevant Departmental policies
- Review of relevant Departmental internal protocols
- Review of relevant Departmental protocols with criminal justice partners
- Interviews with representatives of criminal justice partners
- Review of Departmental guidance
- Interviews with next of kin
- Interviews with Crown Office and Procurator Fiscal Service staff
- On site visits to Procurator Fiscal Offices
- Contact with specialist agencies
- Comparisons with procedure in England

A considerable volume of material and input from a wide range of individuals and organisations was obtained. The report concentrates on:

- General background information
- Views of service providers
- Views of service users
- Conclusions and recommendations

A number of particular issues stood out and receive separate treatment in particular Road Traffic Deaths and those cases where post mortems had taken place whether or not any organs had been retained. Additionally diversity issues are covered in a discrete chapter (8).

Papers relating to over 400 cases were examined in Procurator Fiscal Offices across all parts of Scotland. As our thematic reports run in tandem with office inspections the opportunity was taken while doing the latter to gather information on this topic and meetings with staff dealing with deaths took place on about 21 occasions.

Additionally a request for information from staff was placed on the Crown Office and Procurator Fiscal Service Intranet to capture as much staff input as possible. Some feedback was obtained from this.

Questionnaires were used extensively. All District Fiscals received a detailed questionnaire

covering a wide range of issues. The results of these have been analysed and are presented in Chapter 3.

In relation to the sample of over 400 cases it was decided to send questionnaires to the person or persons who had had contact with the Procurator Fiscal's Office. This was always going to be a delicate operation and advice was sought from Victim Support Scotland. In the event 200 or so such questionnaires were sent out inviting comment on an important range of issues and seeking first hand "user" feedback. Surprisingly, response rates were very high for a survey of this nature running at about 36% (or 72 replies). These are also analysed and contained in Chapter 4.

An advertisement seeking feedback was placed in a national newspaper and a limited number of replies received from this. Some of these involved a follow up by way of face to face interviews.

Additionally SCID (Scotland's Campaign against Irresponsible Drivers) provided details of a number of next of kin involved in road traffic deaths and contact was made with all of these leading to face-to-face interviews in the majority of cases. Given the continuing level of public concern over the issue of road traffic deaths these are covered separately in Chapter 7.

Part of the work of the Review Group on Retention of Organs chaired by Professor McLean included an audit of retained organs. It was decided it would be useful to carry out a similar exercise with emphasis on the number of post mortems carried out and the number of retained organs. Accordingly with the consent of the Chief Executive of the NHS in Scotland all Chief Executives of the NHS Trusts were asked to supply an update on this information. This was obtained and the updated figures can be found in Chapter 6. This gave some interesting comparative material with implications for training and research.

A significant number of pathologists (both NHS and those based at University Forensic Medicine Departments) and other medical personnel were contacted and either interviews took place or information was obtained on their perspective of how the system operated.

Additionally a large number of organisations including Churches, Faith Groups and interest groups were contacted and information obtained either in the form of face-to-face interviews or in writing. A list of these is provided at Annex 2.

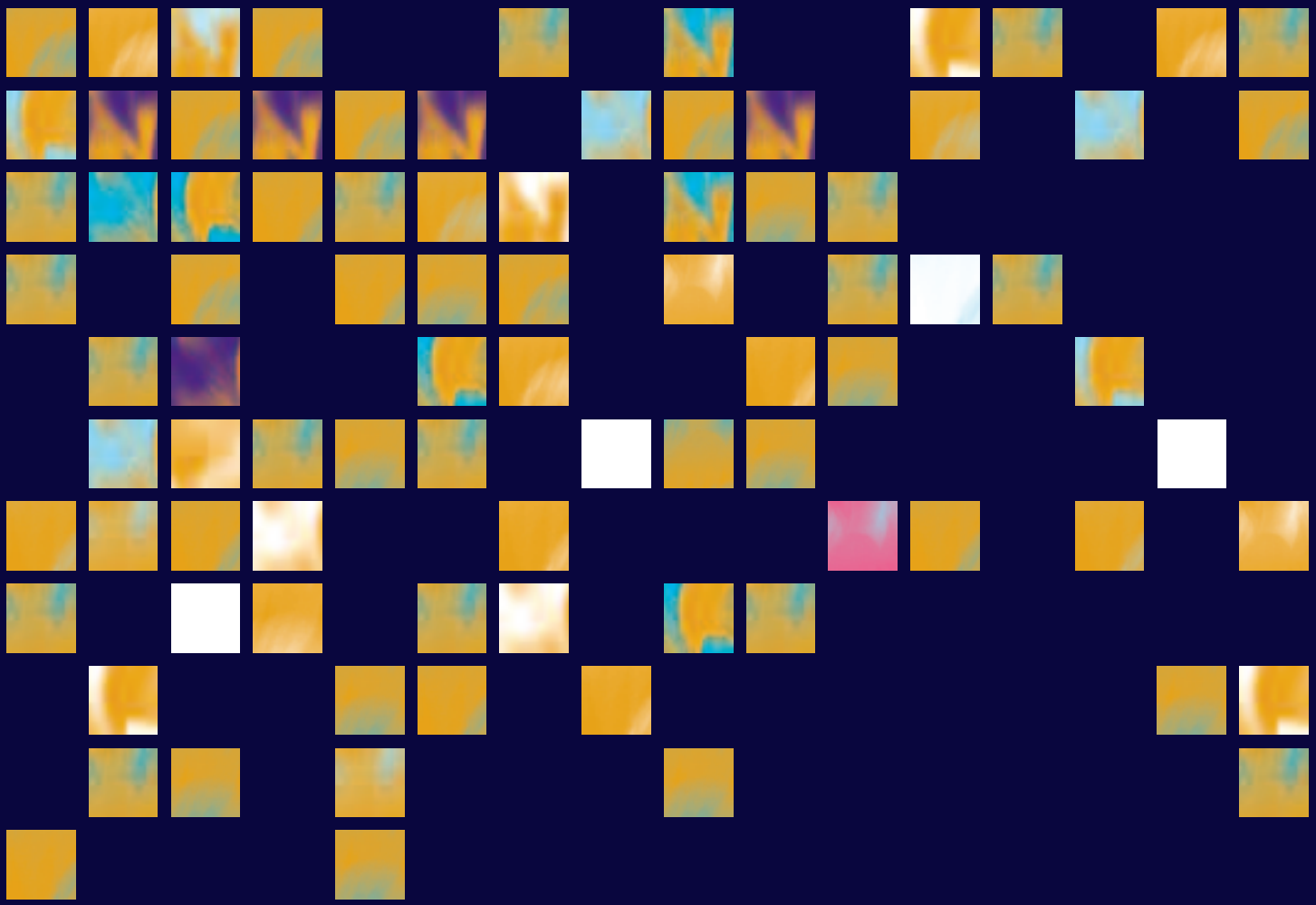
We would like to record our thanks to the considerable number of organisations and individuals who gave of their time to supply us with information, thus giving as wide a perspective as possible. We have selected a range of quotes from various contributors as a background to the text.

Joseph T O'Donnell
Chief Inspector

February 2007

CHAPTER 2

Background Information and Guidance



Role of Procurator Fiscal

Primarily the role of the Procurator Fiscal in Scotland is in connection with the prosecution and investigation of crime. Separate, but frequently related to that role, is the duty of the Procurator Fiscal to investigate all sudden, suspicious, unexplained, unexpected or accidental deaths and also to investigate any death occurring in circumstances which may give rise to an issue of public safety or concern.

Deaths in Scotland

Table 1 is reproduced from the latest statistics published by the General Register Office for Scotland. It shows total numbers of deaths in Scotland on an annual basis, by gender.

Table 1 – Deaths by Gender, Scotland, 2000 to 2005[1]

	2000	2001	2002	2003	2004	2005
Male	27,511	27,324	27,743	27,832	26,775	26,522
Female	30,288	30,058	30,360	30,640	29,412	29,225
Total	**57,799**	**57,382**	**58,103**	**58,472**	**56,187**	**55,747**

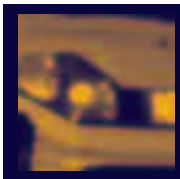
[1] Source: General Register Office for Scotland

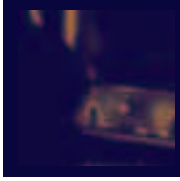
Table 2 below shows the numbers of deaths reported to individual Procurator Fiscal Offices across Scotland over the last two financial years.

Table 2 – Deaths Reported to Procurator Fiscal Offices in Scotland, 2004–05 and 2005–06[2]

Procurator Fiscal's Office	2004–05	2005–06
Aberdeen	741	718
Airdrie	496	533
Alloa	103	110
Arbroath	135	123
Ayr	404	429
Banff	25	34
Campbeltown	21	22
Cupar	180	149
Dumbarton	393	412
Dumfries	333	356
Dundee	400	416
Dunfermline	377	421
Dunoon	66	57
Edinburgh	1,666	1,567
Elgin	110	119
Falkirk	431	376
Forfar	64	70
Fort William	59	65
Glasgow	2,542	2,373
Greenock	306	254
Haddington	150	167
Hamilton	1,013	1,026
Inverness	268	264
Jedburgh	184	164
Kirkcaldy	436	449
Kilmarnock	609	615
Kirkwall	42	31
Lerwick	36	36
Linlithgow	359	391
Lanark	159	156
Oban	54	45
Paisley	618	624
Portree	12	8
Perth	258	282
Peterhead	47	47
Selkirk	162	159
Stonehaven	24	23
Stranraer	50	39
Stirling	221	264
Stornoway	58	40
Tain	168	171
Wick	39	41
Total	**13,819**	**13,646**

[2] Source: Crown Office National Database





It can be seen from the above tables that approximately 25% of deaths in Scotland are the subject of a report to the Procurator Fiscal. In contrast in England about 45% of deaths are reported to the Coroner.

There are no Coroners in Scotland although the area of activity undertaken by the Procurator Fiscal is not dissimilar to the role of the Coroner in England. There are some important differences, however, mainly in procedure.

Guidance to Procurators Fiscal in this important part of the work is provided by the Crown Office in the form of a Book of Regulations and also in individual Minutes and Circulars sent out to Procurator Fiscal Office staff.

> "I had a meeting with a deputy Procurator Fiscal. He was helpful and informative."

In the Book of Regulations a complete chapter (Chapter 12) is devoted to the investigation of deaths. This was updated as recently as June 2006.

Chapter 12 gives very detailed advice and instructions to Procurators Fiscal in the investigation of deaths. The range of deaths reported to the Procurator Fiscal is considerable including murder cases at one end of the spectrum and sudden deaths which have resulted from natural causes at the other.

The stated objectives of the Crown Office and Procurator Fiscal Service in relation to the investigation of deaths include:

- To ensure that all sudden deaths made known to the Procurator Fiscal are investigated impartially, speedily, thoroughly and sensitively and that appropriate action is taken including the conduct of public inquiries.
- To provide services that meet the information needs of victims, witnesses and nearest relatives in co-operation with other agencies.

> "The Procurator Fiscal's Office contacted me by letter .... I was very pleased with the tone of the letter, it was well phrased and entirely appropriate."

The guidance states that no other official has any duty in relation to enquiry into death comparable to that of the Procurator Fiscal and accordingly, having been entrusted with this public duty, Procurators Fiscal must undertake it with the greatest care and attention.

The principal aims of inquiry into and further investigation of deaths are:

- To minimise the risk of undetected homicide or other crime
- To determine whether a death has resulted from criminal action
- To eradicate dangers to health and life in pursuance of the public interest
- To allay public anxiety
- To preserve evidence
- To determine whether a Fatal Accident Inquiry or any other form of public inquiry should be held and to take appropriate steps to prepare for such an inquiry
- To ensure that the deceased's nearest relative is kept advised of the progress of the investigation consistent with the proper conduct of investigation and also consistent with the wishes of the family
- To ensure that full and accurate statistics are compiled.

"At the time of my wife's death the Procurator Fiscal was very helpful to myself and my family."

The Book of Regulations provides a list of deaths which must be further investigated and these include deaths arising from industrial disease or industrial poisoning, any death where the circumstances indicate suicide, any death where there are indications that it occurred under medical or dental care, any death resulting from a road traffic collision, any death by drowning and a number of others.

So far as the method and level of investigation is concerned the Book of Regulations also gives guidance to Procurators Fiscal and makes it clear that it is the duty of the Area Procurator Fiscal to set in place systems to receive and take cognisance of reports of all deaths, 1) from the Police, 2) from hospital doctors, 3) from doctors in general practice, 4) from Registrars, 5) from relatives of the deceased, 6) from any other source including the media, 7) resulting from accident in the course of employment at occupation from the Health and Safety Executive or any source and 8) occurring while the deceased was in legal custody.

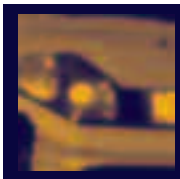
So far as the level of investigation is concerned on a death being brought to his or her attention it is the duty of the appropriate Procurator Fiscal to make initial inquiry and decide whether and to what extent further investigation is required and carry out such investigation. The level of investigation is left to the discretion of the Procurator Fiscal.

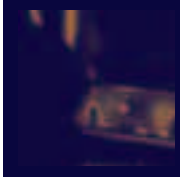
Further guidance is given to Procurators Fiscal by way of a manual of practice including advice on scientific examination, forensic examination etc.

The Book of Regulations provides that Area Procurators Fiscal must ensure that all staff dealing with death investigations are aware that they should be carried out in accordance with the guidance in the practice manual and must monitor investigations to ensure compliance with the guidance so far as is reasonably practicable.

The options available to the Procurator Fiscal on receiving an initial report of a death which can be by way of a telephone report by a doctor including hospital doctors or by a Police Report or from the Registrar are to:

1. Take no further action. This would be the decision if the doctor reporting the death was prepared to issue a Death Certificate certifying the cause of death and the Procurator Fiscal was satisfied from the history reported that the death occurred from natural causes and did not require further investigation.
2. Very occasionally, when a death has not been certified, a hospital doctor will inform the Procurator Fiscal that the hospital has received permission from the relatives to carry out a post mortem examination. In these cases, where a hospital post mortem has been agreed to and it is obvious that the death comes from natural causes but the cause has not been accurately ascertained, the Procurator Fiscal may agree to a hospital post mortem being carried out but inform the doctor that he must be informed of the cause of death once it has been ascertained after the post mortem.
3. Carry out further investigations. Further investigation is usually required in the case of deaths associated with the provision of medical or dental care. The extent of the further investigation will depend on the circumstances of the case but would certainly normally include the carrying out of a post mortem examination.





4. Instruct a Police Report. Occasionally where the cause of death has not been ascertained or there are further enquiries required the Procurator Fiscal may request the Police to submit a report.

Clearly the extent of investigation in any death will reflect the circumstances in which it has occurred and the degree of suspicion concerning criminality.

So far as further reporting to Crown Office for Crown Counsel's instructions is concerned the guidance gives categories of such deaths to be reported by the Procurator Fiscal, some by way of what is known as a summary report and some by way of full precognition (where witnesses have been seen, interviewed and their statements noted).

Special mention should be made of suicides. Procurators Fiscal will report a death where the circumstances point to suicide to Crown Office by way of an abbreviated report. The abbreviated report as the name suggests contains the essential information only regarding the deceased and the circumstances of the death and includes in particular the views of the next of kin in relation to whether or not a Fatal Accident Inquiry should be held.

> "My daughter's death was only another 'statistic', her name was not spelled properly on her file. In reference to her suicide letter it was said that it was offensive but it was not explained in what way."

Other categories of deaths to be reported to Crown Office for Crown Counsel's instructions by way of a summary report include:-

- Where it is considered that criminal proceedings should be taken but the offence is a minor one unrelated to the cause of death
- Where death occurs under medical or dental care and it is considered that it is appropriate to hold a Fatal Accident Inquiry
- Where there has been a request by a person having an interest that a Fatal Accident Inquiry should be held into the circumstances of the death.

In relation to the cases which have to be reported to Crown Office by way of a full precognition as opposed to simply a summary detailed guidance is given as to what the full precognition should contain.

Mention is necessary also of the **Fatal Accident and Sudden Deaths Inquiry (Scotland) Act 1976** which provides for the holding of mandatory Fatal Accident Inquiries (in the Sheriff Court) where for example a person has died in prison or in custody or been killed in the course of their employment. Twenty-three persons were killed at work in 2005/06 (thirty three in 2004/05). In 2006 four persons died in Police custody (eight in 2005) and 19 persons died in prison in 2005 (five from natural causes and ten as a result of suicide).

The 1976 Act also provides for discretionary inquiries at the request of the Lord Advocate usually in circumstances which give rise to serious public concern and where it appears to the Lord Advocate to be in the public interest that an inquiry should be held into the circumstances. This discretionary power of the Lord Advocate is discussed in Chapter 7 on road deaths.

In 2005/06 71 Fatal Accident Inquiries were held. In 2004/05 68 were held and in 2003/04 the figure was 55 showing an approximate increase of 30% in that period.

Post Mortem Examination

The Procurator Fiscal is responsible for deciding if a post mortem examination is necessary and appropriate and for directing the level and type of examination subject to advice from a number of others including Police Officers, medical experts and other expert advisers.

The Procurator Fiscal has authority at law to direct that a post mortem be carried out. There is no other person in Scotland with such an authority. We give more detail in Chapter 6.

Until he releases the body the Procurator Fiscal has full jurisdiction over it.

The guidance manual instructs that Procurators Fiscal should send to the nearest relative a general information leaflet headed "Advice for Bereaved Relatives" which is designed to provide basic essential information to families in the immediate period following a sudden death (we return to this topic when we analyse the questionnaires sent to the next of kin). This leaflet recognises that at this stage in bereavement many relatives do not want to receive detailed information but that it is important to provide a contact point so that further information can be sought. The current leaflets are under review and likely to be updated during 2007. A Crown Office Working Group has been established to consider all publications relating to the investigation of death by the Procurator Fiscal.

> "I am not a professional and should not be expected to carry the burden of the knowledge of what they told me."

A **Victim Information and Advice Service** has been created as part of Crown Office and The Procurator Fiscal Service which has three main functions:

1) To provide information to certain victims, witnesses and bereaved next of kin about the criminal justice process.
2) To keep victims, witnesses and bereaved next of kin informed about the progress of cases.
3) Advise on and facilitate referral to other agencies for specialist support and counselling as required.

Certain categories of cases are referred to Victim Information and Advice and these include (updated October 2006).

The **next of kin** in cases involving **deaths**:
- Which are reported for consideration of **criminal proceedings**,
- Where a **Fatal Accident Inquiry** is to be held,
- Where there will be, or there are likely to be, significant further **enquiries**,
- Where in all the circumstances it is agreed that referral is appropriate.

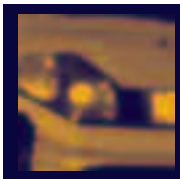
Additionally, all cases where the nature of the charge is indicative of solemn proceedings (ie trial by jury as opposed to trial before a judge sitting alone) and there is a **Victim of** Homicide or a Road Traffic death must be referred to Victim Information and Advice.

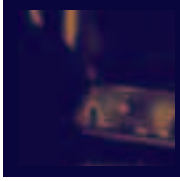
> "My mother was a person, not just a case number."

The Crown Office Book of Regulations lays down what is expected of Fiscals.

> "We felt the gap between … death and contact with the Fiscal seemed a long time given we had no information from anyone."

It is the duty of the Procurator Fiscal to meet the information needs of nearest relatives and other interested parties in co-operation with other agencies.





Victim Information and Advice (VIA) have a particular part to play in meeting the information needs of nearest relatives in death cases.

VIA is the dedicated service within Crown Office and Procurator Fiscal Service, which provides information on the prosecution investigation and court process, including appeals, in a supportive manner to victims, nearest relatives and some witnesses. The nearest relative in any road death case must be referred to VIA.

> "VIA automatically send out letters about court appearances and who to contact."

VIA itself is not a support agency.

VIA's remit covers serious crimes and crime related deaths.

VIA contacts victims, witnesses and nearest relatives after the case is referred. People can choose to opt out of the service.

There is also a protocol for referring relevant people to the Witness Service for pre-trial visits.

VIA produces leaflets on a variety of topics including crime related deaths.

We did receive some criticism of VIA.

> "We were happy with what (the Procurator Fiscal Depute) did …. she went to the scene, she saw the witnesses. You should not need to go and look for VIA, they should be knocking on your door …. (the Procurator Fiscal Depute) was great to me."

Such criticism may be not be particularly well merited as the main function of VIA is to provide information, especially about court dates which all agreed happened. VIA is not in itself intended to be a support agency but an information agency.

However, one lady in particular spoke positively of the role one particular VIA Officer played.

> "She kept in touch and kept me updated on the case progress …. she was very helpful and gave as much information as she could."

Some people want as much information as is available with nothing left out including information on how decisions are reached.

> "You ask us what improvements can be made – let people know every minute detail."

Procurators Fiscal are expected to communicate with the appropriate relative or relatives within 2-3 weeks of the death. A progress report should be sent within 6 weeks of the receipt of the death report. On completion of the investigation but prior to reporting to Crown Office the Fiscal should meet with the appropriate relative or relatives.

> "There should be more contact between the Fiscal and the family, a letter every two weeks with an offer to meet."

At the meeting the available options should be discussed and explained. The opinion of the nearest relative on the proposed course of action should be sought and included in the report.

> "We wanted someone to listen and not to scoff."

The nearest relative should thereafter be advised of Crown Counsel's instructions and offered a meeting to explain the consequences.

If there are to be no criminal proceedings or they have concluded without a full examination of the facts, if the nearest relative wishes, a meeting with the Fiscal, Reporting Officer or Accident Reconstruction Investigator may be appropriate.

Finally, echoing sentiments expressed elsewhere the view was put that Crown Office and Procurator Fiscal Service should have bereavement officers. We doubt that would be practical but could perhaps form part of in-house training.

> "Crown Office and the Procurator Fiscal Service should have a Bereavement Officer, separate from Victim Information and Advice. They should be particularly trained in specific types of cases."

Conclusions

Guidance for staff is comprehensive and easily available on the Department's intranet.

Information booklets could do with updating and the Department has already commenced a review, new editions should be available during 2007.

The Department has recently commenced training on death case handling which we welcome. Feedback from pilots was encouraging and we would support a roll out as soon as possible to relevant staff in the first instance. The further rollout is required as some of our contacts suggest that not everyone follows the policy laid down by the Book of Regulations.

There has been new and updated guidance issued to Fiscals in the summer of 2006.

Bereaved families frequently need a great deal of time to go through their issues and also to have the Procurator Fiscal explain court and other procedure. Dealing with the bereaved can be demanding and emotionally draining. Information may need to be repeated several times but this could avoid or minimise the possibility of misunderstanding.

There has to be awareness that some people do want to be as involved as possible in any decision to be made about the deceased.

> "You are powerless, someone has killed someone you know, it is important to get some of the power back and make a decision about their belongings."

Some families would appreciate a debriefing session when the case has concluded. This is a difficult area of work requiring sensitivity and empathy on the part of staff dealing with such areas of work.

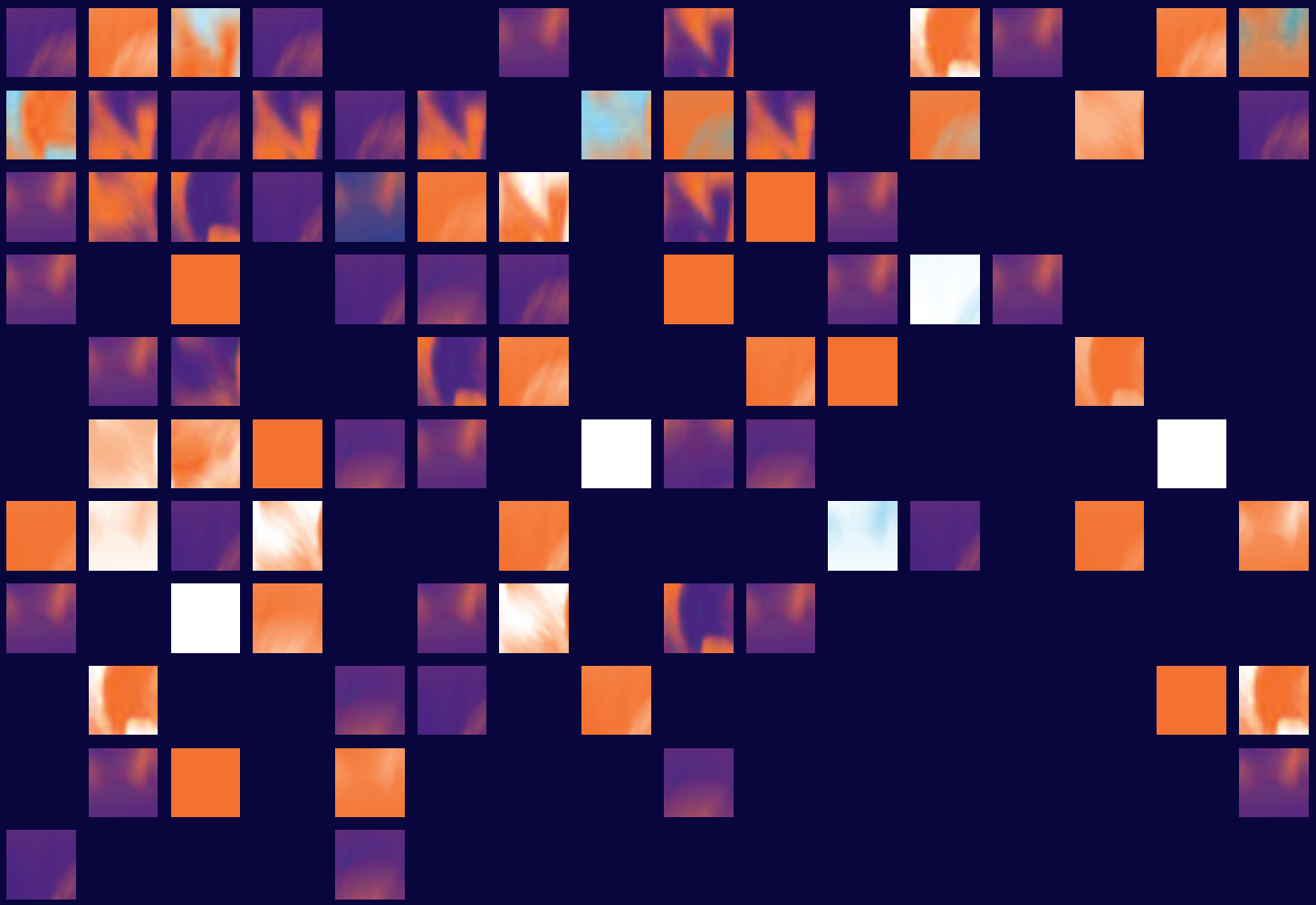
> "Service was good particularly e-mail contact as this resulted in a speedy response to questions."

Throughout their investigations Procurators Fiscal are encouraged to consult the Crown Office Diversity Team's guidance on cultural issues (we report on that separately at Chapter 8).

In conclusion very helpful and detailed advice is available to staff on the investigation of deaths. We obtained staff views which are contained in Chapter 3.

CHAPTER 3

Views from Staff



A questionnaire was sent to all District Fiscals in Scotland with the aim of gathering information about liaison arrangements with next of kin which are currently in place in Fiscal Offices across Scotland in relation to deaths cases. A total of 31 replies were received and the results are presented in the following section. Not all questions have a total of 31 responses as the questionnaire used initially (information gathered between February and July 2006) was modified slightly. 9 responses were received to the original and 21 received in respect of a later version (information gathered between August and November 2006). The later version had an additional two questions which are highlighted in the analysis below. The responses to one further questionnaire are also included which was essentially a pilot (an earlier version of the original, data obtained in January 2006).

Due to rounding, percentages may not add to 100.

Communication and Liaison

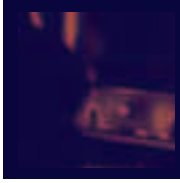
We asked a series of questions aimed at finding out about the **communication/liaison process** between Fiscal staff and next of kin.

Fiscals were asked how they ascertain who the nearest relative contact person is in the deaths which are reported to their office. A total of 30 responses were received and all indicated that the information is obtained from the Standard Police Report. Many respondents indicated that if any clarification was required, this was usually sought verbally from the Police. The registrar's intimation was also mentioned as a source of information in this respect (albeit much less frequently). In non-Police cases indications were that the information was provided by and or sought from medical practitioners.

In relation to a question asking about the steps that are taken to ensure that translation and language needs are met in deaths cases a total of 30 responses were received. All responses indicated that the usual arrangements in relation to criminal cases for interpreting/translation needs would apply (5 of these noted that the need has never actually arisen). The majority (21, 70%) stated that initially notification from the police would be expected, usually via the Standard Police Report or verbally and then arrangements would be made by administrative staff re any needs which were highlighted therein. The remainder of the replies simply stated that they would use the services of the standard interpreting agencies as appropriate. Two of these indicated that they would contact the relevant consul if appropriate. Only three of all replies received explicitly stated that they would pursue enquiries with the Police if they suspected a need might exist which had not been flagged up in the Standard Police Report. One response indicated that the local hospital was good at informing the Procurator Fiscal (in cases involving hospital deaths).

A question was asked about the use of the **"Checklist for Contact with Bereaved Relatives"** (an aide memoire supplied by the Crown Office) and a total of 30 responses were received. The majority (21, 70%) indicated that staff did not make use of the checklist. Of those who stated that it was used and subsequently responded to a supplementary question, 6 out of 7 indicated that they did find it useful.

Similarly, Fiscals were asked if the **"Advice for Bereaved Relatives"** leaflet was issued in all cases where contact was made with the nearest relative. 29 responses were received and it was found that just over half of those (16, 55%) did issue the leaflet. 11 respondents (38%) indicated that they did not issue the leaflet in all relevant cases while another 2 revealed that it was not always issued. Those who responded negatively to the initial question



gave a variety of answers as to what was done in place of issuing the leaflet. The most common response was that personal contact was made with the nearest relative (in preference to simply issuing the leaflet), either via telephone or the Police Family Liaison Officer. A few indicated that they gave the leaflets to other bodies for distribution (for example, undertakers, Police and GPs).

Fiscals were also asked if the information leaflet **"Post Mortem Examination"** was issued when an invasive autopsy was instructed. Of a total of 21 responses received, only one (5%) indicated that they did with another one respondent saying it was issued sometimes. The majority (17, 81%) revealed that they did not issue the leaflet. The remaining two respondents (10%) indicated that cause to issue the leaflet had never arisen.

Responses received (a total of 21) relating to how soon initial letters were sent to the nearest relative after the death report was received by the office revealed a fair amount of variation in response time. (The "target" is 2 to 3 weeks.) The results are summarised in the table below.

Length of time taken to send out initial letter	Number of responses
Immediately	3
Within a week	4
Within 2 weeks	7
Within 3-4 weeks	3
When cause of death is certified	4

A related question enquired as to whether there were any local styles of letters used in addition to the standard Crown Office letters in communicating with relatives and pathologists. 29 responses were received and were fairly evenly split between those saying yes, there were local styles used (10, 35%), those saying no, there were not (11, 38%) and those indicating that adaptations of the standard letters were used (8, 28%).

> "The … Department should answer complaints and queries in a much speedier time rate. All correspondence should be posted first class."

We asked Fiscals whether pathologists assist in relation to communication with relatives. All responses (a total of 31) indicated that if pathologists were required to assist they did/would do so. It was clear, however, that there was variation in the regularity with which input is required. Responses ranged from those which revealed that pathologists regularly attended meetings/spoke with relatives, to those indicating that this happened only very occasionally or that the need had not arisen. There was only one instance of a respondent indicating that pathologists were not as willing to assist as they used to be. Geographical location could obviously have an impact – one respondent revealed that this kind of practice was not really feasible for the islands but further indicated that they were confident that if the need arose it would be met. Where particular questions had arisen in the past they had been put to the pathologist by legal staff who then communicated with relatives. Shetland had in fact once held a telephone conference between the next of kin and the pathologist.

A series of questions then enquired as to the number and nature of deaths which had been reported to offices.

Firstly, we asked how many deaths had been reported in the previous 12 months which had required special consideration arising from religious and cultural considerations as required

by the Book of Regulations. Of the 28 responses received the majority of offices indicated that there had been none (22, 76%). Two offices indicated that they had had one such death reported, while another two offices reported each having two deaths reported. A further two offices (Glasgow and Edinburgh) intimated that they could not be sure how many deaths they had had in this category as the IT system did not allow recording of such details. Glasgow reported dealing with around 2,500 deaths annually. It was easier for small offices which dealt with relatively few deaths generally, to identify (from memory) any requiring special consideration. We look at this in Chapter 8.

> "The post mortem was against my mother's religion, as she was Jewish, however, I understood that it was part of the process and was happy for it to go ahead. I was able to bury my mother within 48 hours."

Secondly, we asked how many deaths were reported and investigated over the past 12 months where the ethnicity of the deceased was in some way related to the cause of death. This yielded a nil return from all 29 respondents save one (Glasgow) which again reported that it could not ascertain if they had any deaths in this category as the IT system did not record such details.

Lastly we enquired as to how many deaths reported and investigated had required organs to be retained. A total of 31 replies were received. Twenty of these (65%) indicated that they had had no such cases. Five offices indicated that they had had one case requiring organs to be retained; one office said they had had two cases, while another two offices stated that they had each had 3 such cases. One office noted 5. Again, Glasgow and Edinburgh commented on their inability to know how many cases there had been as these were not recorded by the IT system.

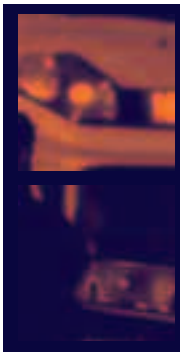
Organ Retention

Following on from this, we enquired as to whether the family was advised in writing of the possibility of organ retention and procedures for disposal. The 28 replies received were evenly split in this regard with 11 (38%) indicating that they did advise the family in writing and another 12 indicating that they did not. 6 respondents recorded 'non-applicable', presumably because they had no cases requiring organs to be retained over the past 12 months.

A supplementary question related to what was done by those who did not inform the family in writing. Of the 12 relevant responses 9 revealed that they enlisted the help of the Police Family Liaison Officer (usually done verbally) to notify the family. Two respondents said the family would be notified by telephone (a call from the Procurator Fiscal) and one indicated that the pathologist undertook to intimate and explain the procedure to the family.

> "You have to think very carefully about retention if you want to retain and we go out of our way not to."

Fiscals were also asked whether they had procedures in place with pathology providers to let them know when organs had been retained and analysis was completed. The vast majority responded positively in this respect (30 out of 31, 97%) albeit one acknowledged that the procedures they have in place were informal. The one remaining office indicated that they had never had any cases where organs had been retained but they would nevertheless expect notification from the pathologist in any case.



A supplementary question then asked if the procedures in place were always followed – only one respondent indicated that there had been an instance recently when procedures had not been followed. It appeared that there had been a breakdown in communication between the Pathology Department and the Procurator Fiscal's Office which resulted in an unfortunate situation where the body of a deceased was returned to relatives without notification that an organ had been retained (this case is discussed more fully in Chapters 5 and 6). However, we understand that new procedures have subsequently been put in place which should prevent recurrence of such an incident.

We enquired also as to whether the release of organs for disposal was authorised in writing. While 21 out of 30 (70%) of respondents indicated that they did, a further 5 (17%) stated that although they had not had occasion to as yet, they would authorise the release of organs for disposal in writing if required. Three responses (10%) simply intimated that they had not had occasion to (no further information given). Only one respondent responded by saying no to this question, stating instead that the pathologist dealt with this issue.

Three Fiscals reported difficulties in relation to cases involving organ retention.

One office quoted the problem case referred to above.

Another office referred to 2 murder cases in 2005 where brains were retained. Retention, completion of neuropathology and return of organs to bodies was confirmed in writing by the mortuary. The bodies were then released apparently whole. Months later, the mortuary discovered two brains in a fridge. This resulted from miscommunication between the examining pathologist and mortuary technicians. The families were advised of the mortuary's error and instructions were sought and implemented re the disposal of organs. The mortuary subsequently revised its systems for ensuring the return of organs to a body, they now have a double entry system and the pathologist and technician both have to verify when an organ is retained and returned to the body before informing the Procurator Fiscal.

The final one referred to a case where problems had been experienced in relation to communication with the local hospital when there was no relevant staff available in the Procurator Fiscal's Office who could be contacted. This highlighted the fact that no fallback procedure was in place. The situation was a very urgent one as the hospital had switched off the life support machine.

Another office also raised a concern that the bereaved may incur additional costs to have the organs placed with the body at some later stage in the process.

> "We ended up with two funerals."

We deal with organ retention in greater detail in Chapter 6.

Organ Donation

We enquired as to the number of deaths reported and investigated over the past 12 months that required approval for removal of organs for donation. Of the 30 responses received, the majority of offices indicated that there had been none (22, 73%). 5 offices (17%) indicated that they had dealt with such a case within the past 12 months with one of these having dealt with 3 cases. The other 4 responses gave no indication of how many deaths had actually been reported to their office. A further 3 offices indicated that they

could not be sure as to whether they had had any cases, again because the system did not allow for recording of relevant details in this respect.

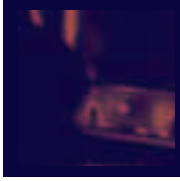
> "There are good experiences with heart valves and corneas, there is a 72 hour window and they (Procurators Fiscal) are good at giving the ok quickly."

We asked Fiscals what practices they followed in relation to requests for organ donation in criminal and non-criminal deaths reported to them. 28 responses were received. 5 indicated that they had never had any such cases (hence no details were provided by these respondents). A further 12 respondents (43%) indicated that they would follow the Crown Office guidelines as laid down in the Book of Regulations in relation to requests for organ donation, albeit 3 indicated that was what they would do (they had not yet had any such cases). Generally, the other responses indicated that in non-criminal deaths, organ donation would be agreed to (although there was variation here in Fiscal involvement, with some saying they were not involved at all and some saying they discussed it with the pathologist and then approved the request). In respect of criminal cases, responses indicated that practice depended on the circumstances of the case but that wherever possible the request would be approved provided it did not compromise the forensic pathology, that any organs removed were not related to the death and guidelines were followed. One respondent mentioned canvassing the issue with Crown Counsel. Another respondent highlighted the fact that until recently they would not routinely have agreed to organ donation in criminal cases but the revised Chapter 12 in the Book of Regulations advised that this could be done provided all guidance was followed.

> "So far as organ donation is concerned I know the transplantation teams always want more organs."

The Linlithgow Office revealed that Edinburgh Royal Infirmary Tissue Services had a mortuary donation programme where they sought permission for hearts to be retrieved for donation. The Procurator Fiscal had been notified of this and was asked for permission in Fiscal cases. Another separate programme being carried out by the Departments of Pathology, Forensic Medicine and Neuropathology at Edinburgh University sought consent from the Fiscal to approach the family of the deceased and ask if they could use diagnostic samples, take extra small samples and for the brain to be donated for research purposes. At Edinburgh Royal Infirmary, Tissue Services made the approach and discussed donation. Road Traffic deaths and suicide deaths were of interest to the Tissue Services – contact would be made with the Procurator Fiscal and he would consider the implication for the investigation.

The Glasgow Office supplied us with information on a recent homicide case where the cause of death had been a head injury. The hospital approached the Procurator Fiscal's Office for permission to take organs for transplantation. The family was apparently keen for this to be done. Contact was made out of hours with the on call Fiscal Depute and Crown Office gave consent to the taking of organs with the exception of the eyes. We understand that the organs taken were subsequently used in transplants. All this happened in the course of one day.



Staff Dealing with Deaths Work and Related Issues

We were interested to find out if Fiscal Offices had dedicated staff who dealt with deaths and organ related issues. 22 out of 30 offices (73%) indicated that they did have dedicated staff who dealt with this type of work. Of the 6 offices who stated that they did not, 2 were small offices where there was only a very small number of staff. Of the remaining 2 offices, one revealed that they used to have dedicated staff (the implication being that they did not any more) and the other that they have dedicated administrative staff but not legal staff.

> "Day in and day out they (Fiscals) are asked to deal with bereaved people and are not prepared or trained."

Following on from the initial question we enquired as to how staff were selected for dealing with deaths and conducting sensitive discussions with relatives. A total of 30 responses were received. 12 (40%) cited experience as the determining factor for selection with 2 of these 12 also mentioning that this type of work was regarded as a development opportunity. Another of these 12 also detailed attendance at deaths training and familiarity with national guidance as factors. Another made reference to the fact that deputes' experience tended to be general rather than deaths-specific and since they had a high proportion of inexperienced deputes (as do a number of other offices) it was a challenge to adequately staff the post.

> "That opens the question about help for those in the service who have to deal with highly stressful situations such as the above or attend particularly gruesome crime scenes. The emergency services have in place help for their staff, should we not for ours? It strikes me that we are ill prepared for many of the appalling sights we see and the deeply upsetting meetings we have with victims and relatives with no clear back up available."

Only one response stated that ability to deal with next of kin in a sensitive and appropriate manner was the sole basis on which staff were selected, although another respondent mentioned it as part of their criteria. A third of offices (10) indicated that selection was not relevant for them as they were such small offices that the deaths work was in all cases conducted by available legal staff (almost exclusively the District Fiscal). One office cited availability as the defining factor as all staff in the office were deemed sufficiently experienced to deal with such matters. A further 6 offices (20%) listed no specific selection criteria at all although 2 of these noted that legal staff are supervised initially. Another of these replies noted that there was no selection in their office due to the fact that only the District Fiscal and his Personal Assistant dealt with deaths cases.

Training

A question was also asked as to whether there was training and support available to staff with regard to dealing with bereaved relatives. Of 30 responses received a third indicated yes while almost two thirds (19, 63%) said there was no training available. One Fiscal indicated that there might be but had never enquired to find out.

> "Training is needed for any staff dealing with next of kin and, in particular, specific training on the types of case they would have to deal with."

Fiscals were then asked to provide details of what this training involved and whether it was thought to be adequate. Of the 10 relevant responses 6 made mention of the Departmental deaths training with 4 of these making specific reference to the new training which was planned to accompany the revised Chapter 12 guidance. Another stated that although they felt what was available was reasonably adequate experience had shown it was extremely difficult to obtain training in this area. The remaining respondent quoted Crown Office guidance material which was available if required while also citing advice and guidance from senior colleagues as always being available.

Of the responses which had indicated no to the previous question one noted that training would be useful.

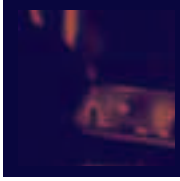
One Area Fiscal reported (separately) that he arranged for staff to "shadow" him and others before being allowed to handle this work. Fiscals were also asked if their office provided any local training (for example, shadowing of an experienced member of staff). 23 offices (77%) out of a total of 30 responses indicated that they did, while 6 indicated that they did not. The remaining respondent indicated that local training was provided only if required.

We discovered that 17 out of 31 offices provided or contributed to training for outside bodies on the role of the Procurator Fiscal in relation to deaths. Of those who indicated that they did, most frequently, this involved contributing to junior hospital doctor training in local hospitals, GP surgeries and input to the Police. Also mentioned was training with Victim Support and the Witness Service as was an example of the District Fiscal contributing to/providing training for the Local and National Association of Funeral Directors. The Fiscal in Hamilton stated that he chairs a Lanarkshire Medical/Fiscal Liaison Group at which training issues are identified and dealt with.

While 13 respondents said that they did not contribute to training for outside bodies, 2 indicated that they are attempting to initiate this. The remaining office revealed that they had provided such training previously (but presumably no longer did so).

It appeared, however, that there was no external input into Fiscal training in the majority of instances (29 out of 31 responses). There were only 2 offices who responded positively – Hamilton, where arrangements had been made for new Deputes to attend post mortems and Dumfries which indicated that local pathologists and other medical staff are involved in training (no details given) and that there was locally organised training on death certification.

> "Is it not time that more intensive training is given to staff dealing with deaths? Having to see relatives on a regular basis can be upsetting for staff, and as society becomes ever more a litigious blame culture these meetings become more and more fraught. If the NHS train staff specifically to break the news of organ retention should we be asking legal staff with no such training to break such news?"



With regard to the adequacy of Crown Office guidelines available to staff in the investigation of deaths, well over half (19, 66%) of Fiscals indicated that they were (of a total of 29 responses). 4 responded in the negative with another 3 saying that the guidelines were only partially adequate. A further 2 indicated that they were adequate but too lengthy/ cumbersome.

Comments received in relation to the adequacy of the guidance included the requirement for guidance on the conduct of Fatal Accident Inquiries, better clarification needed as to the types of deaths to be reported to Crown Office (children and Road Traffic deaths in particular) and the need for a checklist for each type of death.

Around a third (9, 29%) of Fiscals indicated that their office had local instructions over and above Crown Office guidance.

Victim Information and Advice (VIA)

We asked Fiscals whether their office involved the services of Victim Information and Advice in deaths where proceedings were possible, where a Fatal Accident Inquiry was to be held or where significant further enquiries were required (ie in accordance with the criteria). Overwhelmingly, the answer was yes, in 29 out of 30 instances (97%). Only one office indicated that Victim Information and Advice was not involved. Of the 29, over half (16, 57%) said they found Victim Information and Advice's involvement useful. 5 (18%) indicated that they found the input very useful. One Fiscal remarked that the combination of the Police Family Liaison Officer and Victim Information and Advice was good and that it allowed the Fiscal to remain objective.

"(VIA was) very helpful and courteous."

Only 2 offices gave slightly negative responses in this respect – one where it was noted that Victim Information and Advice were unfamiliar with deaths liaison and preferred direct liaison between the District Fiscal and next of kin and another where it was felt that Victim Information and Advice involvement was not particularly useful until the case got to court. 3 offices reported that Victim Information and Advice's involvement was useful sometimes – 2 of these highlighted the fact that there could be an overlap between Fiscal/Victim Information and Advice roles and the possibility existed for too many people being involved. (Recent changes to the management structure of Victim Information and Advice should reduce the chance of this.) The third indicated that since generally next of kin were on islands they could have easier, regular and personal contact with the local Procurator Fiscal Office. The remaining two Fiscals reported that they were unaware of how useful Victim Information and Advice was as they had had little personal involvement with it.

"In those two trials the Witness Service was not involved that much, VIA was and the families were getting less support from VIA than they would have from the Witness service."

General Comments from Fiscals

- Training was needed – bereavement counselling would be good.

"COPFS should have a Bereavement Officer, separate from VIA."

- It would be beneficial to have guidance on how to contact relatives who live abroad.
- There was a real need for standardisation of practice, both on the part of crematorium

medical referees and Procurator Fiscal staff in relation to deaths where, although there were no suspicious circumstances, the cause of death was unascertained. In practice this usually meant that the death was drug or alcohol related and that toxicological analysis of post mortem samples was required. Some referees were clearly content to accept such cases whereas others are not. The latter view, although resulting in practical difficulties, is consistent with Crown Office guidance. When difficulties arose the Fiscal was caught in the middle, relaying information between crematorium referees and pathologists/GPs, in the interests of assisting the family. It would be beneficial therefore to have standardisation of crematorium practice on the one hand and clarification of the limits of the Fiscal's responsibility on the other. It seemed appropriate that any further information required by crematorium authorities with regard to the cause of death should be requested by them directly from the relevant GP or pathologist.

- The revised Chapter 12 and abbreviated Deaths manual were major improvements. The absence of an adequate search facility or index facility on the intranet reduced the user friendliness of these invaluable resources. Deaths investigation was an extremely important area of work. There was a need to have a post created centrally at senior level to co-ordinate the policy and practice of the Department in this area of work.
- There have been occasions when deaths had not been reported by the hospital.
- Perhaps more training was needed for doctors on certain categories of deaths to be reported to Fiscals. In one case, for example, the hospital doctor issued a death certificate without referring to the Fiscal but the consultant spotted this and referred the death.

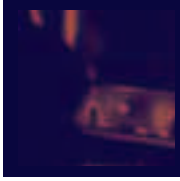
> "There is no joint training, we have not been asked. There have been no talks given in the hospital (by Procurators Fiscal) in the last few years."

- The categories of cases which required to be reported to Crown Office were not always clearly understood. The 12-week target for the holding of a mandatory Fatal Accident Inquiry was felt to be unrealistic as it was outwith the control of the Procurator Fiscal. Sometimes a court slot in order to meet the target was not available. There was also a query as to why a Fatal Accident Inquiry was necessary in some road traffic deaths where someone has been killed in the course of their employment eg when gales blew a lorry over or when driving too fast. It was argued that there should be some discretion.
- There had been problems getting independent expert advice within the constraints of current rules on payment of fees.
- For young Deputes (those who came straight from university with little life experience) bereavement counselling would be good. Also there should be greater familiarity with the options that are available to pathologists in terms of identifying causes of death. Training from pathologists would be useful.

In addition to the District Fiscal Questionnaires referred to above observations were made when examining the case records of approximately 400 deaths.[3] Some examples are as follows:

- Notes of meetings and discussions with nearest relatives, pathologists and Police were on file.

[3] Approximately 400 files were reviewed at 21 offices during period January to November 2006



- Evidence was shown of the Procurator Fiscal taking account of nearest relative's particular wishes. In two deaths the widow and daughter requested that a post mortem was not done and after review of the death files a "view and grant" was instructed on both occasions. In one case a relative requested an early post mortem and this was done.

> "The service, support and help that my wife and I were given from our arrival following the sudden death of my mother right through to the registration of death was absolutely first class."

- There was evidence of accommodating families' wishes regarding who the contact person should be (sometimes the "legal" next of kin would not have been appropriate).

- There was evidence of accommodating families who wished further enquiries by way of post mortem. There were two cases, one where there probably could have been certification but the widow was keen to have a post mortem to establish the exact cause of death as the deceased had been desperate to have a biopsy but was never well enough and another where the Police casualty surgeon was willing to certify but the spouse wanted a post mortem as he had concerns about treatment and there was a complaint against the NHS.

- Where appropriate there was fairly extensive contact with next of kin.
- Some Fiscals communicated with insurance companies assisting the next of kin.
- We found good evidence of close working relationships between pathologists and Fiscals in some areas of the country, including joint meetings with next of kin.
- One file showed that given the circumstances of the death the Procurator Fiscal had worked with others to try to get the doctor to certify the death. Another showed a successful attempt to have the Police casualty surgeon certify. There had not simply been recourse to instructing a post mortem.

> "It would be good to see Fiscals taking a firmer stand on such cases and not accepting them."

- In another case the file showed that the initial contact letter had not been sent to the nearest relative due to her distressed state. The Procurator Fiscal liaised with the Police in this matter.
- There was evidence of the Procurator Fiscal taking account of more than one nearest relative. Examples included: ex-wife and fiancée; brother and wife; son and daughter; wife and parents; father and sister.
- Where appropriate we found that racial and cultural issues were taken into consideration when making decisions on how to proceed.
- Another case showed the Procurator Fiscal had considered the particular travel difficulties of the nearest relative in that he had offered to meet with this person in three different offices.

> "I appreciated all the offers of help and the time the professionals gave me."

- In one case where there was the possibility of medical error or negligence and the post mortem would in the normal course of events have been carried out at the same hospital it was done at another forensic facility instead.

- In two cases letters of appreciation had been sent to the Procurator Fiscal from the next of kin.
- In another case there was a note on the file to say that the next of kin had phoned in and thanked the Procurator Fiscal and his staff for all their help.
- One family informed the Procurator Fiscal that they found it beneficial that their child had remained at the sick children's hospital to help them in their grieving process rather than the child being taken to a funeral directors.
- One file showed that the funeral had to be stopped because a junior doctor had certified the death and not reported it to the Procurator Fiscal when it later came to light that he should have.

As can been seen from the above findings legal staff appeared to be taking into account all the circumstances of the case when making decisions on how best to proceed with the death investigation and in communicating with relatives.

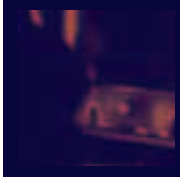
Although there were varying methods of contact with some Procurators Fiscal preferring initial oral communication, others preferring written and others using the services of the Police Family Liaison Officer, the majority of relatives were happy with the contact made with them and felt they were treated with courtesy and respect (*see Chapter 4*).

Given the above findings and the results of the questionnaire analysis we consider that there are some areas that could be strengthened:

- With regard to maintaining an audit trail there were some areas of good practice that could be used throughout the whole of the Crown Office and Procurator Fiscal Service. For example, use of forms to record instructions to pathologists and to receive information from pathologists on retention and also use of a standard form to record the progress of work performed.
- In respect of the data retained in the computer system, it is considered that a field covering racial origin and organ retention/donation would be of benefit in carrying out future analyses and audits of such deaths.
- With regard to providing information to relatives some Procurators Fiscal always issued the appropriate leaflets whereas others did not (*see Chapter 4*). We understand that the information leaflets are currently being revised. Once new leaflets are available Procurators Fiscal should be reminded to issue them where appropriate.
- We found that timing in communicating with nearest relatives varied from immediately to up to four weeks. This appeared to be dependent on the method of communication. The target for making initial contact is three weeks.

> "Perhaps contact could have been made sooner."

- We also found that Fiscals use different styles of letters in communicating with relatives with some preferring the standard Crown Office letter whilst others preferring to amend these letters or have there own style.
- Larger offices tended to have a dedicated "Deaths Unit" and some Areas were setting up a centralised "Area Deaths Unit". This style should be considered for the whole of the Procurator Fiscal Service with a view to having dedicated, efficient, and well-trained staff.
- With regard to training we were informed that more external training would be useful in how to deal with bereaved relatives. It is therefore considered that further training would be of benefit not only to staff dealing with the issue but also the bereaved relatives.



We also sought input from staff on a general basis and a request for such was put out on the Crown Office Intranet.

One member of staff informed us a father had picked up a chair and threatened to kill him when he told him that his baby's brain would have to be retained. Fortunately the incident was resolved peaceably but is indicative of the depth of emotion such situations can cause.

In another case a family reacted badly to similar news and the staff member questioned whether Fiscal staff were best placed to break such news. Additionally he thought more training for staff dealing with such issues would be beneficial. On a similar theme he felt there was inadequate support for those staff who have to attend gruesome crime scenes, support being available for others involved.

Another contributor highlighted problems with cremation of organs following retention in a murder, the crematorium being apparently unable to cremate these when the body itself had not been cremated.

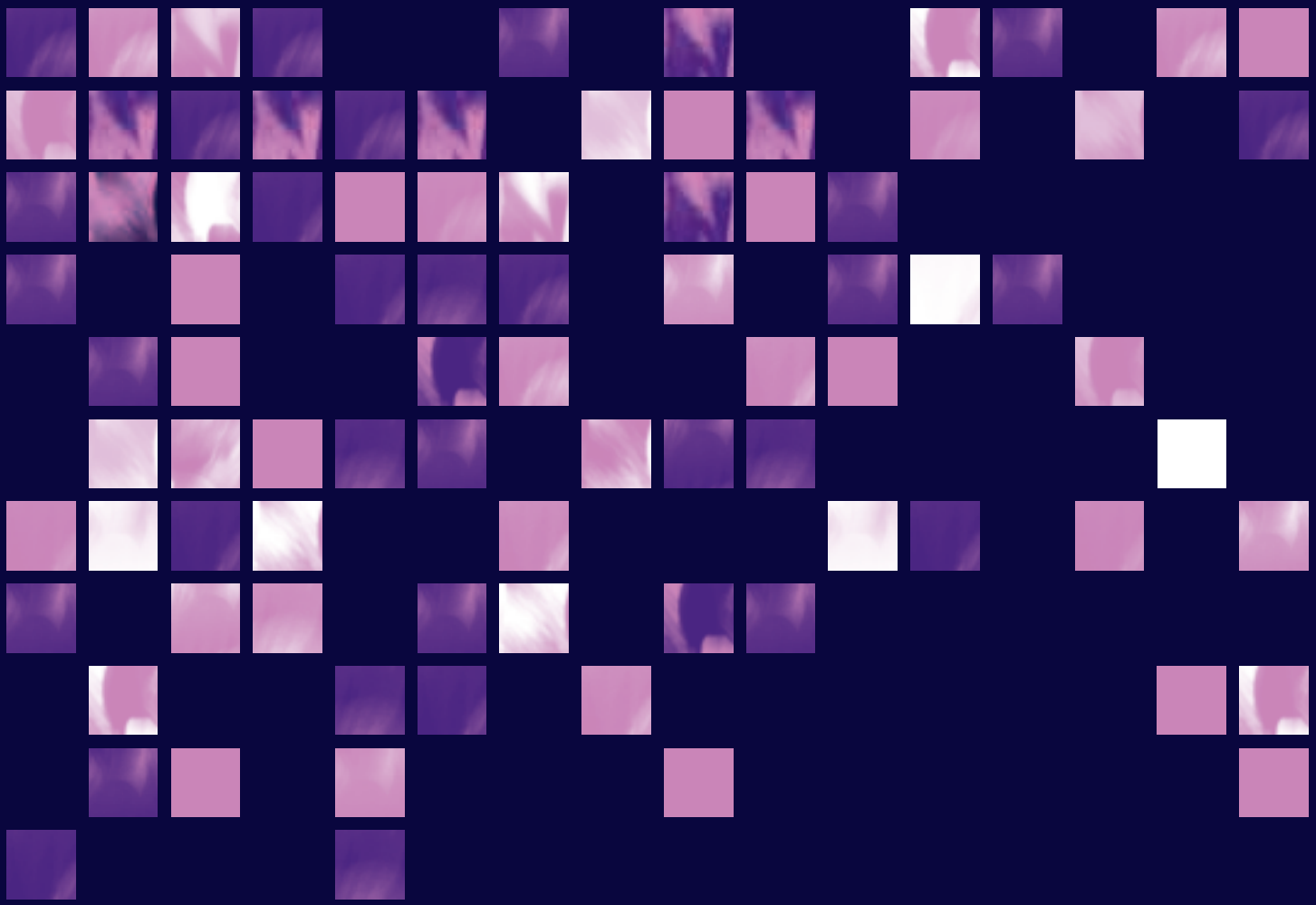
Overall, a positive picture emerged from the views of staff subject to the comments/ suggestions outlined. The investigation of deaths is an important but not very well known area of the work of the Procurator Fiscal. Training can obviously play a crucial part and we would strongly recommend the rollout of the Departmental training as soon as circumstances allow. Feedback from the "pilots" was good and although we were unable to assess for ourselves the training provided (due to cancellation of a course) we do not doubt that it will be beneficial.

DEATH CASES

A Thematic Report on Liaison in **Death Cases** with Particular Reference to **Organ Retention**

CHAPTER 4

Feedback from Service Users



The Inspectorate seeks to make recommendations which will improve service delivery and takes wherever possible a "user perspective". Any conclusions/recommendations must be evidence based rather than conjecture.

The area of investigation of sudden deaths posed particular problems in ingathering evidence. Clearly causing further distress to those recently bereaved was to be avoided especially those bereaved in circumstances which necessitated the death being referred to the Procurator Fiscal.

However, without some first hand input any conclusions/recommendations could only be tentative. Consequently we decided among other ways of ingathering evidence to examine a significant number of death cases reported to Procurators Fiscal throughout Scotland and send questionnaires to those identified as the next of kin or contact person.

Accordingly 400 cases were examined in Procurator Fiscal Offices throughout Scotland to get as wide a geographical spread as possible and covering all categories of deaths from non-suspicious deaths to suicides, murders, accidents at work, road traffic collisions etc.

> "I was very satisfied with the information I got."

Cases were examined in a number of locations including Grampian, Ayrshire, Strathclyde and Lothian and Borders. 200 were identified from the sample as being suitable for the survey and a questionnaire sent out. The letter accompanying the questionnaire was carefully drafted to try to minimise any distress and promised anonymity. Victim Support Scotland was consulted in advance of sending the questionnaire.

A high percentage of replies were received. 72 people replied (36%) out of the 200. This is a high rate of return compared to other surveys and the Inspectorate is very grateful to those who took the trouble to reply at what must have been a difficult time in their lives.

The questionnaire was designed to be sufficiently brief to encourage completion and was a mixture of questions inviting a yes/no answer and space for some general comments. The questions were designed to elicit a general picture of the perception of the user of the service provided by the Procurator Fiscal. Ideally it would have been much more detailed but response rates would probably have suffered as a result.

As has been described previously a wide variety of deaths are reported to the Procurator Fiscal some requiring more investigation than others including carrying out a post mortem examination and possible changes to initial death certificates. The range of deaths chosen in the sample reflects the diverse nature and complexity of deaths reported to the Procurator Fiscal.

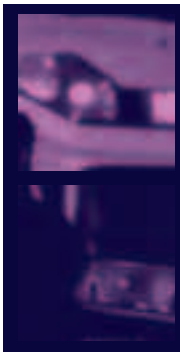
The following is a question by question analysis of the results. It should be noted that not all questions were answered by every respondee.

Question 1

Did you receive any written communication from the Procurator Fiscal?

Of the 66 people who answered 45 (or 68%) said they had received written communication from the Procurator Fiscal.

It should be noted that the Procurator Fiscal has a certain degree of discretion as to how to contact the nearest relative, if at all. A number of cases may be reported to the Procurator



Fiscal which are dealt with by relatively speedy initial enquiry and no further investigation is required and it would not be usual for the Procurator Fiscal to have any contact with the nearest relative in such cases unless contact had been initiated by them.

> "The Procurator Fiscal phoned me to let me know the death certificate had been released and asked would I like to know what was the cause of her death."

Our survey deliberately targeted people who had had some contact with the Procurator Fiscal so cases where the Fiscal had not needed to contact the nearest relative do not feature in our survey. This was done to save distress to people who had not been contacted in case our questionnaire suggested to them that something had been missed in the investigation of their relative's death which would not have been the case.

Question 2

Did you receive any verbal communication from the Procurator Fiscal?

Of the 66 who answered this question 48 (or 72%) said they had received verbal communication. 34 of the 66 who responded to these questions had received both written and verbal communication (or 51% of the total).

Of those who had received only one form of communication which was 26 in total this was evenly split between verbal (12, or 17%) and written (14, or 20%).

Question 3

Did you receive any information leaflets?

Of the 65 persons who answered this question only 19 said they had received any information leaflets (or 29% of the total). On the face of it this seems quite a small percentage.

Instructions to Procurators Fiscal state that:

"in all cases where the Procurator Fiscal has had contact with the nearest relative/family they should be sent the general information leaflet 'Advice for Bereaved Relatives'.

This is designed to provide basic essential information to families in the immediate period following a sudden death. The Book of Regulations recognises that at this stage in bereavement many relatives do not want to receive detailed information but that it is important to provide a contact point so that further information can be sought by those who require it at a time when they are able to deal with it.

Given that contact had been made in 64 out of the 68 responses we received this figure for sending the leaflet is fairly low and suggests underuse of the Departmental leaflet.

However, having said that it is important to take into account the answers to the next question.

Question 4

Did you receive all the information you required?

Of the 64 who answered this question 54 (or 84%) said that they had received all the information they required. This is particularly significant for the Department especially in view of the relatively small number of cases where the leaflets were sent out. It tends to suggest that the written or verbal contact made by the Procurator Fiscal was sufficient for the purposes of the nearest relative. It shows a very high level of "customer" satisfaction on this arguably most important part of death investigation. There were, however, a few exceptions.

> "I felt totally in the dark regarding the post mortem. I only received a 30 second phone call from the Procurator Fiscal's Office. I would have found someone to liaise with a great help."

Question 5

Were you treated with courtesy and respect?

59 of the 68 respondents specifically answered this question and said 'yes'. No respondent answered 'no' (one respondent was slightly ambivalent, the explanation provided indicating it had more to do with coping with grief than the manner in which the respondent had been treated).

> "The help and sympathy were exceptional. All concerned could not have been more helpful."

Given the difficult circumstances of such work and the stress relatives are suffering this is reassuring information for the Department. Even those who answered other questions in a more negative fashion (including those who said they did not get all the information they required) answered "yes" to this question.

Clearly it would be expected that people would be treated with courtesy and respect but nevertheless this is a resounding endorsement of the manner in which the Department deals with relatives.

Question 6

Did you have any contact with Victim Information and Advice (VIA) Division?

Only 4 of the 39 respondents who specifically answered this question said they had had any contact with VIA (10%). Those who did not specifically answer the question are of course likely not to have had any contact either. The figure is surprisingly low but the remit of VIA in death cases is strictly limited.

> "It was a relief to have contact with the VIA Division."

Certain categories of deaths are automatically referred to VIA for a full VIA service to the family and these are murder, other homicides, definite or suspected Road Traffic Act Section 1/3A cases, Section 3 cases, Road Traffic Act cases in which no criminal proceedings are being taken, accidents at places of work in the course of employment, child deaths and deaths identified as potential discretionary Fatal Accident Inquiries. Deaths in the following categories may be referred to VIA subject to discussion and agreement between the relevant Procurator Fiscal and VIA staff and these include drug related or solvent abuse, suicide, drowning, medical negligence and deaths in custody.

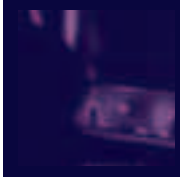
It should be noted that within the past 12 months the management structure of VIA has been reorganised and it no longer operates as a separate division within Crown Office and the Procurator Fiscal Service. Area and District Fiscals now have responsibility for the management of the VIA staff in their areas. This provides a better opportunity for more focused work in this area.

Question 7

Any further comments?

We invited respondents to suggest improvements/comments. 32 of the 68 respondents took the trouble to add some comments.

- 13 of these were testimonials to the helpfulness etc of the Procurator Fiscal and Crown Office staff.



"Can't think of any (ie improvements) for you as all the service I received was great. Many thanks for all you did."

- 5 complained about delays in getting information, one complained that a post mortem examination which had taken place had been unnecessary.

"Explain to parents the need for an autopsy and obtain approval before it is performed. I feel the autopsy was an unnecessary violation/invasion of his body."

- 1 was a complaint about the medical emergency services.
- 2 felt that the deaths were being treated as statistics including mis-spelling of the deceased's name on a file.
- Another concerned mistakes in correspondence.
- A further respondent said they had felt left out of things although the "family" had kept them informed.
- Another complained about having to write for a copy of the post mortem report.
- In another case there was a complaint that the medical notes had not been present at the time of the post mortem causing an apparent later change in the cause of death given by the pathologist.
- Another related to a complaint about access to a body after a death in an institution.
- One related to a lack of support for families of missing persons later discovered to be suicide.
- One suggested information on support groups would be useful (a suicide).
- Another suggested feedback following a post mortem to the hospital consultant who had carried out a procedure two days earlier.

In addition to the Questionnaire contact was made with a number of support organisations.

The Stillbirth and Neonatal Death Society (SANDS) made some comments. In particular it was highlighted how reluctant many people felt with regard to post mortem examination and the hurt that unknown retention (of organs) could cause.

"The problem was with the heart, it had been used for teaching for 13 years."

On the other hand we were told how altruistic families could be in difficult circumstances.

"I don't have a problem with it (retention) now. I see it as a positive thing."

"If we had not had a post mortem we would not have known what was wrong."

The importance of early contact with families was also emphasised.

"Time is the worst and they can probably do nothing, just inform you that some of the tests will take 12 weeks."

The organisation Families of Murdered Children (FoMC) made some comments.

> "For 10 years we have been pushing and there is progress being made."

FoMC volunteers provide court support and liaise with the Procurator Fiscal Service on behalf of families. The group has been in existence for 10 years and supported, in various ways, 700 families worldwide.

> "In 100% of murder cases the victim's family want their day in court even if the accused walks out of it. People would prefer that the accused walked than a plea to a reduced charge."

In 10 years FoMC feel that they have seen changes for the better:

- The introduction of Police Family Liaison Officers
- The introduction of Victim Information and Advice
- Most prosecutors will now speak to the family and that made a difference
- Prosecutors giving warning of when they intend to lead possibly distressing medical evidence.

> "All in all it is quite good."

They would like some improvements, however:

- Improved communication with nearest relatives and smoother handover from Victim Information and Advice to the Witness Service
- For Victim Information and Advice not to be subsumed into the Fiscal Service
- Clarification of the role of Victim Information and Advice.

We also met with a number of nearest relatives as a result of our postal survey and an advertisement placed in a national newspaper.

In one case both relatives spoke of the kindness and helpfulness of the Fiscal.

> "The Fiscal gave us peace of mind."

We were told a written pamphlet would have been useful but these relatives got as much information from the Fiscal as they needed.

On the other hand in another case the nearest relative was dissatisfied with the manner of the Fiscal and also with the Police and the hospital concerned.

In another, the nearest relative again stressed the grief caused to her by the unknown retention of organs.

> "I don't know how I am supposed to get any closure on this by just being told it was practice at the time."

Our final contributor also stressed the hurt caused by undisclosed retention.

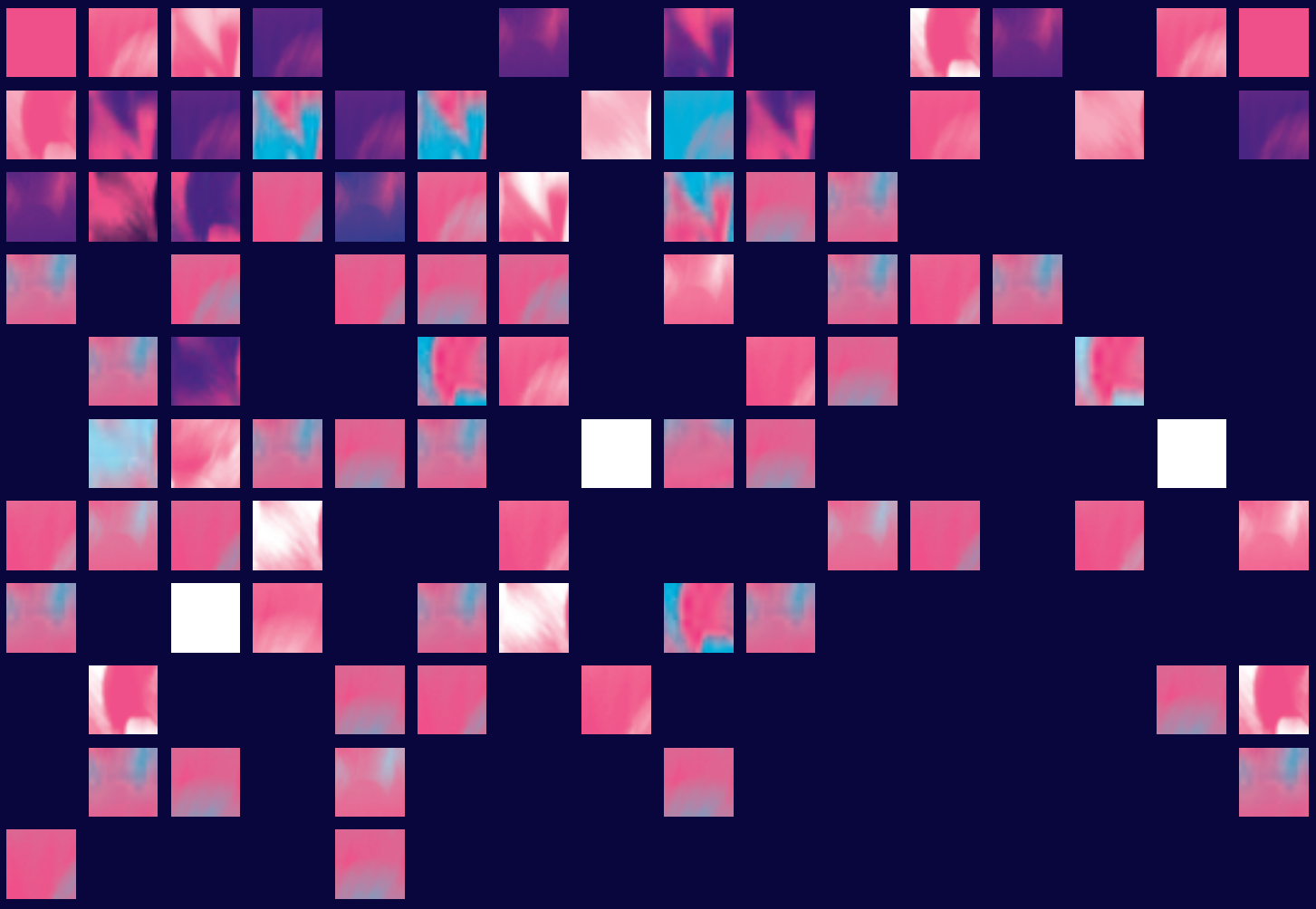
> "It goes on and on and it hurts so much to have to try and deal with this, it is soul destroying."

The changes which have taken place (particularly regarding organ retention) since the experience of these contributors should hopefully make such comments unlikely in the future.

Overall, the feedback from system users was fairly positive again subject to the comments/ observations made.

CHAPTER 5

View from Pathologists and Other Medical Personnel



Contact was made throughout Scotland with a wide variety of medical personnel including Forensic Pathologists and NHS Pathologists who do forensic work. In particular contact was had with the 4 Departments of Forensic Medicine at Aberdeen University, Dundee University, Edinburgh University and Glasgow University. A full list of those who contributed is contained in Annex 2.

We stress these are views put forward by certain service providers. We comment on them in Chapter 9.

As previously stated the Procurator Fiscal may instruct a post mortem dissection of a body in certain cases. A warrant from the Sheriff used to be obtained for this but this is now done on the instructions of the Procurator Fiscal. Full post mortems are undertaken by either one or two pathologists. Two doctors are usually used in cases where there is a likelihood of criminal proceedings and where the cause of death may be a critical issue at any trial. Post mortems raise, of course, the possibility of retention of organs and the possibility of donation. We consider this in greater detail in Chapter 6.

There has been previous widespread concern, as noted elsewhere in this report, regarding retention of organs without the knowledge of the next of kin. A number of contributors to this report were at pains to make us aware of the hurt they had endured as a result and in some cases were still enduring

> "I did not find out until 5 years later that his brain had sat in a cupboard and nothing done."

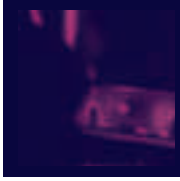
The system now is based on **full disclosure** and the overwhelming weight of evidence we received in preparing this report is that retention for diagnostic purposes (ie to ascertain the cause of death) is now a rare event. We have elsewhere updated the information on the number of post mortems which take place in Scotland and the number of organs retained. The term "retention" is itself capable of ambiguity. We use the term in this report normally only to cover those situations where an organ (or other material) has been retained beyond the release of the body back to the next of kin. Where, for example, an organ is retained for a very short period and then returned to the body prior to its release then that is not in our opinion properly described as "retention".

The dramatic drop in recent years in the number of hospital post mortems has been highlighted to us as causing considerable difficulty in the training of pathologists and the reduction of the number of organs retained (for research as opposed to diagnosis) is potentially having an impact on medical research.

> "Getting experience is a problem."

We visited one particular project designed to try and alleviate this problem in Edinburgh at the Western General Hospital. There a team of neuropathologists under the leadership of Professor Jeanne Bell have made special arrangements with the Crown Office and with the local Procurator Fiscal in Edinburgh to have access to next of kin in cases where a death has been reported to the Procurator Fiscal. Basically the system allows Professor Bell and her team to approach the next of kin where there is a Fiscal post mortem with a view to the team retaining material, normally brains, for research purposes.

It was highlighted to us by the team that there is no real shortage of "diseased" brains for research as many people who suffer from



disease are willing to donate their brains for medical research purposes but there is a dearth of "normal" brains for comparison purposes.

> "Normal samples are needed. One problem with studies is they need something to compare it with. There is a worldwide shortage of normal brains for use in research."

In Edinburgh in practice the system is that once the team has been advised of the necessity to carry out a Fiscal post mortem a nurse co-ordinator from the team makes contact with the family. This is normally by phone but can be in person. The nature of the request is put to the family and, of course, full disclosure is made of the purposes of the proposed retention. In contrast to that system one member of the team explained that in hospital post mortems there has to be very clearly defined "consent" – the form being very specific and lengthy. Rates of consent (following Alder Hey etc) for hospital post mortems were described as having initially fallen but starting to rise again. It was explained to us that the success rate in getting authorisation from relatives in this project is currently running at about 95% which is largely put down to the method of approach and the total transparency.

> "The problem in the past was because people were not told … the need for human tissue for research is vital and we need high quality material with the relatives' consent."

It was described to us that many Fiscals did not understand the process which the pathologists followed and were not aware how blocks and slides were formed and similarly the same problem arose with the Police. The question was then posed by the team as to how the Procurator Fiscal or the Police could explain this to families if they did not know the process themselves.

> "There is now close communication between the medical and legal staff, which did not exist before. We learn their role and they learn ours."

We were also informed that there was in Scotland a golden opportunity to co-ordinate this kind of research as the existence of the Procurator Fiscal Service with a centralised headquarters in the form of the Crown Office enabled negotiations to be made with a single unitary body. In contrast, in England because of the separate jurisdictions of Coroners similar exercises would require separate agreements with all the individual Coroners.

> "My wish would be that this is seen as a national resource and funded as a national resource by the Scottish Executive rather than by research bodies, it is a unique high profile facility that Scotland is giving to the world."

The team were also very interested in getting involved in the training of Police and Fiscals. This project in Edinburgh is, in our opinion, an excellent example of good joint working between the medical and legal authorities for the benefit of society as a whole. It involved close liaison with next of kin, the Procurator Fiscal being the bridge between the research team and the next of kin. The question of funding is for

others to decide but we would strongly recommend this as an example of good practice.

Another group of health professionals were concerned with the way maternal deaths were investigated and reported to the Procurator Fiscal. They were keen to make maternal deaths a mandatory "must report" category of deaths to the Procurator Fiscal. Their view was based on the impact such deaths have for both the families involved and staff. Current statistics show that these run at about 10 per year in Scotland. A number of these, but not all, are reported to the Procurator Fiscal and post mortems instructed. If the mother dies in hospital and the death is not sudden or unexpected it would not under the current guidelines be necessary to report such a death to the Procurator Fiscal although the doctors would obviously be free so to do.

So far as definitions are concerned the team were keen to describe maternal deaths as those which occurred within 12 months of the birth to capture, for example, deaths resulting from post natal depression. Their view was that all such deaths should be followed by a post mortem. One statistic given to us is that maternal deaths are over-represented in statistical terms in the minority ethnic population where there might be added cultural or religious reasons discouraging post mortems. The lack of consistency in the way maternal deaths were dealt with was contrasted by the team with SIDS (Sudden Infant Death Syndrome) deaths where there was guidance from the centre and less variability.

We recommend that the Crown Office and the relevant medical authorities take forward discussions on this particular topic.

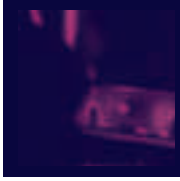
Information was also provided by medical staff at a meeting in the Royal Alexandra Infirmary in Paisley. Some concern was expressed that there was a lost opportunity in Fiscal post mortems for organ donation although recent experience with heart valves and corneas was described as good.

The reduction in hospital post mortems was seen as a problem as was a lack of information back to the hospital in cases where a patient had died and the Procurator Fiscal had instructed a post mortem. De-skilling and lack of experience of pathologists was also highlighted as a problem as mentioned elsewhere.

> "Our pathologists are getting more and more reluctant to do post mortems and they do so few that they don't feel skilled enough. It is quite traumatic for them to do them now there is a lack of post mortems."

It was reported that the hospitals did in the past do Fiscal post mortems but on the basis of the new forensic medicine contract only Forensic Pathologists were doing them now. This occurred at the same time as the number of hospital post mortems was reducing.

> "Now the norm is not to have a post mortem (ie a hospital post mortem). Pathologists are required to do other things, eg on the spot breast cancer diagnosis, the slant of the job has changed there is a shortage of pathologists."



It was explained that after Alder Hey behaviour changed and people became more wary of post mortems. The authorisation requirements also meant that "consent" went from a single sheet to a 10-page booklet.

> "When you are faced with grieving relatives it is the last thing you want to do. In more cases we can get a diagnosis – CT scans – but there are a group of patients when it would be nice to know."

Some concern was also expressed on the question of Fatal Accident Inquiries and the impact these can have on medical staff and we were informed that liaison for witnesses in Fatal Accident Inquiries did not work particularly well in practice locally.

Further concern was expressed over "critical incident reviews" which take place when a case is reviewed by the medical staff to ascertain what had happened and what lessons could be learned. In the past these were based on a free and open exchange of views but more recently these had become inhibited because of the possibility of the information discussed at the review coming into the public domain and possibly being used in court proceedings.

In the Lothians relations between the NHS hospitals there and the Procurator Fiscal were described as generally very good and since 1999 we were informed that the hospitals had had a policy to encourage doctors certifying a death to positively consider whether the death should be referred to the Procurator Fiscal. A form was devised to go into each case note reminding doctors that they had to record a proper medical diagnosis as being the cause of the death.

Some practical difficulty was experienced, however, in cases where a person had died in hospital and the Procurator Fiscal had instructed a post mortem. It frequently fell to hospital staff to explain to the relatives what the arrangements were for the post mortem albeit it was a "Fiscal" as opposed to a "hospital" post mortem. As elsewhere some concern was expressed that the results of the post mortem were not always fed back to the appropriate medical staff. This can on occasion inhibit meetings between the hospital staff and the next of kin which sometimes have to be delayed until the post mortem results are known. Some concern was also expressed that medical staff possibly under-report deaths to the Procurator Fiscal.

As elsewhere the number of hospital post mortems was described to us in Lothians as having declined very much in recent years. This was not all put down to publicity surrounding Alder Hey etc but in some cases because of increased diagnostic ability in life such as CT and MRI scans to such an extent that it was described to us as unusual nowadays for there to be any puzzle as to why someone has died in hospital. It was explained that surgeons are now the most likely category of doctors to request post mortems whereas in the past geriatricians tended to have requested the most post mortems.

> "We are missing the prevalence of some diseases because we don't do post mortems."

The significant shift in procedures for post mortems was highlighted to us. Obtaining agreement to a post mortem in the past had apparently been straightforward, the doctor going through with the family what had happened and indicating that a post mortem

would help to find things out and might help others. There would be no discussion of organ retention or that material could be kept for teaching.

It was described to us that the new requirements meant that the majority of doctors were reluctant, it took much longer and a detailed discussion was needed with the family. The new authorisation form was described, however, as much better, giving the public a clearer understanding but that it could limit the investigation and was more explicit. The medical staff who obtain this agreement felt the process was better but doctors could be put off the process of asking due to the increased requirements. They had to weigh up the benefit of spending the time for what might be obtained.

Post mortem rates on children remained, however, as high as ever because deaths in children were relatively uncommon. Doctors believed that the new process here was much better, it took longer but the gains were considerable.
We were told that in hospital post mortems not many organs were retained (see separate statistics) and certainly very few whole organs.

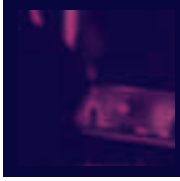
In relation to Fatal Accident Inquiries the role of the NHS Central Legal Office was to co-ordinate work for the NHS including time lines and issues to be addressed. It would liaise with the Procurator Fiscal and the solicitor for the family if there was one. Obviously agendas between the professionals and the family might differ. It was confirmed that if there had been an internal hospital inquiry then the findings would be passed on to the Procurator Fiscal.

The issues surrounding organ retention were described as having a huge effect on the NHS. The McLean Report was described as a driver to change practice, first in children's services and then in adult services. Common documentation was now being used by all NHS hospitals which had not been the case before. The down side was described as the decline in the number of post mortems but it was indicated that had been happening anyway because of increased diagnostic techniques. It was not agreed that the increased bureaucracy was stifling research and teaching. What there was now was transparency and openness.

Some concern was expressed where a case was subject to legal process that there could be a difficulty in getting information to be shared until the legal process was finished. Speedier feedback might be helpful particularly, for example, in the case of children where it was regarded as good practice to meet with the bereaved parents at about 6-8 weeks after the death and take them through the circumstances. If there had been a Procurator Fiscal post mortem this could not always be done as the information might not be available until later. Therefore the same level of service to bereaved families could not be offered in the case of a Fiscal post mortem as opposed to a hospital post mortem.

We recommend that in Fiscal post mortems the results and copies thereof should be shared with the appropriate medical authorities as soon as possible.

Contact was also had with Dr Gray of Aberdeen Royal Infirmary who specialised in what was normal or abnormal in children up to 15 years. She carried out about 10 post mortems a year for Procurators Fiscal. In addition she dealt with neonatal deaths although most of these came through the hospital post mortem route rather



than the Procurator Fiscal unless there was a suggestion of criminality or neglect.

She also confirmed that the number of post mortems had dropped dramatically since the organ scandal particularly in the age group with which she was concerned.

Liaison arrangements between herself, the local Forensic Pathologist and the Procurator Fiscal were described as good. Liaison with next of kin was normally by the Fiscal or by the Forensic Pathologist.

She described the arrangement (fairly universal) whereby if something suspicious arose during a post mortem which she was doing alone she would stop the post mortem and get the Forensic Pathologist and Police involved and move to a two doctor post mortem.

So far as organ retention was concerned in Procurator Fiscal post mortems (all done at the Police mortuary), the parents were usually asked to attend to carry out an identification which gave the Forensic Pathologist a chance to speak to them. She thought that some misunderstanding had arisen in the past about retained organs in Fiscal post mortems because the parents did not understand that they were Fiscal post mortems as opposed to hospital post mortems.

She described how prior to the organ retention problem it was believed to be good practice to retain the brain for full pathological examination. Brains were kept for examination after being fixed and no-one would be advised. It was a different culture then.

Current practice in Fiscal post mortems was that the Forensic Pathologist would explain to the parents if the brain had to be retained. Clearly they had no choice in these situations but it was a distressing experience and it needed to be explained to them. In addition, the various options about disposal thereafter would be explained to them. The same choices were extended to the next of kin in Fiscal post mortems as in hospital post mortems regarding ultimate disposal of any retained material.
Dr Gray felt that the most common option was to delay a funeral to allow body parts to be reunited prior to burial. She thought that so far as who was best placed to explain this to the next of kin, in her opinion, it was local pathologists either herself or the Forensic Pathologist.

She did on occasions, as did the Forensic Pathologist, attend meetings with parents after a post mortem. She said she found it useful that the Procurator Fiscal was present.

Although there was pressure now not to retain organs such as brains this could cause some problems. Normally a number of standard blocks from parts of the brain were removed and the brain then returned. After the brain had been returned if something turned up from the blocks it was of course impossible to go back and take further samples. That was described as a weakness in the current situation.

> "With the long-term fix you can go back and take more samples and get the whole picture."

Obviously this would not apply in suspicious cases where the brain would be retained in appropriate cases.

Dr Gray indicated that she did not do defence post mortems but she knew that these can on occasions delay release of the body. A point also made to us by a Police Family Liaison Officer. There is a particular shortage in Scotland of paediatric pathologists.

Indeed the difficulty of defence post mortems was highlighted to us on several occasions.

Overall, Dr Gray indicated that she was happy with the current arrangements on liaison and that she preferred to do post mortems in the Aberdeen hospital mortuary as opposed to the Police mortuary although the latter would have to be used for suspicious deaths.

Information was also received from Mr Robert McNeil, Divisional Mortuary Services Manager for North Glasgow University NHS Hospital Division based at Glasgow Western Infirmary and Chair of the Association of Anatomical Pathology Technologists UK.

He described how following the McLean review and the audit undertaken by NHS QIS that a retention protocol was implemented. Databases now tracked in great detail anything that had been retained. Every specimen was removed from hospital and stored in "respectful storage" in a ward in Stobhill Hospital. Mr McNeil raised the question of what was to happen after the 5-year moratorium came to an end. He indicated it would be a huge dilemma for the NHS to decide what to do with all of the specimens. He felt that as a former Curator of the museum that it would be a tragic waste if all the specimens were lost. (Since our meeting with Mr McNeil Glasgow University has apparently agreed to take responsibility for the collection.)

> "A lot of these specimens are unique pathology specimens which could be used for exam purposes for mortuary technicians and pathologists if not used for teaching. To lose them is to lose a great part of history."

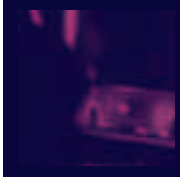
Again the lack of post mortems was highlighted as they were not now routinely being asked for by clinicians as they have to get informed "consent". Mr McNeil thought there would be a great benefit in bereavement services being offered to relatives in Scotland as happened in England. Only Yorkhill Hospital had such a service in Scotland. In England every Trust had it following Alder Hey. Services could vary but typically took the family through the "consent" procedure and could involve speaking to clinicians, pathology and mortuary staff who could give information to relatives. If there was information provided via such bereavement services it was more likely that "consent" to a post mortem would be given.

Again highlighted to us was the increasing tendency over the last few years for pathologists or trainee pathologists to be less involved in post mortem work and to be more involved in diagnosis.

Another concern expressed to us was the level of "consent" in hospital post mortems where it was not uncommon for relatives to give only limited "consent". There was a danger that the Fiscal is relying on that information and it might be incomplete and sometimes it could not establish the exact cause of death because the pathologist could not examine all of the organs.

The Care of Bereaved Group had been set up in Glasgow. It looked at a wide variety of initiatives to try to make the process of death more acceptable to the public and to provide support to nursing and other staff.

One of the main remits was to see what could be done in providing bereavement services. There were issues around who should pay for it. One idea was to create a bereavement centre where health professionals and a Bereavement Officer could take the family through the



process and pathologists and transplant co-ordinators, if necessary, could be involved. One benefit of the Care of Bereaved Group was that issues cropped up that could be dealt with there and then instead of through the complaints procedure.

Mr McNeil indicated that the rate of organ retention or tissue retention was now negligible and that pathologists were now "terrified" of keeping anything.

Mr McNeil indicated that he had been asked to speak to medical students regarding death certification and the "consent" process for post mortems. Prior to this there was no specific medical student training on this subject. Professor Sheila McLean had recommended in her report that senior doctors/consultants approach for "consent" but it just did not happen. Often, Mr McNeil said, it was left to the junior doctors who contacted him and said their consultant has asked them to get a post mortem and they were asking for information on how to do so. He described how it all came down to consultation and proper communication.

Some concern was expressed that Fiscals put pressure on junior doctors to have hospital post mortems done as it would be quicker and that in turn put pressure on the relatives to agree to a hospital post mortem.

Mr McNeil was concerned that there was a potential for missing out on transplant material in Procurator Fiscal cases. One centralised mortuary would assist in that regard.

In Fife information was supplied by the Medical Director, Dr Birnie.

Echoing points made by Mr McNeil, Dr Birnie indicated that when he had worked in England there was a Bereavement Officer who could contact the next of kin and deal with all the forms etc and that they were currently looking for the creation of such a post in Fife.

In cases where a patient had died in hospital and it was referred to the Procurator Fiscal some information would be given by the hospital staff regarding the involvement of the Fiscal but then generally the hospital would step back.

Liaison with the Procurator Fiscal in Fife was described as good. Again echoing earlier concerns Dr Birnie thought it would be an improvement if the results of a Fiscal post mortem could be given or at least given sooner. Any staff who wished to get a copy of the post mortem report usually had to contact the Procurator Fiscal. This was particularly useful in medical misadventure cases. One difficulty highlighted by Dr Birnie was the involvement of the Police in Fiscal cases which tended to make the next of kin and family think that it was a criminal investigation and that in some way the doctor had killed the patient.

Overall, Dr Birnie thought that a bereavement service would be very useful. It was difficult for hospital staff after losing a patient to find the time to speak to the next of kin. A Bereavement Officer could however make an appointment to see the family and take matters forward.

The relationship between NHS Fife, the hospitals and the Procurator Fiscal was good. Any individual problems were often due to a lack of communication between individuals and were not a systemic problem.

Information was also received from Professor Stewart Fleming of the Royal College of Pathologists.

Professor Fleming told us that generally pathologists working in the autopsy field would be happy to talk to relatives but to his knowledge this was only routine in some specialist centres.

He highlighted that in the past liaison was probably not done well in relation to giving information on retention of tissue and organs. For example, for most diseases affecting the brain optimum pathology was obtained if the brain was retained and fixed for about 6 weeks. That was not something that the public or indeed even some professionals were aware of and liaison to explain that might have been helpful.

Taking of samples for histology (histology is the examination of tissue under the microscope) was recognised as good post mortem practice across Europe. The Royal College and its European counterparts have protocols that samples should be taken and kept as part of the record of the post mortem. Subsequently anyone could go back and review as necessary. This could even assist the healthcare of relatives.

Under the new Human Tissue Act blocks and slides were to be retained as part of the health record and this allowed clinicians to conduct a review. This also now meant that there was a permanent record of the post mortem through the blocks and slides. This contrasted with organs which were replaced in the body which then were buried or cremated and could not, therefore, thereafter be further examined. Professor Fleming was of the view that the permanent record was useful from both the legal and health point of view.

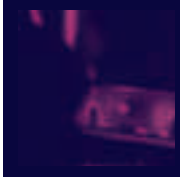
It was highlighted that there were problems around record keeping and that it was necessary for the Procurator Fiscal/ Pathologist/Crown Office and Health authorities to resolve these. He described how from a professional point of view one of the difficulties was sometimes linking findings and outcomes from the Procurator Fiscal post mortem to the patient's health records, getting the information into the health records or the health records for the Fiscal.

Once the post mortem was instructed it normally took place within 3 days but sometimes it could take that length of time to get the case records together as these could be located in several different sites. Equally, getting the post mortem findings into the health records was also problematic. It did not affect the outcome of the post mortem but it could affect the family if they went to the GP to find out what had happened.
He indicated that as staff in the Fiscal's Office were not usually medically qualified they might not be best placed to talk through what post mortem findings might mean. The Professor would welcome a better liaison set-up, a formal procedure of interaction between the pathologist, Fiscal, family and Police.

He drew a particular distinction between post mortems on the one hand for natural deaths and on the other unnatural deaths with possible criminal prosecutions, the two being quite different.

In the case of natural deaths he thought the family would benefit from getting more information than they got at the moment once the pathologist had identified the cause of death.

He indicated that there was an informal mechanism when there had been a post mortem, the family through their GP (or through the hospital consultant) could speak to the pathologist.



Professor Fleming confirmed that far fewer organs were retained than previously.

He indicated that the people of North Fife and Tayside were particularly generous towards medical research and the medical school.

A number of initiatives in the North Fife and Tayside area had borne fruit, for example, all cancer patients were asked for permission for Cancer Research to use their tissue and it was very rare for anyone to refuse this.

In the post mortem field relatives were asked about the retention of tissues or organs for teaching purposes and again it was found that most people agreed to this.

Once it was explained to the families what was going to happen and why, most families were supportive. It was important for young doctors and nurses to see the effects of disease. This was mostly in the area of NHS post mortems but could apply equally to Procurator Fiscal post mortems.

Again, echoing previous contributors, Professor Fleming indicated that he thought Bereavement Officers were the way forward. The aim was to have a hospital bereavement officer as a point of contact and staff there could answer questions to a certain point or know the most appropriate person to ask.

Under the new contract agreed with the Crown Office the hospital pathologist would do Fiscal autopsies on hospital patients so any hospital liaison process could support these as well as normal hospital post mortems.

On the question of liaison with the Procurator Fiscal the Professor explained that some are exemplary and some less so and it could be variable. In his own area he dealt with 3 or 4 different individual Procurators Fiscal who could all do things slightly differently. He indicated that a standard way of operating with all Fiscals would be helpful.

On the question of "view and grant" post mortems the Royal College was reluctant to get involved in so far as this related to policy but if they were to be done the college would support training for them.

NHS QIS (Quality Improvement Scotland) supplied information from their perspective.

> "It is not easy as there has to be understanding that there are certain things that the Fiscal has to do in certain cases so their deaths are not the same as a natural death."

NHS QIS wished to see:

- More joint training
- Training on bereavement issues and communication
- Common post mortem standards for Fiscal and hospital post mortems
- Common levels of communication with nearest relatives in Fiscal and hospital post mortems
- Greater understanding of the role of other professionals

> "… People felt they were operating two different systems when dealing with relatives."

QIS had a number of other issues:

- A higher rate for refusal to junior doctors seeking authorisation of post mortem examination.

> "Anecdotally if the clinical staff thought there were reasons for post mortem but the family didn't consent they would report these deaths to the Fiscal. Some pathologists said they had had Fiscal post mortems that should not have been. It was a question in people's minds."

- That Fiscals might not be up to speed with the more unusual ethnic and cultural customs surrounding deaths
- The reduced number of hospital post mortems.

> "You ask why the numbers are down; people don't like to ask for authority because, anecdotally, the authorisation form is so complex."

Examples of good practice were given including in a Fiscal case a death where the family had a requirement that the body be left in the same position for 12 hours without being touched. The death happened in hospital and it was not possible to leave a body in a ward for that length of time. The Fiscal rang the local hospice and asked to use one of their quiet rooms to allow the 12-hour window and the hospice agreed.

NHS QIS welcomed the provisions of the Human Tissue (Scotland) Act 2006 which laid down that blocks and slides were now part of the medical record.

The British Medical Association reported that communication had improved and more pathologists were willing to meet with bereaved relatives.

Concern was, however, expressed about who in the future would approach families about future retention for education, research etc. in Fiscal post mortems.

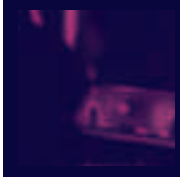
> "Authorisation is needed but mechanisms need to be put in place to ensure this is sought (in England there was some reluctance among coroners to take responsibility for this and so it seemed to fall between the responsibilities of different people)."

One NHS pathologist reported that as a pathologist dealing with adult deaths:

- Organ retention was exceptionally rare
- Fiscals locally had been reluctant to sanction retention
- The majority of neurological conditions could now be dealt with by histology alone precluding the need for retention.

His personal experience indicated that if relatives chose to delay a burial/cremation until completion of neuropathology (2-3 weeks later) to allow for the brain to be re-united with the rest of the body distress usually ensued with almost daily phone calls to the mortuary asking when the body would be released.

One medical contributor reported that the involvement of the NHS in Fiscal post mortems was less than previously. However, the NHS interacted with the Fiscal in many ways as pathologists in the NHS were involved in providing specialist pathology services (eg paediatric pathology) and there was contact between the NHS and Fiscals in hospital deaths.



Yorkhill Family Bereavement Service advised (echoing other comments) that families do not always retain information and that a leaflet with contacts would help.

The importance of the role of the Police was stressed.

> "Family's perception of how they are treated usually depends on the Police who are involved with them. Therefore, it is important that they have a good experience and feel they can liaise with them."

Another NHS source described communication between the Fiscal and the next of kin as excellent. We were advised that in deaths where there was a suspicion of a complaint or a critical incident the Fiscal would have little interest in pursuing a Fatal Accident Inquiry if reassured that a full Critical Incident Inquiry had been held and steps taken to identify the root causes behind any failures of care.

One particular such case was highlighted to us as a result of which changes had been introduced and the family notified. In this case the family wrote to the Fiscal expressing their satisfaction in particular that their concerns had been taken seriously.

Views of Forensic Pathologists

As previously indicated there are 4 centres in Scotland for the provision of forensic pathology services under the auspices of the universities namely, Aberdeen, Dundee, Edinburgh and Glasgow. These posts typically are academic with the title of Professor of Forensic Medicine and related staff and traditionally there has been close contact between the Crown Office and these Departments including input by the Crown Office into the appointment of the Professor of Forensic Pathology.

As with other pathologists there was considerable evidence put to us of the shortage of trained Forensic Pathologists in Scotland. This has resulted in a practice of recruiting from England and further afield.

Input was obtained from Professor Pounder at Dundee University.

Although organ retention was an important issue Professor Pounder reported in terms of cases, numbers were very small. Even before the Alder Hey scandal Dundee did not retain much in the way of organs.

Professor Pounder's own view regarding material which was currently held by Dundee University (or in Scotland) is that it would do more harm than good to contact families. Because of the publicity anyone who had concerns would have made enquiries already. Dundee University have had enquiries going back 30-40 years. As far as those who have not pursued it he saw little point in potentially giving them a problem by pursuing it now.

So far as the present situation was concerned Professor Pounder felt inhibited about retaining organs and would only retain if absolutely necessary. Whether that affected the quality of the work was arguable but he suspected it did not.

In terms, however, of spin-off benefits he suspected it did.

Professor Pounder stated that when he trained he had access to 30 years of retained organs and pathology which was tremendous for training purposes. This was in the area of

children's hospitals. Later he had an interest in cardiac pathology and also had access to a collection of hearts. So in terms of training and education he felt there was a problem but not in terms of the service given to the Procurator Fiscal.

A new (Crown Office) contract came into effect on 1 July 2006 and under this he had a specific arrangement to leave 100 Fiscal autopsies at Ninewells Hospital, Dundee for the hospital pathologists to perform so they could obtain post mortem practice. Otherwise hospital pathologists would have to come to the Police mortuary to train.

In Tayside, Fife and Central there was a system where most of the "natural" deaths were left in the hospital and only the "unnatural" ones taken to the city mortuary.

The result of this was that 100 post mortems would be done at Ninewells Hospital which previously would have been done at the Police mortuary. He thought this was the best "mix" for providing the service for the Fiscal and still leaving cases in hospital to maintain skills there. He has therefore pursued a collaborative relationship with the NHS in Dundee. NHS Pathologists provided a very good service. He thought for Scotland as a whole the tendering process was a bit of a missed opportunity to pull the NHS Pathologists in with the Forensic Pathologists and to deal with competing interests.

The Royal College of Pathologists had stipulated that trainee pathologists had to conduct 25 autopsies a year and a number of hospitals just did not provide enough so he felt they had solved that problem in Dundee.

So far as retention was concerned Professor Pounder indicated that it had to be thought about very carefully and he went out of his way not to retain although it was still a thought in criminal cases but not the overriding issue.

Previously, tissue for histology had been retained from a variety of organs in all cases whether it was intended to process it or not so that it could be referred to again if necessary.

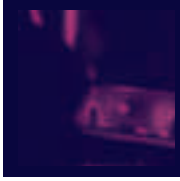
After the organ retention scandal it was only done if there was a real possibility that it might have to be referred to in the future and that was the current practice, so a very reduced amount for histology purposes was retained. These samples went into paraffin blocks.

In cases where there had been retention involving the Procurator Fiscal he did not liaise with the family but informed the Fiscal that there had been retention and he assumed that the Fiscal then dealt with the family.

There had been a recent breakdown in communications concerning a case where a brain had been retained but the Fiscal was not informed until after the body was released and therefore the family did not know. It did show up a failure of communication but it also highlighted the fact that the Fiscal communicated with the family by letter which caused him some concern.

Following from that recent problem he had, in communicating the retention of the brain to the Fiscal, devised a "tick box" system which at the end of the post mortem would be faxed to the Fiscal which would intimate retention. At the end of the autopsy a death certificate was faxed. Now the fax would include the form and the death certificate.

So far as liaison with the family was concerned Professor Pounder thought someone medical was probably better placed to do it. Inevitably



questions would be asked on procedure and practical issues and he would be prepared to deal with these.

He thought the best system would be for the first contact to be by the Fiscal regarding retention but then an explanation given that the pathologist would contact the person and explain everything to them later or offer to let the pathologist deal directly with the undertaker. Inevitably undertakers had a very good relationship with families.

The pathologist was, in his opinion, in a better position to explain why there had to be retention and the various available options but the initial contact should be by the Fiscal. Retention was by the legal authority and the legal authority should make that contact.

He did get involved with families in Fiscal post mortems. Identification was always done through the pathologist and at that point the pathologist would meet the family.

After the post mortem he would only meet with the family if there was a problem with the case and the Fiscal wanted him to discuss it with the family and he would do that with the Fiscal present. He found he did most of the talking but the Fiscal was there as a facilitator and he was happy with that.

> "The family wants to hear it from the horse's mouth, it may take an hour but once it is done it is settled."

The average number of organs retained in Dundee was between 3 and 5 a year. He thought the contact with the family in these situations should be oral and not written. So far as he was concerned toxicology and histology were essentially destructive and the material obtained should be disposed of like surgical or hospital waste. It would not be disrespectful to the deceased to do so.

Organs like the heart and brain were different, due to social and cultural considerations, and were of important significance. Tissue and bodily fluid should be seen as a different issue.

Prior to the problem referred to the Fiscal was informed only if an organ had been retained and if there was no communication then it was assumed there had been no retention so any lapse in communication as occurred here meant that the Fiscal thought that nothing had been retained. He had communication with many Fiscal Offices so it was easy for mistakes to arise. This new system should ensure that these problems did not occur in the future.

Organs that are kept are stored in the Police mortuary in Dundee although the brain might need to go to Aberdeen for examination and then come back.

There are choices for what people want done afterwards. In Dundee the cremation rate for retained organs was about 80%. His view was that cremation changed people's views on what happened with organs. He could not think of a single case of anyone asking for any organ back.

He would have no objection to the post mortem report being sent to the GP. He did not know if they particularly made use of it. If he had to mail it to the GP he would need to know who they were and would also need the Fiscal's permission as the Fiscal had copyright over the document.

When he first came to Dundee the cause of death was in fact mailed to the GPs but he had stopped this practice and no-one appeared to notice which indicated to him a lack of interest.

If there were real interest they would contact him and get the result. Anything else was just expensive bureaucracy.

He thought if the nearest relative was asking for the post mortem report it was better for them to speak to pathologists rather than the GP.

He did not have any problem with giving copies of the non-technical part of a post mortem. His view was that any member of the family should get access to the commentary but if they wanted the full report they should have it although they should be warned it could be unpleasant and technical.

At the moment nothing was sent electronically but if that was to be done there might be problems about security. In hospital cases where there may have been 2 or 3 consultants involved there would have to be some sort of central e-mail address, with the GPs there was no problem as the Police could get the name and address.

The main calls he did get were from hospital doctors and they could get the information immediately. All they needed was the key information and they could get that in the course of a phone call.

Professor Pounder reported that he was well aware that the organ retention scandal had created problems for organ donation.

There were no systems which would allow for permission for bone, skin and eyes to be donated in the way that they should. He thought it was not the role of the pathologist to do that.

In some countries large city mortuaries did facilitate donation such as in Melbourne and Calgary. It seemed to him that where there were large public mortuaries such as Aberdeen, Edinburgh and Glasgow it was a lost opportunity that they were not tied in with a tissue bank.

It had to be said though that, even if there were the maximum kidney donations from potential kidney donors who were dead, it would still not meet the demand and that might be true of livers also.

He thought there were lost opportunities probably not in the case of organs like the heart, lungs, kidney and liver but things like skin, cornea and bone which at the moment needed to be done in one or two centres to service all of Scotland.

It would be helpful to have legislation authorising the taking of these, it being difficult to approach an acutely bereaved person for such authorisation.

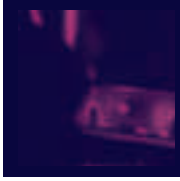
Information was also obtained from Professor Busuttil recently retired Professor of Forensic Medicine at Edinburgh University.

Professor Busuttil reported that in his experience pathologists were willing to meet with the family in Fiscal cases to explain what had happened and that such meetings were always successful.

He indicated no problems in liaison with the Procurator Fiscal's Office in Edinburgh and that there were good relationships.

Copies of post mortem reports could be given either directly to the family or through the GP. It was indicated that some GPs were keener than others to be involved in this activity.

The Pathology Department in Edinburgh carried out approximately 1300-1400 post mortems per year and this generated about 120 meetings with next of kin.



It was reported that in the past pathologists were discouraged from speaking with families at least until after court proceedings were concluded. However, as a result of the Dunblane public inquiry, measures had been put in place to communicate and keep in touch with families before and throughout proceedings.

In the recent cases of Jodie Jones and Rory Blackhall there had been particularly good liaison between the pathologist, Procurator Fiscal and next of kin. This liaison meant that there would be no surprises for the family when the evidence was heard in court whether it was a Fatal Accident Inquiry or a criminal prosecution although clearly there were restrictions on detail which could be provided to next of kin while there was an ongoing criminal case. The more distant Lockerbie case was cited as an example of bad practice where the relatives were not told anything and there was no liaison until after the conclusion of the court case by which time relatives were "queuing up at the door".

In murder cases families might still have questions to ask after the court proceedings were finished and pathologists who were going to meet the family members at this point could provide explanations etc.

Echoing previous contributors Professor Busuttil indicated that there was a lot of medical terminology in post mortem reports and Procurator Fiscal Office staff were not medically trained and might not know how to inform families and might even on occasion misunderstand the terminology.

Changes in personnel in the Fiscal Office Deaths Departments were highlighted as causing occasional problems, some staff being more adept than others in dealing with next of kin.

The Professor indicated that there was a perceived resistance from Fiscal Office staff where organs could be donated, for example, where there had been a death as a result of a head injury in a homicide case and the pathologist was satisfied that no other organs contributed to the death. Professor Busuttil reported that he had persuaded Fiscals to approve release of organs for donation in some cases.

Professor Busuttil suggested some improvements, one in particular being for Fiscal's Office staff to use the Pathology Department to explain terminology etc so that they could be better informed to speak with next of kin. It was also suggested there should be some selection criteria in choosing Fiscal Office staff in dealing with deaths.

Further it would be helpful for Fiscal staff dealing with deaths to stay in post for longer periods than in other Departments to build up experience. In particular Professor Busuttil felt that performance was better in Fiscal's Offices where there was a dedicated Deaths Unit.

Also the Professor indicated that Fiscals should be persuaded to consult pathologists more regarding possible organ donation in homicide deaths.

Professor Busuttil commented on the research project undertaken by Professor Bell at Edinburgh University and the high success rate in getting authorisation from next of kin to retain material in such post mortems.

Views from the University of Glasgow

A collegiate view was received from the Forensic Pathologists at Glasgow from Dr Clark.

Communications in Glasgow with Fiscal Offices (Glasgow serves most of the Fiscal Offices in the Strathclyde area) was generally very good particularly with the Glasgow Procurator Fiscal Office which benefits from having a dedicated Deaths Unit. The experienced nature of the staff in Glasgow was commented on as an important consideration given the relatively frequent turnover of Fiscal staff.

It was reported that there was concern about Forensic Pathologists being asked to carry out post mortems in cases where the purpose might be questionable. Invariably these were deaths where people had died in hospital where the hospital doctor was uncertain as to the precise cause of death although satisfied it was entirely natural and not entirely unexpected. It was reported that it would be helpful to see the Procurator Fiscal taking a firmer stand on such cases and not accept them.

It was indicated that a well written post mortem report should anticipate and answer most questions raised in practice but that the pathologists were happy to amplify it with follow up communication and correspondence as required. However, on the reverse side, nothing was received back by way of feedback to pathologists on cases and they had no way of knowing what the Fiscal was interpreting from the reports and what comments might be being imparted to relatives.

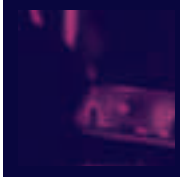
Only a small number of cases progressed to a formal Fatal Accident Inquiry and even then they could be 2 or 3 years later with the pathologist's role being simply one of presenting the evidence from the post mortem report. In comparison in England and Wales with frequent Coroner's inquests and shared and open inquiries the system was different and that in Scotland there was an awful lot of information from cases which never got fed back to the pathologist, clinician or anyone else which was unsatisfactory as a learning experience.

So far as suspicious deaths were concerned it was reported that there was some concern on the part of the pathologist about the relative junior status and lack of experience of Fiscals dealing with suspicious deaths. This frequently resulted in recourse to "rule books" rather than to common sense. Junior staff were not always aware of the protocols involved and sometimes contacted the pathologist unnecessarily early with unreasonable requests for attendance at briefings etc.

Concern was expressed at the number of people present at the homicide scene and later at the post mortem. This concern was largely based on the advances in modern scientific investigative methods especially DNA profiling and the risk, however small, of contamination.

Concerns were raised about formal identification by relatives at the mortuary prior to the start of the post mortem and the strict necessity for this, at least the apparent requirement that it be done formally to pathologists. To insist on this possibly within a short time of death was seen as heartless and in the case of someone who had spent some time in hospital and well-identified pointless. It was highlighted, however, that the protocols now do put evidence gathering above the requirement for formal identification. In the case of persons who have been injured or worse in the course of a crime it is of course particularly damaging to have to make the body presentable prior to the dissection taking place.

Doubts as to the necessity for a two doctor post mortem were also raised but it was appreciated that was a matter of law.



So far as retention of organs and tissues was concerned it was reported that procedures in respect of this had been tightened up considerably in recent years both to ensure that tissues were taken lawfully and that as appropriate they were returned to the body.

It was reported that in a substantial number of post mortem examinations (probably 50-60%) tissues would be retained at the end for further investigation, either small pieces of tissue (histology) for examination under the microscope and blood and urine samples for toxicology investigations. Notification of the retention of these was given to the Fiscal within 24 hours by means of faxing to the Fiscal a form giving basic details, cause of death, material retained and what investigations had been carried out. The histology tissues were processed in the University itself to form blocks and slides which would ultimately be permanently stored as part of the medical record.

In a small number of cases it was reported that in addition to the histology and toxicology a whole organ might require to be retained (invariably the brain). The practice nowadays in Glasgow was that this would be examined within a few days and returned to the body prior to release. As a result there was seldom any hold up in the body being released to relatives. Specific forms and special operating procedures were in place to ensure that the brain was not inadvertently retained instead of going back into the body and at all stages the Fiscal's Office would be kept informed by fax. These procedures were designed to comply fully with the requirements of the new Human Tissue (Scotland) Act.

So far as giving evidence in court was concerned, echoing other comments regarding feedback on post mortem examinations, it was reported that little if any feedback was given when it came to giving evidence in court. It was indicated that pathologists had no way of knowing if their evidence was presented as well as it could have been and that there had to be a lot of Police and scientific evidence brought out in the course of a trial which would be interesting to learn about in respect of the pathologist's own interpretation of injuries and events.

It was conceded that it was difficult to know just how such feedback might be provided but generally liaison between Crown Counsel and pathologists was virtually non-existent. This contrasted in his experience with defence advocates where the pathologist regularly discussed cases with them but sadly no such dialogue existed with the Crown. As a result he felt that the defence often had a far better understanding of complex pathology issues than the Crown and that banalities continued to be asked of pathologists in the witness box by Crown prosecutors and evidence continued to be presented in unimaginative and dated formats.

We recommend that the Department gives consideration as to how feedback can be given to Forensic Pathologists on the contents of post mortem reports and on the use of their evidence in court.

Views from Dr J Grieve, Senior Lecturer in Forensic Medicine, Pathology Department, The University of Aberdeen

Dr Grieve felt that the furore over the retention of organs had to be seen in the historical background of what pathologists were trained to do. In the past it was felt that retaining organs was the best way to examine them. In retrospect he thought it might have been better

if the relatives had known, but the practice was based on improvement and learning. It was a benign position and doctors being attacked as monsters did not sit well with the reality of trying to protect relatives from distressing knowledge of what was regarded as an essential practice. There had been problems even prior to Alder Hey for example back in the 1980s there had been problems over the sale of blood products.

Dr Grieve believed that the new Scottish legislation in regard to Human Tissues was better than that in England following the McLean Report. It might be very difficult in England to retain any material but in Scotland the position, for example, regarding blocks and slides being part of the medical record was very useful.

So far as retention now was concerned when a Procurator Fiscal instructed a post mortem he thought that he or she could reasonably expect that the post mortem would include some standard items and it was good practice to take samples for histology purposes in all post mortems. He would not routinely report to the Procurator Fiscal the fact that he had taken these samples as they should be part of a normal post mortem which the Procurator Fiscal has authorised and instructed. Indeed the Royal College of Pathologists' Guidelines on doing post mortems required taking of histological material and it must be regarded as the professional body governing good practice. The Procurator Fiscal should rely on the fact that when he instructs a post mortem a competent pathologist is carrying out the dissection and following good professional practice. The Procurator Fiscal has to have confidence in the work of the pathologist.

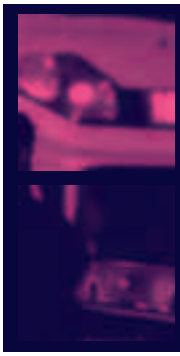
He noted that other pathologists might inform the Procurator Fiscal about the taking of any samples including those for histology but he did not routinely do that. Organs were, of course, different and he would inform of the retention of an organ. He believed that "retention" in these circumstances meant retention of organs beyond the time of potential release of the body. He was asked how he was going to notify the Procurator Fiscal when finished with material which had been retained but did not yet have a working formal system for that.

In Aberdeen, to put this in some sort of historical context, the number of organs retained out of on an average of 550 post mortems prior to the problems would have been between 125 and 150, mostly brains. As he indicated before he thought it had been the right thing to do and indeed there could have been criticism if brains had not been retained. In comparison in the 12 month period from June 2005 to June 2006 only 3 brains were retained out of a total of 552 cases.

Now the usual practice was to retain the brain for a very short term and he did not think that there was much loss regarding findings as a result of short-term retention as opposed to longer-term retention.[4] In Aberdeen bodies were not necessarily released on the same day as the post mortem in any event as the toxicology result was always awaited where such investigation was performed before completing the death certificate.

If Dr Grieve had kept but expected to reunite material with a body prior to its release he would not routinely inform the nearest relative. He would of course give full information, if asked, but he would not pro-actively inform if he intended the material to be returned. He was always happy to explain to relatives when things

[4] See Sharma and Grieve, Rapid Fixation of Brain; a Viable Alternative? *Journal of Clinical Pathology* 59:393–395, 2006



had been kept for a little longer thereby inducing delay in release of the body and in his experience relatives were usually content with that. On the few occasions when organs were retained he spoke to the relatives and told the Procurator Fiscal that he was doing so. He usually did this in the presence of a police officer and explained to them why he was keeping an organ and the likely length of time. These were invariably homicide cases and he indicated to them that he probably would have to retain it until after a High Court trial if there was one and even possibly until after any potential appeal.

At these meetings he would explain the three options regarding disposal to the relatives.

He indicated that one of the effects of the move to full disclosure was that pathologists were possibly telling people things that they would rather not know. However, that was the position.

When he did see relatives he tried to gauge their response and to accommodate any of their wishes. Some required more explanation and reassurance than others and it came down to human interaction and communication. If, for example, nearest relatives were violently against retention he would offer to speak to the Procurator Fiscal and at least explore the possibility of some options although he would indicate to the family that it might be inevitable. He would also particularly do that on the few occasions in practice where there were cultural or religious concerns. He would always do his best to accommodate people's wishes. He indicated that in comparison to the shock of losing someone, usually in violent circumstances, retention of an organ might be seen by some as a minor issue.

He thought it was good that he saw the nearest relatives. He was not saying that all pathologists need do that but it worked for him in Aberdeen. In one case he could not do so because the family was in England but he used the Police Family Liaison Officer to make the contact and that seemed to work well in practice. It was in his opinion a useful use of his time and he thought it was a matter of communication and consideration and was happy with what was being done. He felt it was necessary to be robust sometimes and explain the harsh realities to people.

One Procurator Fiscal Depute had said to him that it was important for him (the Depute) and others like him to learn more about this communication. He thought there might be a problem regarding communication and that role models were important. Teaching in a didactic fashion might not be the best option. Experience, however, was hard to teach.

When he was a junior doctor he said that they had been committed to doing post mortems in hospitals. They saw it as important in training and research. For example, in those days there would be approximately 1,000 adult post mortems a year in Aberdeen hospitals, now it was less than 100. The reasons were somewhat complex with a combination of influences. He thought public perception was important and had a big impact on authorisation. Various public "scandals" had impacted on people's willingness to authorise post mortems. Curiously as post-mortem numbers fell and medical students were less involved in post mortems as part of their teaching and training the issue tended to become self-perpetuating and they were less inclined to ask for something that was outwith their experience. The students now were not learning the same way as he had and, therefore, might have a different attitude. He thought it was a fallacy, however, to say that

better diagnosis in life has reduced the need for post mortems. Things like MRI scans did help of course but they were no substitute for a full visual exposure following a dissection. He thought the drop in post mortems in hospitals was having an effect on teaching, training, audit and research.

Alder Hey of course had had a huge impact. The authorisation forms under the new legislation were probably too complex. It was well known that people took in very little information at times of stress and to get authorisation for a post mortem there was a very short window of opportunity to try and give people information and get them to think about it. You could not give them the information and ask them to come back in a week's time; it would be too late then. You also had to bear in mind he reported that some people simply could not read; pamphlets containing information might not be sufficient and individuals might need things explained verbally to them in greater detail.

So far as organ donation was concerned he stated that the transplantation teams always wanted more organs.

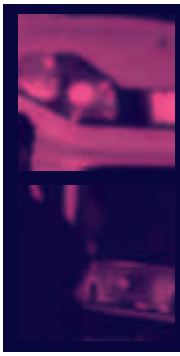
In Aberdeen there had been fewer donations from his caseload in the past couple of years, possibly linked to the retirement of the transplant surgeon in Aberdeen. Three or four years ago he might have seen five to seven cases a year where donation had taken place, usually in fatal traffic incidents, but not now. It had to be pointed out, however, that in Fiscal post mortem situations a very small number were going to be suitable for transplantation. Really only those persons who had been in hospital on a ventilator would be suitable. The exception to that was corneas. The window of opportunity for corneas was greater being up to 24 hours after death. He was happy in appropriate cases to accommodate requests for corneas for transplantation but it involved communication among the various parties. He had had a recent bad experience, for example, of agreeing to cornea donation where he had confirmed to the transplant team that he would take a blood sample (necessary for the transplant) but discovered that a blood sample had been taken prior to his dissection of the body, thereby impairing his ability to obtain samples for the Procurator Fiscal's purposes. This was a communication breakdown which showed how important co-operation and communication were.

Even potential donors in hospital might not be suitable especially if there had been an infection and again this left a very small number of suitable candidates. Given the small number of potential cases in the first place and the level of consent, the overall numbers of cases that he dealt with who might have been potential organ donors was very small.

So far as the pathologist being present at the time the organs were taken for transplant was concerned he did not think that was appropriate. It would not be useful for him to be present when the transplant team took the organ in question but it was essential that the transplant surgeons took a responsible attitude at the time of harvest and adequately documented their procedures and the condition of organs and tissues which they had disturbed.

Having said all that, however, he would endeavour to accommodate relatives' wishes for donation.

Overall, his comment was that communication and co-operation were the answer. Handling death cases was not a competition amongst the various agencies involved, it was a team activity and discussion might be necessary, even robust discussion.



He felt a national forum for Forensic Pathologists was needed. There were only about 8 or 9 Forensic Pathologists in Scotland and such a forum could be a useful platform for discussing good practice and talking about things in an open and robust fashion. He thought the Crown Office would probably be best placed to arrange and host these events. For example, there had been a recent discussion on how drugs deaths were treated involving representatives from all 4 major Scottish centres, facilitating exchange of information regarding practices and allowing participants to consider in a non-contentious, non-dictatorial and non-recriminatory way how they might modify their own practices. The forum would be useful for discussion of matters of common concern.

So far as feedback on his cases was concerned he did not see it as a problem in Aberdeen as he regularly had inter-agency discussions and of course the forum he recommended would also be very useful for feedback on the quality and usefulness of post mortem reports and on the effectiveness of evidence given in court by pathologists.

He did agree that the whole business of the Procurator Fiscal's role at the scene of a murder and at the post mortem needed review and needed to be argued robustly by all the participant parties. People needed to understand each other's roles and functions and again the forum might be a useful platform for discussion of matters such as this.

Finally, in the spirit of the new legislation he did not think that certain categories of death should necessarily lead to post mortem examinations, for example maternal deaths. A woman might well suffer a cerebral haemorrhage, for example, during pregnancy, well documented by investigations prior to death. It would be inappropriate, in his opinion, to subject her to a mandatory, Procurator Fiscal instructed, post mortem simply because she was pregnant when the cause of the death was well known prior to it taking place. He would, nonetheless, encourage enquiry into maternal deaths and would enthusiastically urge that permission for autopsy was sought in any maternal death (under the terms of the Human Tissues Act) but not using the Procurator Fiscal unless the circumstances otherwise would require the death to be reported.

He did agree with some of the views expressed elsewhere regarding some deaths which were overtly natural and explainable being unnecessarily reported to the Procurator Fiscal. Again that was something that could be discussed at the forum he previously recommended and might be further debated through the forum with appropriate Medical Royal Colleges.

In view of the above we recommend that:

The Crown Office host a forum for Forensic Pathologists where issues of mutual interest could be discussed.

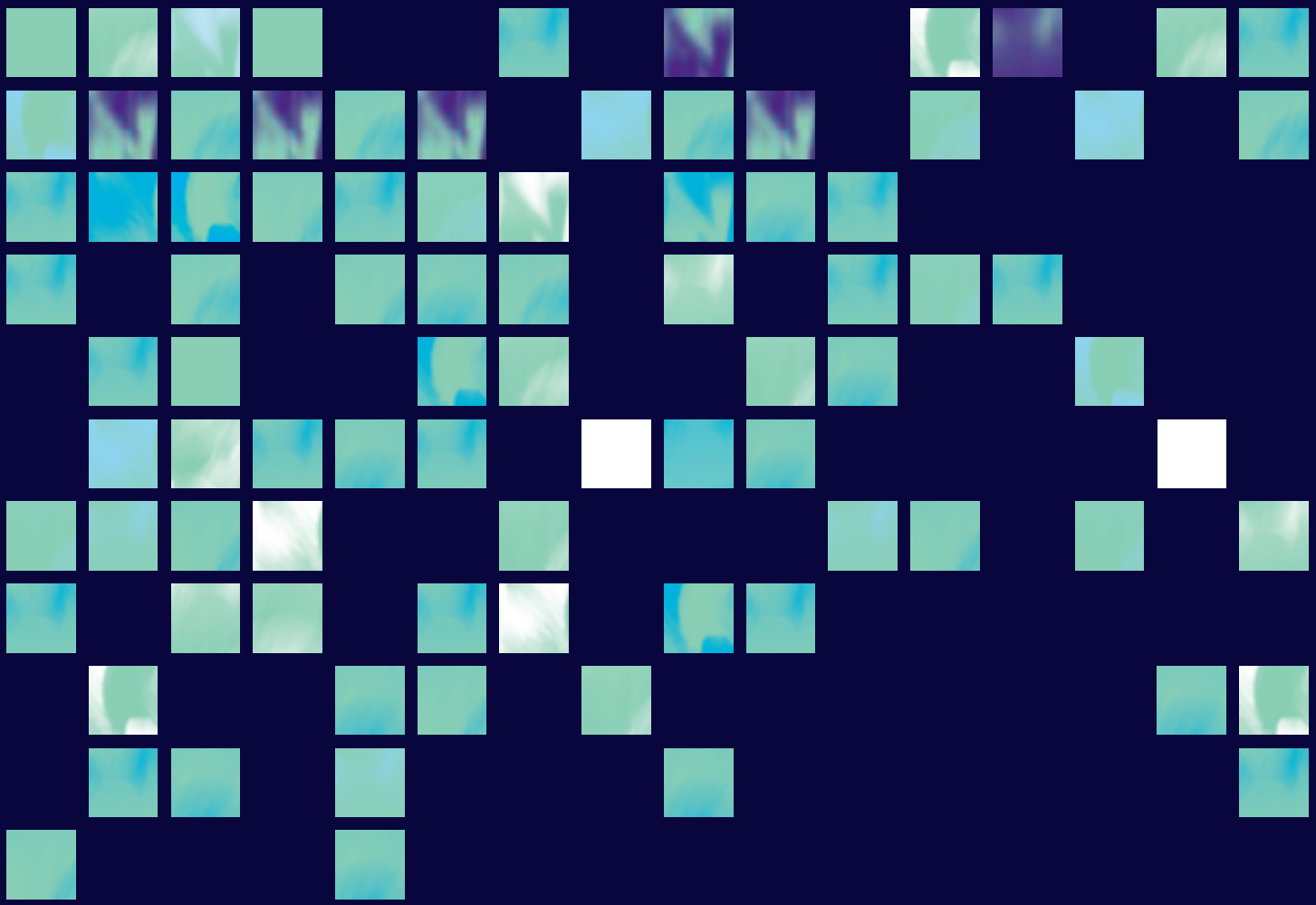
We are grateful to the large number of contributors to this chapter who freely gave of their time and experience. We return to the issues in Chapter 9.

DEATH CASES

A Thematic Report on Liaison in **Death Cases** with Particular Reference to **Organ Retention**

CHAPTER 6

Post Mortems, Organ Retention and Donation



The Procurator Fiscal has a responsibility to inquire into all sudden, suspicious, accidental, unexpected and unexplained deaths. If a cause of death cannot be ascertained or certified then the Procurator Fiscal will decide to instruct a post mortem examination. There are a number of types of post mortem examination available:

- A non-invasive examination of the deceased with certification being based on an external examination and a review of the facts surrounding the death and the medical records of the deceased. This is referred to as "a view and grant".
- In cases where HIV or Hepatitis are likely an initial blood screen will be required and an external examination with toxicological and other supplementary evidence may be sufficient. If criminal proceedings are likely then an autopsy will have to take place.
- A limited post mortem examination that may be restricted to an external examination and a more detailed examination of certain parts of the body.
- A full post mortem examination conducted by a single pathologist, which examines all parts of the body including internal areas.
- A full post mortem examination conducted by two pathologists, which is commonly referred to as a double doctor post mortem and carried out in cases where a criminal prosecution is likely and the cause of death required to be established by corroborated evidence.

Procurator Fiscal Post Mortems, by type, in Scotland, 2004/05 to 2005/06[5]

Type of Post Mortem	2004/05	2005/06
One doctor (NHS)	1,881	2,458
One doctor (University)	3,088	2,314
One NHS doctor and one university doctor	20	5
Two doctor (NHS)	98	130
Two doctor (university)	557	516
View and grant (NHS)	78	190
View and grant (university)	760	727
View and grant (police surgeon)	210	3
Other (blank)	1	-
Total	**6,693**	**6,343**

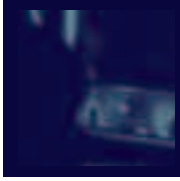
It can be seen from the foregoing table and the number of deaths reported to Procurators Fiscal that post mortems are instructed in about 50% of cases. This is very similar to the rate in England instructed by Coroners. The Procurator Fiscal is responsible for deciding which pathologist(s) to instruct in any particular death.

> "There is still confusion out there between hospital and Fiscal post mortems."

Specialist pathologists will be instructed in appropriate cases, for example, paediatric pathologists in child deaths and neuropathologists in head injury cases.

> "There is a UK wide shortage of pathologists."

[5] Source: Crown Office National Database



If there is a requirement to retain an organ for further enquiry the nearest relative should be informed and arrangements made to deal with the organ after all the necessary tests have been done in accordance with the wishes of the nearest relative.

In deaths where there is the possibility of criminal prosecution there is likely to be a second (or even more) post mortem examination instructed by the defence. The problem of delays caused by defence post mortems was highlighted to us.

In criminal cases the body of the deceased will not be released to relatives for cremation or burial until the defence post mortem examination or examinations have been concluded and that information received in writing. Needless to say this can be a source of great distress for grieving relatives. Defence post mortems are a relatively new phenomenon.

The Crown Office guidance instructs that where a post mortem is instructed arrangements should be made to ensure that the nearest relatives are notified. Again the guidance manual provides a leaflet for giving to families where a post mortem is to be held. This leaflet is designed for situations where an invasive post mortem will take place or has taken place and discusses organ and tissue retention. It also instructs the Procurator Fiscal to obtain information about the religious or cultural requirements applicable to the deceased and that every effort should be made to facilitate the observance of such requirements. The Crown Office Diversity Team has prepared a series of information packages dealing with various religious groups etc and their attitude to what should happen after death.

The leaflet giving information on post mortems also includes information on organ retention and gives advice where an organ has to be retained by the pathologist in order to ascertain the cause of death and instructs the Procurator Fiscal to contact the next of kin as soon as possible to inform them that the organ has been removed and advise them of the options available to them.

So far as organ donation and transplantation is concerned it is recognised by Crown Office that successful organ transplants can be life saving and for many people both organ and tissue transplants are the most effective form of treatment. It is also recognised that many people are not benefiting from transplant because of a shortage of donated organs and tissues.

Accordingly a protocol has been agreed between Crown Office and the Procurator Fiscal Service and the Scottish Transplant Group for dealing with cases where organ and/or tissue transplantation might be contemplated. The important point here is that no donation can take place without the consent of the Procurator Fiscal and this is preserved in the Human Tissue (Scotland) Act 2006 which provides at Section 5 that where there is reason to believe that the Procurator Fiscal may require an examination of a body no part of that body may be removed without the consent of the Procurator Fiscal.

The Book of Regulations has a particular section on retention of organs and highlights the fact that it is a highly sensitive subject and the Procurator Fiscal must take the greatest care when dealing with it. It states that Victim Information and Advice Division (VIA) can assist in communications with relatives and certain deaths must be referred to them. The deaths which must be reported for VIA's involvement are what are known as Category A deaths and these include murder, other homicides, definite or suspected contraventions of Section 1 or 3

of the Road Traffic Act, contraventions of Section 3 of the Road Traffic Act where there has been a death, road traffic collision deaths where no criminal proceedings are contemplated, accidents at the place of work or in the course of employment, child deaths and deaths identified as potential discretionary Fatal Accident Inquiries.

The Book of Regulations Chapter 12 states that although organ retention is comparatively uncommon in practice there are several possible situations where it may be necessary to retain organs or tissue for additional expert examinations. It is most common in the cases of unexplained death in infancy (Sudden Infant Death Syndrome (SIDS)/Sudden Unexpected Death in Infancy (SUDI)).

> "I trusted the hospital with his body and I was let down."

It draws a distinction between retention of whole organs such as brains or hearts and the retention of tissue samples such as blood specimens.

In cases where retention of a whole organ such as a heart or brain is considered necessary the Procurator Fiscal is instructed to ensure that the nearest relative should be forewarned. If necessary this can be done through the Police Family Liaison Officer if there is one but the essential point made is that the nearest relative must be made aware of the possibility of organ retention at the earliest opportunity and this information should preferably be imparted by someone already known to them.

So far as tissues are concerned the guidance highlights the fact that these are invariably very small and that the Human Tissue (Scotland) Act 2006 now specifies that such samples will be considered to be part of the medical records of the deceased and can be destroyed with the medical records when appropriate. However authorisation is still needed from the nearest relatives to use these samples for training, education or research beyond what is needed to ascertain or review the cause of death. Further information is also given on paraffin blocks and slides for microscopy.

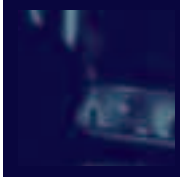
Regarding disposal the guidance instructs the Procurator Fiscal to have arrangements in place with local pathologist service providers to ensure that the Procurator Fiscal is notified promptly in all cases where an organ is retained in the course of a post mortem and where tissue blocks or slides are made.

Liaison arrangements are to be put in place between the Procurator Fiscal and pathologist service providers to ensure that the Procurator Fiscal is notified, in writing, as soon as the analysis of any retained material has been completed.

In the case of organs, disposal should be in accordance with the reasonable wishes of the nearest relative. Generally there should be no need to retain an organ beyond the period of time required for diagnostic purposes.

In respect of samples, tissue blocks and slides unless the nearest relative has sought return of this material these should be destroyed. Tissue blocks or slides should be retained with the post mortem records on the understanding that this material cannot be used for any purpose unconnected with the Procurator Fiscal's inquiry without the pathologist obtaining the necessary consent or authorisation.

So far as disposal options are concerned the need for sensitivity is stressed in the guidance and it is highlighted that the word "disposal"



itself may be offensive to some and that other terminology such as "burial or cremation" should be used.

The options for disposal are:

1. Sensitive disposal of the retained material by the pathologist.
2. Separate burial or cremation of the retained material.
3. Delaying the funeral so that material can be reunited with the body for burial/cremation.
4. Authorisation of retention of the material for medical research, education or for other possible inquiries unconnected with the Procurator Fiscal's investigation.

At the time of writing so far as options 2 and 3 are concerned the Department had not taken a final view as to who should be responsible for the costs but in the interim the Department was willing to make a contribution up to a maximum of £250 in these cases.

It is not necessary here to rehearse all the instructions given in the Book of Regulations but these go on to include detailed instructions on suspicious deaths and reporting cases where a compulsory or discretionary Fatal Accident Inquiry will be appropriate.

As a result of the heightened public concerns over retention of organs at Alder Hey in Liverpool and Bristol Royal Infirmary (The Royal Liverpool Children's Inquiry and The Bristol Royal Infirmary Inquiry) it came to notice that, in Scotland, organs had been retained after post mortem, in some cases, without proper consent.

> "Parents all over Scotland are suffering."

A Review Group was announced in September 2000 against a background of these concerns and was chaired by Professor Sheila McLean, Professor of Law and Ethics in Medicine at Glasgow University and members were drawn from academia, health, a leading children's charity and Crown Office.

The remit of the Group was:

"…to review previous post mortem practice in Scotland, in particular in relation to organ retention, and current documentation on consent and guidance, taking account of developments across the UK; to develop a Code of Practice for Scotland with particular emphasis on issues of informed consent and the most effective mechanism for keeping that Code of Practice under review; and to clarify current legal issues with a view to making recommendations".

The Group's recommendations in respect of Procurator Fiscal instructed post mortems were referred to the then Lord Advocate, Colin Boyd, he replied that revised guidance would be issued to Procurators Fiscal to take the groups recommendations forward.

As a result of the Review Group's work, the Human Tissue (Scotland) Act 2006 was enacted and came into force in September 2006. It is based on the principle of 'authorisation[6]' and deals with the lawful storage and use of body parts, organs and tissue from the living or the deceased. It has three main elements:

1. Provisions relating to hospital post-mortem examinations
2. Provisions relating to organ donation and transplantation
3. Modernisation of the Anatomy Act 1984

[6] In the past the Fiscal would have told the doctor that the examination could take place with the consent of the relatives but the more modern term favoured by the Independent Review Group on the Retention of Organs at Post Mortem and used in the Human Tissue (Scotland) Act 2006 is authorisation.

Procurators Fiscal were provided with guidance on the commencement of the Human Tissue (Scotland) Act 2006 in a Crown Office Circular, issued in October 2006. The circular provided guidance on its implementation and specified that:

"The Act does not affect the instruction or mechanics of Procurator Fiscal autopsies, but will govern what should be done with organs and tissue samples that have been removed in the course of that autopsy once the Procurator Fiscal's purposes have been served."

The Human Tissue (Scotland) Act 2006 provides a distinction between organs, tissue and tissue blocks and slides. It allows for donors (deceased or living) to express their wishes for transplantation and also for research, education, training and audit. With regard to deceased donors, where no wishes have been left, the nearest relative (for over 12's) or the person with parental rights/responsibilities (for under-12s) can be approached to consider donation. If examination of the body is required for the purpose of the Procurator Fiscal then the Procurator Fiscal must provide consent.

> "Trying to give the opportunity for bereaved relatives to make tissue available for research gives the chance for something good to have come out of their situation."

In the past if a pathologist wished to retain for research or teaching purposes he or she should have obtained consent from the next of kin, advised the Procurator Fiscal and ensured there was no objection to this course of action. This has been updated by the Human Tissue (Scotland) Act 2006. Once the organ is no longer required for the purposes of the Procurator Fiscal the pathologist can do nothing further with the organ without proper "authorisation". Tissue blocks and slides, however, automatically become part of the medical records and can be used for certain purposes eg audit, training, research.

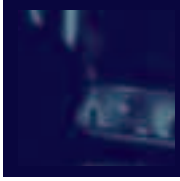
> "I would like a complete shake up of Fiscal autopsies so they are geared up to do them as soon as possible after the death. It would be better for the diagnostic side of forensic work and open up a huge opportunity for transplant and research fields."

In recent years hospital post mortems have fallen drastically to the extent that we found concerns over deskilling of pathologists who simply do not get the opportunity to carry out such examinations, a lack of accuracy in causes of death and the loss of training, education and research opportunities.

> "As hospital autopsies decline the opportunity of gathering comparative material declined and people are less keen to have brain retention in the hospital situation."

In the past we referred to "next of kin" the more modern term contained in the Human Tissue (Scotland) Act of 2006 is "nearest relative". Section 50 defines nearest relative as the person who immediately before the adult persons death was his or her:

- Spouse or civil partner
- Cohabite(e) for more than six months
- Child



- Parent
- Brother or sister
- Grandparent
- Grandchild
- Uncle or aunt
- Cousin
- Niece or nephew
- Friend of longstanding

In practice we found that contact could be with more than one person.

When the Procurator Fiscal instructs an autopsy he or she will not contact the nearest relative if the Police have ascertained from the nearest relative that they have no objection to a post mortem examination. If there is an objection from a nearest relative and a post mortem examination is unavoidable the nearest relative will be contacted by the Procurator Fiscal and the situation explained. Every reasonable effort will be made to accommodate the cultural and religious needs of the deceased and nearest relative where these are known. This is a difficult area of work the sensitivity and difficulty of which should not be downplayed.

In order to establish current practice with regard to deaths where organs were retained or donated we reviewed files at Procurator Fiscal Offices throughout the country. In particular we looked at liaison with relatives, pathologists and Police; whether retention of organs was dealt with in accordance with guidelines; and looked to identify areas of good practice that could be used throughout the whole of the Crown Office and Procurator Fiscal Service.

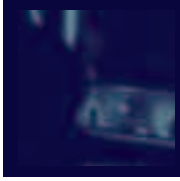
Approximately 400 death files were reviewed at 21 offices during the period January to November 2006. We found that organs were retained on 22 occasions[7] and organs were donated on 3 occasions. We should make it clear that here we also include the short term retention when the organ is returned to the body prior to release. We include these to show the frequency and type of organ “retained”.

The following tables detail the offices visited and provide information on the organs retained (and their ultimate disposal) or donated:

[7] Note that due to there being no field in the computer system to flag cases where organs were retained or donated we had to rely on staff remembering such cases and our own review of files, especially in larger offices where time did not permit a review of all death cases in the period concerned.

Offices Visited, January to November 2006

Office	Area	Month	No. of Cases Where Organs Retained
Paisley	Argyll & Clyde	Jan 06	0
Stirling	Central	Feb 06	1
Arbroath	Tayside	Mar 06	1
Forfar	Tayside	Mar 06	1
Edinburgh	Lothian & Borders	Mar & Aug 06	8
Stornoway	Highlands & Islands	Apr 06	0
Glasgow	Glasgow	Apr & June 06	2
Campbeltown	Argyll & Clyde	May 06	0
Dundee	Tayside	May 06	2
Selkirk	Lothian & Borders	Jun 06	2
Jedburgh	Lothian & Borders	Jun 06	0
Aberdeen	Grampian	Jun & Sep 06	(1 Donation)
Linlithgow	Lothian & Borders	Jul 06	0
Stranraer	Dumfries & Galloway	Aug 06	1
Greenock	Argyll & Clyde	Aug 06	0
Kilmarnock	Ayrshire	Aug 06	1
Peterhead	Grampian	Sep 06	0
Falkirk	Central	Sep 06	0
Cupar	Fife	Oct 06	0
Haddington	Lothian & Borders	Nov 06	(1 Donation)
Dumbarton	Argyll & Clyde	Nov 06	3 (plus 1 Donation)



Deaths Reviewed at Offices Where Organs Have Been Retained/Donated[8]

Age	Organ Retained	Comments
Child	Brain	Brain returned to body and released together
6	Brain	Brain released after body
Adult	Brain	Brain released after body
2.5	Brain	Still ongoing at time of review. Family advised of retention.
25	Brain	Brain returned to body and released together
51	Brain	Approval from family for brain to be cremated by pathologist
46	Brain	Approval from family for pathologist to dispose of brain
62	Spleen and part rib	Organs released with body
2	Brain	Approval from family for brain to be retained and used for medical purposes
1	Brain and spinal chord	Still ongoing at time of review
25	Brain & Lung	Family being contacted with regard to disposal?
37	Brain	Permission given from family for brain to be disposed of by pathologist
93	Brain	Brain returned to body and released together
4 months	Brain	Permission from mother for Yorkhill to dispose of brain
49	Brain	Still ongoing at time of review. Further tests were required.
18 months	Brain	Still ongoing at time of review. Lots of communication with father.
29	Brain	Brain reunited with body and released together
68	Brain	Family advised of retention and they wished for brain to be returned to them for burial. Body already released.
78	Brain	Brain returned to body and released together
23	**DONATION** Left Kidney and Corneas	Donation approved by PF
Adult	**DONATION** Corneas	Donation approved by PF. NB: Pathologist advised that only corneas could be used. This was done.
9	Brain	Brain returned to body and released together
As above	**DONATION** Heart Valves	PF informed of parents wishes
23 months	Brain	Brain returned to body and released together
2	Brain	Brain returned to body and released together

[8] At this point there was some ambiguity of what 'retention' actually meant. Some felt that if the organ is used for further examination but returned to the body before release then it was still retention. For the purposes of this table such action has been recorded as retention.

Our review of files showed that with regard to the 22 cases where organs were retained:

- on 9 occasions the organ had been returned to the body prior to release;
- on 3 occasions the organ was returned after the body was released;
- on 3 occasions the family asked for the pathologist to dispose of the organ;
- on 1 occasion the family asked for the hospital to dispose of the organ;
- on 1 occasion the family gave permission for the organ to be retained and used for medical purposes;
- on 4 occasions the investigations were still being completed at the time of the review; and
- on 1 occasion disposal was under consideration

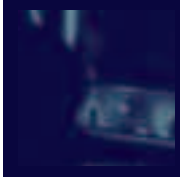
With respect to the 3 cases where organs were donated the Procurator Fiscal approved donation on all occasions.

There was evidence on all the files, with the exception of one where our enquiries prompted consideration of disposal, that the Procurator Fiscal had dealt with deaths adequately:

- Nearest relatives were informed of organ retention issues where appropriate (copies of letters were on file).
- Notes of meetings and discussions with nearest relatives, pathologists and Police were on file.
- One case showed that given the distressed state of the mother the Procurator Fiscal decided not to issue the standard letter but instead asked the Police Family Liaison Officer to personally explain the role of the Procurator Fiscal and the issues surrounding the need for a post mortem. In this same case the Procurator Fiscal had many conversations with the Police on how best to communicate with the mother.
- In another case the post mortem was done on 21 January 2005 and further investigations were required. An aunt contacted the Procurator Fiscal by letter on 21 March 2005 asking when the body could be released. The Procurator Fiscal followed this up and instructions to reunite the brain with the body were issued 31 March 2006.
- In one case the father became very involved with regard to his daughter's cause of death and it was noted that the Procurator Fiscal had taken every step to pursue every avenue.
- In another there was good communication between the family, Procurator Fiscal and pathologist regarding a cardiac abnormality that may affect other family members.
- Another death file showed that there had been a miscommunication issue within the mortuary and this resulted in the brain not being returned to the body although a form had been sent to the Procurator Fiscal indicating that this had actually been done. The Procurator Fiscal released the body (supposedly with the brain as indicated on the mortuary form). When the mortuary discovered the mistake they immediately contacted the Procurator Fiscal. The family were immediately contacted and their instructions sought. The Procurator Fiscal has advised us that the mortuary have since tightened up their procedures.

There were also some examples of good practice:

- Some offices used "Post Mortem Examination" forms that are instructions to the pathologist on requirements.
- Some offices receive "Organ Retention Forms" from pathologists that provide information on the organ retained and for what reason.



- Some offices use a style form that records post mortem details, cause of death, instructions on release, etc.
- In one case the Procurator Fiscal had written to the next of kin within three days. The target is three weeks.

As part of the work of the Review Group on the Retention of Organs at Post Mortem, NHS Trusts in Scotland were asked to provide information about the number of organs retained at post mortem. These figures were published in the first report of the group during January 2001.[9] In response to a request from the Minister during 2001, Audit Scotland was instructed by the Auditor General to undertake an exercise to validate the information provided by the Trusts.

The Audit Scotland review aimed to establish:

- The number of organs retained after post mortem in Scotland
- The robustness of hospital information systems

The results of the review were published by Audit Scotland in March 2002.

In light of this work, we issued a request to NHS Boards across Scotland, asking for the following information:

- Number of post mortems conducted, on an annual calendar year basis, from 2000 to date, specifying whether Procurator Fiscal or hospital post mortem.
- Number of organs retained from post mortems, on an annual calendar year basis, from 2000 to date, specifying whether Procurator Fiscal or hospital post mortem.

We must stress this information, so far as it relates to Fiscal post mortems, and associated organ retention, consists of those primarily carried out at NHS facilities and does not include those carried out at some non-NHS facilities such as the City Mortuary, Glasgow. Figures for 2006 do not reflect a full years worth of data.

The information supplied to us is detailed below in Table 1.

TABLE 1 – Post-Mortems (Fiscal/Hospital) and Organs Retained (Fiscal/Hospital) in Scotland, 2000 to 2006

	POST MORTEMS			ORGANS RETAINED		
	Fiscal	**Hospital**	**Total**	**Fiscal**	**Hospital**	**Total**
2000	3,779	2,524	**6,303**	69	319	**388**
2001	3,677	1,951	**5,628**	45	348	**393**
2002	3,581	1,655	**5,236**	59	397	**456**
2003	3,460	1,616	**5,076**	51	249	**300**
2004	3,394	1,561	**4,955**	61	255	**316**
2005	3,243	1,457	**4,700**	54	233	**287**
2006	2,339	1,180	**3,519**	53	188	**241**

[9] Report of the Independent Review Group on the Retention of Organs at Post-Mortem, January 2001

Chart 1

Number of Fiscal and Hospital Post Mortems in Scotland, 2000 to 2006

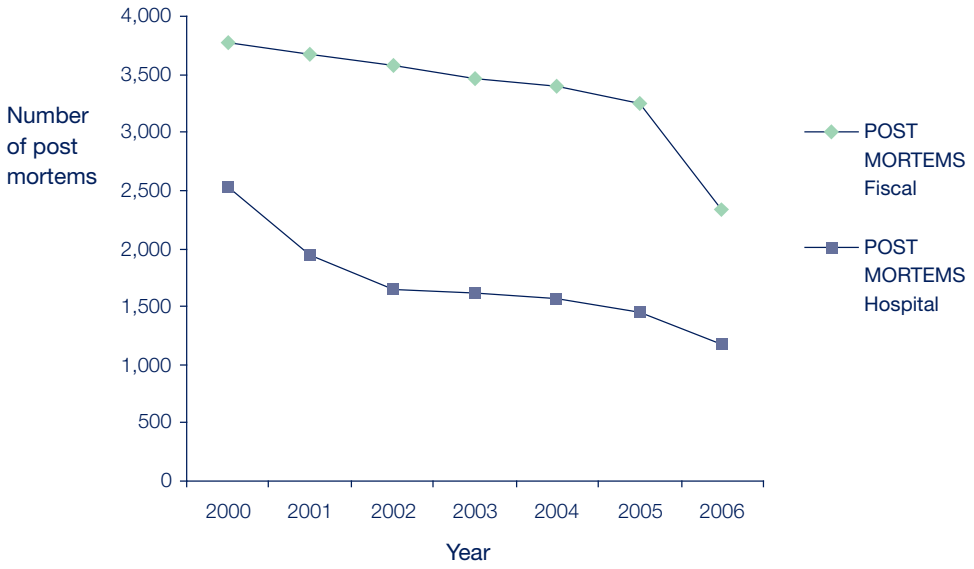
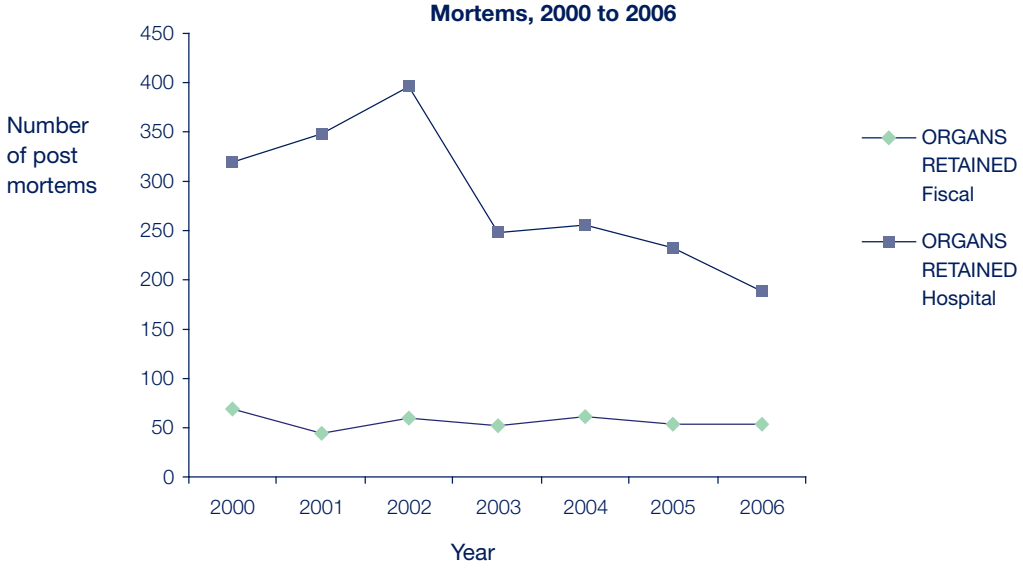


Chart 2

Number of Organs Retained from Fiscal and Hospital Post Mortems, 2000 to 2006

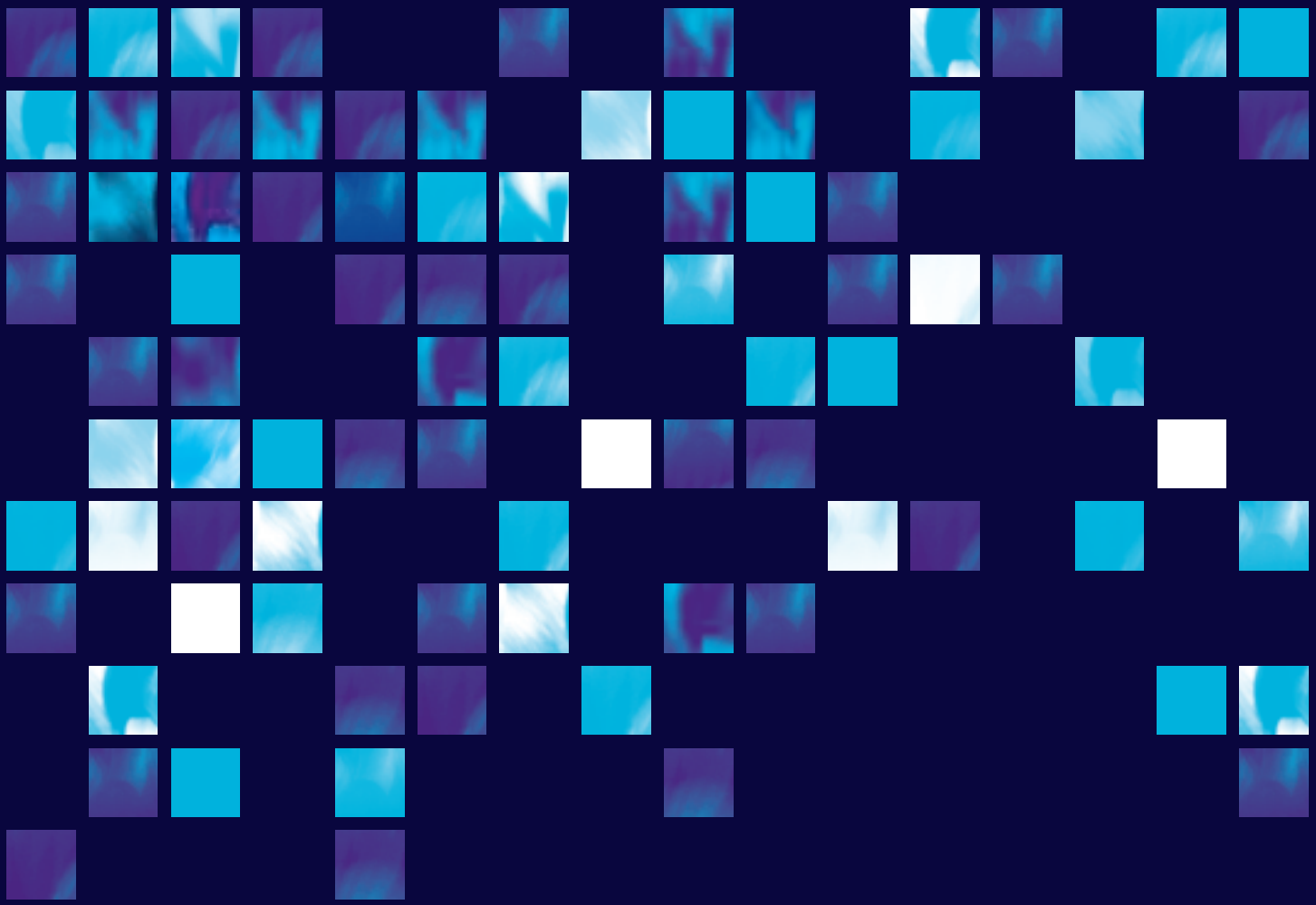


The figures as supplied to us show a considerable reduction in the number of hospital post mortems and organs retained over the period. The number of Fiscal post mortems has remained relatively constant as has the number of organs retained at such.

This information is in line with that supplied to us by others as contained in Chapter 5, in particular the information from the Forensic Pathologists that retention is now a rare event.

CHAPTER 7

Road Deaths



Although there are many categories of deaths, road deaths stood out as an area of particular concern and we received many contributions from people affected by death on the road. We felt it merited, therefore, a chapter on its own.

> "A road death is not a normal death. It is a violent death. The bereaved are shocked and vulnerable. In the overwhelming majority of cases, family have no knowledge of the investigative process and are bewildered by it."

Background Figures

The following statistics and chart are reproduced from the Scottish Executive National Statistics publication *Road Accidents Scotland 2005*.

There were 286 road deaths in Scotland in 2005. This figure was down 7% on 2004 and was the lowest ever recorded. This is part of a clear steady downward trend since the late 1960s/early 1970s.

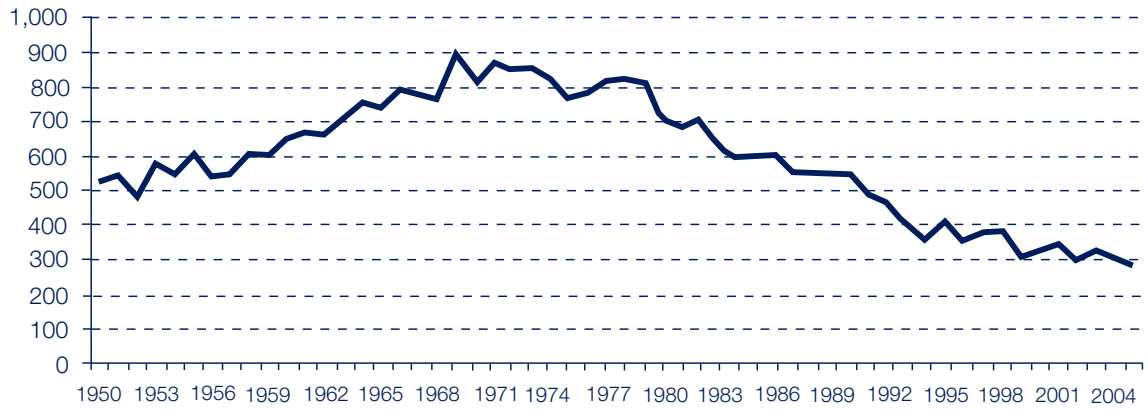
There were 17,821 casualties in 2005, which was 3% less than 2004, and the lowest figure for more than 50 years. Nevertheless concern is still high. As this report was being completed 15 people were killed on Scottish roads in one weekend.

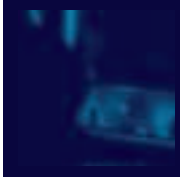
> "Something has to be done about this; there are too many road deaths."

For those affected by deaths on the road the effect is similar to that of a homicide. These are sudden, unexpected, violent deaths which cause great distress to families and others.

There were 93 homicides in Scotland in 2005-06 (Scottish Executive National Statistics 'Homicide in Scotland'.) This was 44 less than the previous year.

Killed – from 1950





Bearing in mind the road deaths figure of 286 in 2005 compared to the homicide figure of 93, this means that the number of people killed in road incidents was more than three times the number who died as a result of homicide. Given the evidence we have that the effects are much the same the number of people affected is far greater in road deaths than frank homicides. The prosecution has a role to play in trying to reduce these deaths by proper investigation and appropriate prosecution.

Background Law

In legal terms deaths on the road can be as the result of an accident or a criminal act. The major relevant offences are contained in Sections 1, 3 and 3A of the Road Traffic Act 1988 and, to a lesser degree, the common law crime of culpable homicide.

Section 1 of the Road Traffic Act 1988, as amended, is the offence of **causing death** by dangerous driving.

Dangerous driving is defined as driving which:

- falls **far** below what would be expected of a competent and careful driver; and
- it would be obvious to a competent and careful driver that driving in such a way would be dangerous.

A person would also be deemed under the Act to be driving dangerously for the purpose of Section 1 if it would be obvious to a competent and careful driver that driving the vehicle in its current state would be dangerous.

Dangerous refers to danger of injury to any person or of serious damage to property. Published figures[10] reveal the number of convictions[11] for causing death by dangerous driving are as follows:

1995/6	1996/7	1997/8	1998/9	1999/2000
23	16	16	16	22

2000/1	2001/2	2002/3	2003/4	2004/5
11	23	16	15	25

In relation to convictions[11] for causing death by dangerous driving when under the influence of drink or drugs the figures are:

1995/6	1996/7	1997/8	1998/9	1999/2000
2	1	6	1	2

2000/1	2001/2	2002/3	2003/4	2004/5
2	2	-	3	4

Section 1 should be contrasted with Section 3 of the Road Traffic Act 1988 as amended. This is the offence of *careless driving* or more accurately *careless* and *inconsiderate driving*. This is committed by driving without due care and attention or without reasonable consideration of other users of the road.

A person would be deemed to be driving carelessly if driving *below* (as opposed to *far below*) the standard expected of a competent and careful driver. Further developments in the law in relation to Section 3 are discussed later

10 *Criminal Proceedings in Scottish Courts 2004/05*, Scottish Executive National Statistics publication

11 References to 'convictions' should be taken to include all persons with a charge proved

in this chapter. However, at the time of writing in a case of careless driving (under Section 3) any death which results from such driving **cannot** as a **matter of law** be taken into account. Thus if the quality of the driving falls into the careless category the law punishes the quality of the driving **not** the fatal consequences.

The distinction between dangerous and careless driving is therefore a crucial one and difficult to explain and understand. It is an almost impossible task to make such a judgement completely objective as these decisions are made by human beings and have to take account of all the circumstances of the case. This can be a difficult decision for legal staff to make (and explain to families) especially where the standard of driving is debatable. When is the quality of the driving *far below* as opposed to just *below* that of a competent and careful driver? Such cases are reported to Crown Office for instructions on how to proceed and this acts as a second check and also enables a more consistent approach to be taken. However, cases are rarely the same and inevitably opinions may differ.

The requirement to report such cases to Crown Office for instructions means that in all of these very difficult cases at least two persons will have considered the circumstances and appropriate charge. These decisions are not taken lightly.

As stated the distinction between the two charges is of great significance as, until the provisions of the Road Safety Act 2006 come into force (discussed later) only in cases of causing death by dangerous driving, Section 1, can the death be referred to and put to the jury. If the case is prosecuted, due to the manner of driving, as careless driving, a contravention of Section 3, the death is not legally relevant.

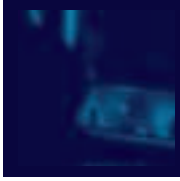
Section 1, or causing death by dangerous driving, can only be charged when there is evidence that the driving is sufficiently bad to meet the test outlined previously.

There is, therefore, a large gap between Section 1 cases and Section 3 cases (now covered by the provisions of the Road Safety Act 2006 which will create a new offence of *causing death* by *careless or inconsiderate* driving which will be discussed in more detail later).

The philosophy on prosecution is that no prosecution can be commenced without there being sufficient, admissible, reliable evidence to prove the charge (Crown Office and Procurator Fiscal Service Prosecution Code). This is not always easy to explain especially to those who have suffered such losses. They quite naturally frequently do focus on the consequences rather than the quality of the driving.

> "I was informed by the Procurator Fiscal Service and the Police and Court Officers that it is quite often difficult to prove dangerous driving and the charge is careless driving because it is easier to get a conviction. To me it is terrible to go for the lesser charge instead of the greater, something needs to be done."

It is obvious on looking at actual cases which have come before the courts that the distinction is not an easy one even for lawyers. In the case of prosecutions under Section 1 it falls to the jury to decide the issue.



"To receive a letter saying that the case was a Section 3 and that our daughter's death was not relevant was terrible."

The question of what constitutes dangerous as opposed to careless driving has been considered on many occasions by the courts.

In the case of Aitken v Lees[12] the Appeal Court quashed the conviction for Section 2 of the Road Traffic Act 1988 (dangerous driving) of Thomas Aitken who overtook a bus at a pedestrian crossing and struck a 5-year-old girl who was hand in hand with her mother on the crossing.

Lord Justice-General Hope said "There are two tests, both of which require to be satisfied and it is only if both of those tests are satisfied that the charge of dangerous driving can held to be proved. Accordingly it is necessary in these cases for the judge of fact to address his mind first to the question whether the driving has fallen far below what would be expected of a competent and careful driver. Then he must ask himself whether it would have been obvious to a competent and careful driver that driving in that way would be dangerous, applying the meaning of "dangerous" which is set out in subsection 3".

This can be contrasted with the more recent case of Angus v Spiers in 2006[13] where two children were crossing at a pedestrian crossing when Ross Angus failed to comply with the red light signal and struck one of the children. The Appeal Court on this occasion refused Mr Angus's appeal against conviction and found:

"The findings are more than sufficient to meet the test laid down in Aitken … the appellant drove across the pedestrian crossing against the red light without concentrating upon that but rather on the traffic lights further ahead. The presence of vehicles already stopped at the crossing and, much more importantly, the fact that he struck the child on the crossing are all material to this consideration. While, of course, it has frequently been said that the consequences of dangerous driving in the terms of injury and the like have to be ignored in the assessment of the driving, the striking of the child bears directly upon the nature of the driving as being part of the commission of the crime. It reflects an element of danger in the driving. In addition, while the speed that was found by the Sheriff to apply at the time was not outwith the limit it can still be categorised as excessive by reason of the fact that the child was struck."

This highlights that in law the fact that a person has died (as opposed to being struck) does not itself provide evidence of the type of driving and highlights the difficulties faced by all in such cases.

Although at the time of writing the new provisions of the Road Safety Act 2006 were not yet in force there was, however, one existing offence involving death in the context of careless driving but only where the driver was under the influence of drink or drugs. This is Section 3A of the Road Traffic Act 1988 as amended and is the offence of causing death by careless driving when under influence of drink or drugs.

In addition to these statutory charges the prosecution can (and sometimes does) make use of common law crimes (as opposed to statutory) relating to causing death.

12 1993 JC 228, 1993 SCCR 845 and 1993 SLT 182
13 2006 SCCR 605

The common law crime of culpable homicide is difficult to define as it covers a wide variety of situations but can be described as any unlawful killing where either the circumstances or the intent of the killer are not such as to justify a charge of murder. This was previously used prior to the enactment of the original Section 1 provisions and is still a competent charge. It is considered that culpable homicide is a more difficult charge to prove than Section 1 of the Road Traffic Act and that juries are more reluctant to convict of the common law charge.

This is sometimes, however, more in tune with what families feel.

> "In my eyes he murdered my son."

We note with interest that in a recent road death the accused have been charged with culpable homicide.

Prosecutions under Sections 1 and 3A of the Road Traffic Act 1988 as amended are currently prosecuted, as a matter of Crown Office policy, in the High Court. This is done to demonstrate the serious view the prosecution takes of such cases and allow for possible maximum sentences. Recent figures tend to show that the High Court does not, at least not routinely, impose "High Court" sentences but the crown policy sends a signal to those affected by such deaths that they are treated very seriously and taken only in the highest court.

The maximum sentence for both Sections 1 and 3A is 14 years imprisonment.

The table below shows average sentence passed.

Persons receiving a custodial sentence in Scottish courts for causing death by dangerous driving[14], 2000/01 to 2004/05[15]

Year	Number of persons	Average length of sentence (years)
2000-01	6	3.1
2001-02	13	3.6
2002-03	13	4.9
2003-04	14	4.0
2004-05	23	4.3

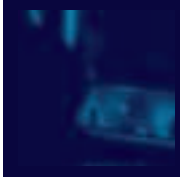
> "For a lot of families, no matter the sentence, it will not be enough."

Contraventions of Section 3 alone are prosecuted in the Sheriff Summary Court and imprisonment is not competent. This will change given the provisions of the new Road Safety Act 2006.

> "It does not matter how you explain to a family about careless driving. They don't see how it can be careless driving and …. the death is only referred to as an injury."

Another area of difficulty for the prosecution is the fact that sentence is a matter for the courts and not the prosecution, a distinction which victims can find hard to understand. There has on occasions been much coverage of the type "What is a life worth" and many judges have been at pains to explain that is NOT what they are deciding, they are deciding the appropriate penalty in all the circumstances of the case. The current practice of prosecuting in the High

[14] Where main offence
[15] Scottish Executive Justice Department court proceedings database



Court for Section 1 means that the fullest range of sentence is available to the court.

Not surprisingly given the foregoing we have found that one of the biggest areas of dissatisfaction with the Crown Office and Procurator Fiscal Service lies in the prosecution of deaths on the road as contraventions of Section 3 of the Road Traffic Act 1988 as opposed to Section 1 as the death is not legally relevant. This may be about to change as the new provisions come into force.

> "We thought it was dangerous driving, that it would be careless driving never crossed our minds."

Nearest relatives cannot understand why the death cannot be taken into account in Section 3, careless driving cases.

> "Families cannot understand why there is no offence of causing death by careless driving. We have always argued that there should be causing death by careless driving to cover the innocent victim."

The other particular area which, we found, caused much complaint and grief was the late acceptance of pleas especially where a Section 3 was accepted where Section 1 was the original charge on the indictment.

The Crown Office Prosecution Code previously referred to deals with "Plea Adjustment" and states:-

"The prosecutor has a discretion to accept adjusted pleas where to do so is consistent with the available evidence or otherwise in the public interest. The deciding factor in discontinuing proceedings or in accepting a reduced plea is the prosecutor's assessment of the public interest. Thus, it will not be appropriate to accept a reduced plea for reasons of convenience or where, despite there being sufficient evidence, to do so will distort the court's assessment of the offending behaviour and of the appropriate sentence."

The prosecutor has to have discretion to reduce charges especially where there is a change in circumstances or a loss of evidence. However, we do not feel it is appropriate to do so in such cases without there having been a significant change in the available evidence and accordingly we recommend that as a general principle:

A reduced plea to a Section 1 charge should only ever be accepted where there has been a significant change in circumstances and not without this being first explained to the relatives or other contact person.

To do otherwise is to invite trenchant public criticism. It might be appropriate, given public concern, that such decisions should always be referred to one of the Law Officers.

Changes to the Law

Some of the criticisms levelled at Fiscals are unfair and may be due to the complicated nature of the law. Changes in the law have now been enacted which should address some of these concerns.

> "I am disgusted that it has taken organisations like SCID 20 years to get this onto the statute book."

The Road Safety Act of 2006 introduces new offences of *causing death* by *careless or inconsiderate* driving and causing death by driving while unlicensed, disqualified or uninsured.

The maximum sentence for causing death by careless driving will be

- 6 months imprisonment in cases heard by a Sheriff alone or
- 5 years imprisonment in cases tried before a jury

The maximum sentence for causing death while unlicensed etc. will be

- 6 months in cases heard by a Sheriff alone and
- 2 years imprisonment in cases tried before a jury.

These provisions are expected to be brought into force in Autumn 2007.

> "The new legislation will be very useful and I cannot understand why it hasn't been brought in before now."

These changes in the law should go a long way to meet criticisms levelled at the Procurator Fiscal Service as deaths on the road arising from careless acts can in the future be recognised in the charge and this can be reflected by the court in sentence especially the possibility of imprisonment. It remains to be seen how enthusiastic juries will be to convict of this new statutory charge but the policy is always to prefer the highest charge the evidence will support so it will be interesting to see how the law and practice develops.

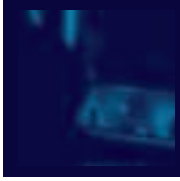
Some of our contacts would wish young drivers targeted as a high-risk group and consideration given to increasing the age at which young people can apply for a driving licence. Statistics show this is the most at risk group. This is outwith our remit but is clearly a concern.

> "The age of licence holders should be increased (from 17 years) and there should be a limit for the first one or two years for new drivers not to have a powerful car."

We also received suggestions that a Fatal Accident Inquiry should be held in all road traffic deaths. As discussed in Chapter 2 there are some mandatory categories of deaths where an Inquiry has to be held but road deaths (unless in the course of employment) are not one of these. Such inquiries could be held under the discretionary provisions of the 1976 Act. They are not, however, routinely instructed by the Lord Advocate but limited to where there are broader issues to be considered. This is more in keeping with what the Act requires of the Sheriff in making his "determination". There could be practical difficulties in instructing a Fatal Accident Inquiry (FAI) where families might be split on the course to be adopted, not that unusual a situation.

This question was during our evidence gathering the subject of a petition to the Scottish Parliament requesting that Fatal Accident Inquiries be held in all "careless" driving deaths. This was, however, rejected although there were calls for the families of victims to be kept better informed about proceedings.

We agree that, as an alternative to holding public inquiries, families should be given as much information by the Procurator Fiscal as they need. Current practice would be to do so. It might however, have to be emphasised in



Crown Office guidance. Reports to Crown Office should, however, under present guidance include the views of the nearest relatives on the holding of a public inquiry so the point can be considered.

All death investigations, by their very nature are demanding intellectually and emotionally of staff but deaths on the road have added complications. Family and friends often view such deaths as violent ones first and foremost and while people generally may view them as accidental they are not always that.

> "A road death is like a murder for the families."

Road deaths are investigated as deaths first and foremost with the investigation moving into that of a criminal one **only** on the express instructions of Crown Counsel which we think gives an indication of how seriously the Procurator Fiscal Service views its obligations in such investigations.

> "We have very little complaint with the local Procurator Fiscal's Office … they kept us in touch, informed."

The Crown Office and Procurator Fiscal Service internal Quality and Practice Review Unit, the predecessor of the Inspectorate, carried out a review of all investigations in road deaths concluded between 1 June 1999 and 31 May 2000.

The Review found no major cause for concern but did make a number of recommendations to enhance the system as it already operated. Changes were made to policy as a result and guidelines issued by the Lord Advocate to the Police.

The Review found no evidence to support the suggestion that prosecutors were accepting reduced pleas not fully justified by the available evidence. This, however, is as has been seen still a concern for some today.

> "The review carried out by the Crown Office Quality and Practice Review Unit said there was no evidence of cases being dumbed down."

Two of the issues highlighted by the Quality and Practice Review Unit were, however, still considered issues by some of the families we contacted who had suffered loss as a result of an incident on the road.

Firstly, but not to a major degree, liaison with next of kin and keeping them informed as soon as possible of the circumstances of the road death and keeping them appraised of each procedural step was an issue in the 2000 report and some of our contributors wanted more information and more contact than there was at present.

> "It was quite intimidating sitting with the Fiscal and being involved in the legal process."

On occasion a lack of sensitivity could be shown in dealing with relatives.

> "Letters from the Fiscal should not have a yellow sticker with "Deaths Unit" on the outside where it is sealed. Call it Unit 4 or Unit D or something."

Secondly, the issue of training for staff in Accident Reconstruction Investigation, legal principles and the practical aspects of handling deaths and bereavement awareness were seen still to be an issue.

> "I said please speak about my son. My son was never mentioned. The balance is all wrong, all wrong."

Guidance to Staff

The Book of Regulations, which is the source of policy and practical guidance for Procurators Fiscal, lays down standards that the Service is expected to maintain. The most recent version of the Book of Regulations section on deaths has moved away from using the term road traffic accidents to road traffic collisions as recommended by the Scottish Campaign against Irresponsible Drivers.

An experienced member of staff should deal with all deaths investigations promptly.

It is the duty of the Fiscal to ensure that there are arrangements in place to receive such a death promptly. Contact can be made out of hours with the on-call Fiscal.

Immediately the Police should be instructed to protect the locus, secure any relevant evidence and to carry out any further investigations.

It is the responsibility of the Procurator Fiscal to ensure the adequacy of those enquiries.

We received some critical feedback:

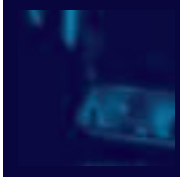
> "(At the Annual General Meeting of Scotland's Campaign against Irresponsible Drivers, SCID) we received a talk from a member or the Procurator Fiscal Service on how he would deal with such cases. He told us how things should happen by the book. It was an interesting comparison with our experience."

Where the Procurator Fiscal considers that there is sufficient evidence to instigate proceedings in relation to contraventions of Sections 1, 3 or 3A of the Road Traffic Act the circumstances must be reported to Crown Office for Crown Counsel's instructions. Such deaths must be expeditiously and thoroughly investigated and managed.

The Police Report should contain the religious and cultural requirements of the nearest relatives with a preliminary view on whether or not a Fatal Accident Inquiry is wanted.

> "We asked about a Fatal Accident Inquiry and were told it is at the discretion of the Lord Advocate, we were not asked if we wanted one."

Where there is the possibility of a criminal prosecution or Fatal Accident Inquiry the Procurator Fiscal should arrange a meeting with the Reporting Officer early in the investigation to review the evidence and consider the focus of the investigation and the instruction of expert witnesses.



> "A Fatal Accident Inquiry would've dealt with the evidence not heard at the trial – issues like the ambulance taking 16 minutes when it would normally have taken 9."

A report is often obtained from Accident Investigation Officers or Accident Reconstruction Investigators. These officers investigate collisions and prepare a report including details and calculations of speed, position etc. This is a specialist area.

The locus or scene must be preserved but life saving operations must, obviously, take priority.

Area Fiscals should make arrangements with the Police that in cases where a prosecution is a possibility no charges are made until instructed by the Fiscal who will report the matter to Crown Office for instruction.

> "Because I was not next of kin he found me irritating and troublesome. He was not used to people asking questions and asking for the rationale."

In the exceptional case where the suspect is in custody the District or Area Fiscal must be contacted to agree the initial charges. If the accused remains in custody the case must be immediately reported to Crown Office for instruction on the charges appropriate for committal for trial.

In our contact with families and friends in road deaths we encountered some criticism of the Police. Criticism was levelled at the level and quality of liaison received and the quality of the investigation.

> "The Police did not do their job. They opened the road, did not take statements, just contact details."

The Procurator Fiscal, particularly in the early stages of an investigation, is very dependent on the quality of the Police investigation.

> "(The Police Officer) was saying all the wrong things. He was very insensitive."

Conclusion

While there is a lot of good work going on in Fiscal Offices throughout the country, as seen in our postal survey, deaths on the road remain still a contentious and difficult area. The Department has invested time and money in looking at and developing this area with such work as the updating of policy and guidance in the Book of Regulations and carrying out training on deaths for staff.

> "We were happy with the way the Procurator Fiscal's Office dealt with us."

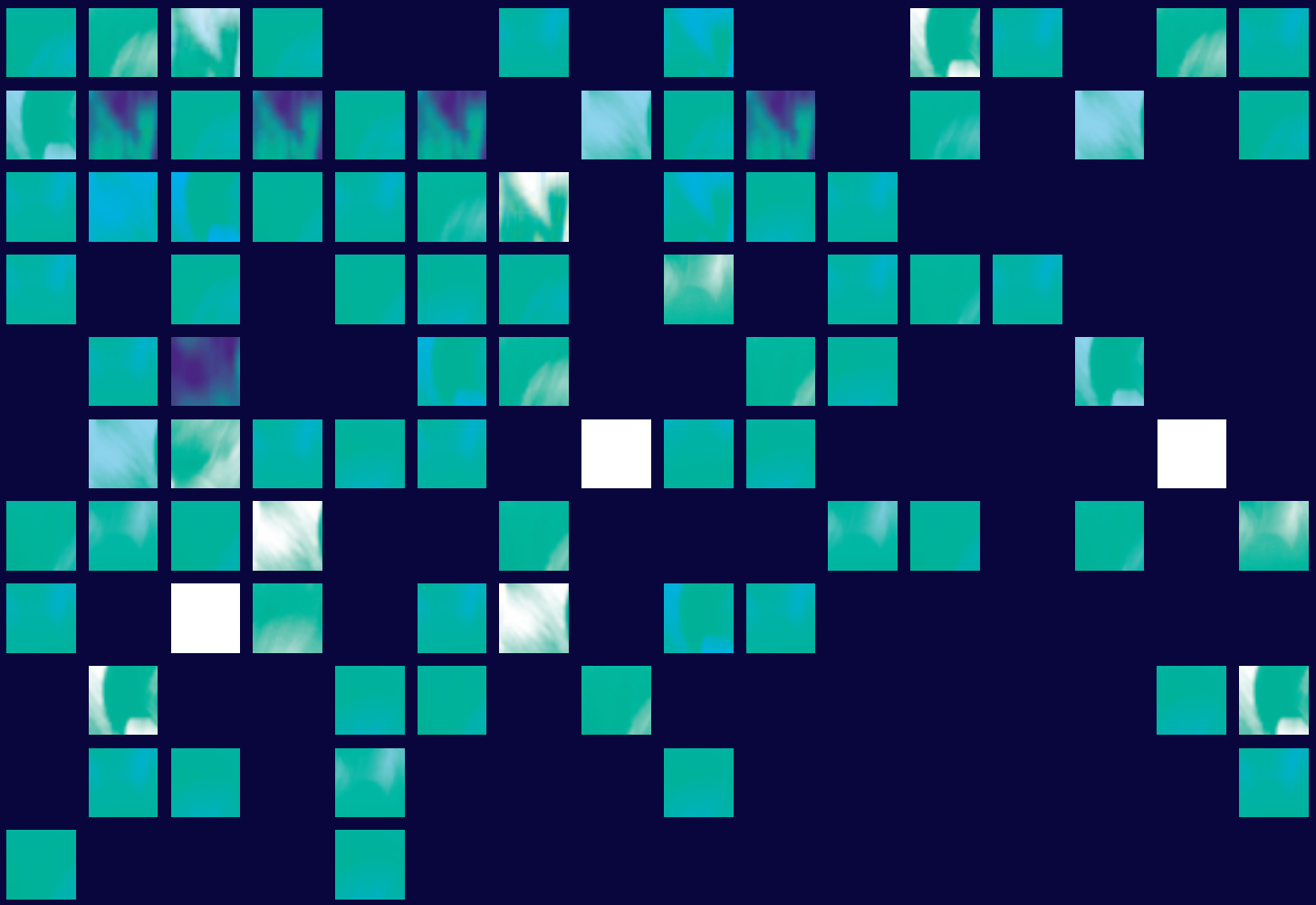
However, our research on liaison with next of kin in deaths shows the difficulty of explaining this area of the law and what the public can and cannot expect to happen. New leaflets (currently being considered) could perhaps specifically deal with this.

DEATH CASES

A Thematic Report on Liaison in **Death Cases** with Particular Reference to **Organ Retention**

CHAPTER 8

Diversity Issues



The Crown Office and Procurator Fiscal Service on its Intranet has a range of Diversity Guidance for staff, including a comprehensive "Cultural Awareness Guide" and guidance on various Faith Groups. These include Muslims, Sikhs and Jews with links to the Scottish Ethnic Minorities Directory produced by Positive Action in Housing in Glasgow and The Scottish Interfaith Council. It is designed to assist Procurators Fiscal in progressing the Departmental strategy of liaison and engaging with local community groups and should be of assistance to Area Diversity Teams (an outreach initiative) when dealing with race, cultural and religious matters.

The Crown Office and Procurator Fiscal Service's own guidance highlights for Muslims the requirement to bury a body as quickly as possible usually within 24 hours. Procurators Fiscal are advised that because of Islamic law and beliefs a delay in burial and/or post mortem can be deeply distressing for a bereaved family. In the context of organ retention it is stressed that only what is absolutely necessary will be done at post mortem and that where possible all the organs will be replaced to be buried with the body. Other detail is given including advice that cremation is forbidden under Islamic law.

For Sikhs information is given that post mortems are not liked but accepted if for legal reasons. Advice is given that all Sikhs are cremated, not buried, and the family will wish access to the body for washing etc. Very young babies may, however, be buried if they die at birth or very soon thereafter.

For the Jewish community advice is given to Procurators Fiscal that no mutilation (ie post mortem) of the body is allowed unless there is a legal requirement for a post mortem and that delay causes particular distress. Cremation is forbidden and ideally, as with those of the Muslim faith, it is considered disrespectful to delay burial which should take place within 24 hours.

> "The Jewish religion places great importance on proper respect being given to the body of a deceased person."

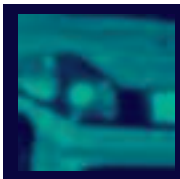
Advice is also given in respect of the Chinese, Buddhist, Hindu cultures and faiths and in respect of the travelling community.

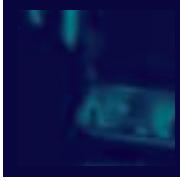
Crown Office and Procurator Fiscal Service is to be commended on the easy availability of such useful information and advice to staff on cultural issues.

The Lord Advocate has also issued guidelines to the Police on the reporting of racist crimes which include instructions regarding assessment of language needs and cultural sensitivities and in particular that the Procurator Fiscal should be advised of both the ethnic and religious background of any individual and any requirement for interpreting services.

In death cases where there is an associated crime report instructions have been given by the Lord Advocate to the Police that the Procurator Fiscal should be advised of the involvement and identity of the Police Family Liaison Officer if one has been appointed (normal in homicide cases).

The Police are advised that the deceased may have an extended family or partner to whom relevant information will require to be communicated. The death report submitted to the Procurator Fiscal should clearly identify the nearest relative and any other appropriate individuals to whom communication should be directed. The need for interpretation or translation services for any such person should





be clearly identified in the report and should specify a particular dialect where relevant.

In particular the Police are advised that where it appears that the deceased's family may have specific cultural or religious needs the death report and associated criminal report should clearly specify both their ethnic and religious background to ensure that liaison can take place in a manner which is sensitive to their cultural and religious needs.

> "Post mortem was against my mother's religion."

On the question of Police reporting the death of someone from the ethnic minority community, where there is not an associated crime report, it is not compulsory for the Police report to include details of religion or other cultural matters although in practice this is usually done. For consistency we recommend that the Lord Advocate's guidelines be amended to include an instruction to the Police to include this information in all death reports not just those with an associated criminal case. Advice from the Police would tend to indicate that this would be relatively easy to do by creating a mandatory "field" in the standard death report submitted by the Police to the Procurator Fiscal.

The guidance available for staff is as stated comprehensive but in the event of difficulty staff are invited to contact members of the Crown Office Diversity Team and this does on occasions occur especially where advice is sought on particular racial charges, acceptance of pleas or issue of warning letters.

So far as translation of correspondence is concerned the Crown Office Book of Regulations instructs that if it is known that a victim or bereaved relative's first language is not English Procurators Fiscal will require to arrange the translation of all the routine and case progress information which is normally issued in the course of an investigation and prosecution.

If the situation is unclear Procurators Fiscal are advised to use a specially designed docquet to be attached to all first correspondence which contains a translation into 30 common ethnic minority languages of an offer to translate the material attached to it if required. This docquet also recognises the need to make information available in other formats such as large print, audio or Braille and that the need for these formats applies equally to members of the ethnic minority communities.

Special mention should also be made in this context of the Crown Office and Procurator Fiscal Service's Equality Advisory Group whose remit is "To provide expert advice to the Crown Office and Procurator Fiscal Service on:

- the impact or likely impact of the existing and future policies on equality issues
- racial, religious and cultural issues which arise in criminal cases and in particular the likely liaison needs of bereaved relatives from a minority ethnic or religious community." (currently under review to cover diversity more generally).

Procurators Fiscal are encouraged to refer any such issues to the Equality Advisory Group and a template has been created to facilitate such referrals. Additionally Crown Office policy staff will routinely refer policy issues/changes to the Group for their input. The new Chapter 12 was referred to the Group for comments.

As part of our ongoing office inspection programme we look at (among other things) how individual Procurator Fiscal Offices have dealt with any death where racial or cultural

issues are involved. To date 34 such inspections have taken place. Individual case papers relating to such deaths are examined covering a 12 month period. Our examination of individual case papers also included some with a cultural or religious background and some of the feedback from our questionnaires (reported at Chapter 4) refers to these.

In Aberdeen five such death cases were examined by us.

In one case the family who were Muslim did not wish a post mortem to take place and having considered the position the Procurator Fiscal decided that a post mortem was not necessary and the family's wishes were taken into account in coming to that decision.

In another case an Asian man died as a result of a road traffic collision which was investigated and reported to Crown Office for Crown Counsel's instructions which were to take no proceedings. The Victim Information and Advice Division (VIA) were advised of the death and the family were contacted (in India) through the medium of the Police.

In a third road traffic death Crown Counsel again instructed no proceedings on the basis of the facts of the case but the nearest relative who was the father had ongoing correspondence with the Fiscal's Office regarding his daughter's death and was being given information as necessary.

In another case again involving a road traffic collision the body of the deceased was returned back to his country of origin and the Procurator Fiscal facilitated the return.

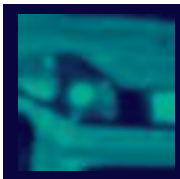
Finally in a death involving a young Asian woman where there were allegations of medical mishap a Fatal Accident Inquiry took place and an interpreter was provided for the deceased's father during the Fatal Accident Inquiry hearing.

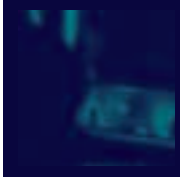
In all these cases it would appear that the guidelines were followed and that the families' wishes were wherever possible taken into account so far as consistent with the obligations of the Procurator Fiscal.

In Airdrie one death in particular was looked at involving a person from a minority ethnic background. Policy was complied with and indeed it was an example of good practice in how to deal with the nearest relative, involving a member of the legal staff and a seconded worker going out of their way to provide an excellent service to the family of the deceased.

In Arbroath two cases were looked at. In one a death from natural causes involved correspondence between the District Fiscal and the relatives, the Consulate and the travel insurers, the Procurator Fiscal again facilitating matters for the family.

The other was a much more dramatic case involving a murder. The file showed that the Police had originally arranged for the family to travel to Scotland and the District Fiscal offered to speak with the relatives (this was in fact declined). The Procurator Fiscal had been in touch with the Consulate through the Embassy and there was ongoing contact with the family through the Police Family Liaison Officer and also a member of the Procurator Fiscal staff at Dundee where the case was to be tried. Interpreters had been arranged. The case did raise questions of travel expenses for overseas bereaved relatives and in this particular case a fund was created by the locals for the family to attend the trial. However, since April 2006 Victim Information and Advice are authorised to make expenditure in such cases.





In Dumfries there were no actual deaths reported within the relevant period at the time of our inspection. However, a local arrangement has been made by the Fiscal for undertakers to be able to contact the on-call Fiscal to deal with any out of hours deaths relating to any minority religious or faith group. We see this as an example of good practice and we would recommend its use elsewhere.

In Dundee five cases were inspected by us.

In one the family were strongly opposed to a post mortem and the Procurator Fiscal arranged for a "view and grant" (ie no dissection took place) procedure to be followed. The body was released on the same day so that the family could return it to Pakistan.

In another, although there were no actual cultural issues involved, the release of the body for burial abroad was expedited.

> "The Procurator Fiscal was very understanding of the extremely distressing circumstances. He accelerated the post mortem to the best of his ability. At our subsequent meeting he was very informative and helpful."

In a further death the family did not object to a post mortem but wanted the body released as soon as possible and the post mortem was instructed, performed, the death certificate issued and the body released all on the same day.

In another case involving a fire the family did not wish a post mortem. However, in order to ascertain the true facts a post mortem was required and a two doctor post mortem was in fact carried out. This in the circumstances was of course the correct decision. This illustrates the need for proper enquiry to prevail in the event of a clash of interests.

In a final case where there were allegations of criminality a two doctor post mortem was instructed but the family were kept advised of the situation.

In Dunfermline one case was examined in detail. The family did not wish a post mortem to be carried out and also requested a burial as soon as possible. However, the family GP was not prepared to issue a death certificate so given the circumstances the Procurator Fiscal approached a pathologist at Dundee University and a death certificate was issued after examination of the medical records of the deceased and an external non-invasive examination of the body by one of the pathologists. This enabled the body to be released on the same day. The family asked the Police to pass on their gratitude to the Procurator Fiscal in expediting this matter.

In Edinburgh we examined one case involving the death of a Jewish woman and as previously stated there was a requirement that she should be buried without a post mortem dissection by her faith. These wishes were considered and again the "view and grant" procedure was followed there being no actual dissection and the deceased's body was released for burial the same day.

In the Glasgow Procurator Fiscal's Office there are 4 Divisions but the investigation of deaths is carried out by a central Deaths Unit. The Deaths Unit in Glasgow, given the size of the local community it serves, regularly deals with routine deaths where representations are made regarding the holding and timing of post mortems due to religious considerations and

every effort is made by staff to accommodate such considerations where possible.

> "We would ask you to be mindful of the added distress that every extra delay in the release of the body would cause."

In particular the office has the services of a secondee from the West of Scotland Racial Equality Council and there had been discussions on the sensitive handling of such deaths. Staff in the Deaths Unit at the time of inspection seemed to be well aware of the concern and impact deaths procedures could have on the minority ethnic communities.

The Hamilton office similarly had a centralised Deaths Unit and at the time of inspection had a number of child and infant deaths where one or both parents were from an ethnic minority. One case was the death of a baby from a Muslim family, both parents being from an ethnic minority, and the mother not speaking any English. The Police had arranged for a Liaison Officer who spoke Punjabi to liaise initially with the family. The Crown Office leaflet "Advice for Bereaved Relatives" was translated by this Punjabi speaking Liaison Officer as it was impossible in the timescale available to have it translated into Punjabi. A post mortem was quickly arranged and the body released so that Muslim burial practices and observances could be met.

At the time of our visit to Hamilton the office was preparing for a Fatal Accident Inquiry which has now taken place into the death of an Asylum Seeker at Dungavel Immigration Centre.

A Police Liaison Officer had been appointed both in London (where the fiancée lived) and also in Hamilton. The Procurator Fiscal had communicated with the family through the Police Liaison Officer and it was realised that interpreters would be required. It was also realised that court documents would require translation.

At the time of the inspection the Depute in charge of the Deaths Unit was intending to meet with the nearest relatives before the inquiry commenced to explain procedures to them.

At Inverness we examined two deaths where there were faith or cultural issues. The deaths concerned two Jewish men killed as a result of a road traffic collision. The Procurator Fiscal at Inverness had arranged for early post mortems to allow the bodies to be released as soon as possible for Jewish burial. The Rabbi had later telephoned the Procurator Fiscal's Office to convey his thanks for the way matters had been dealt with and expressed much appreciation of this.

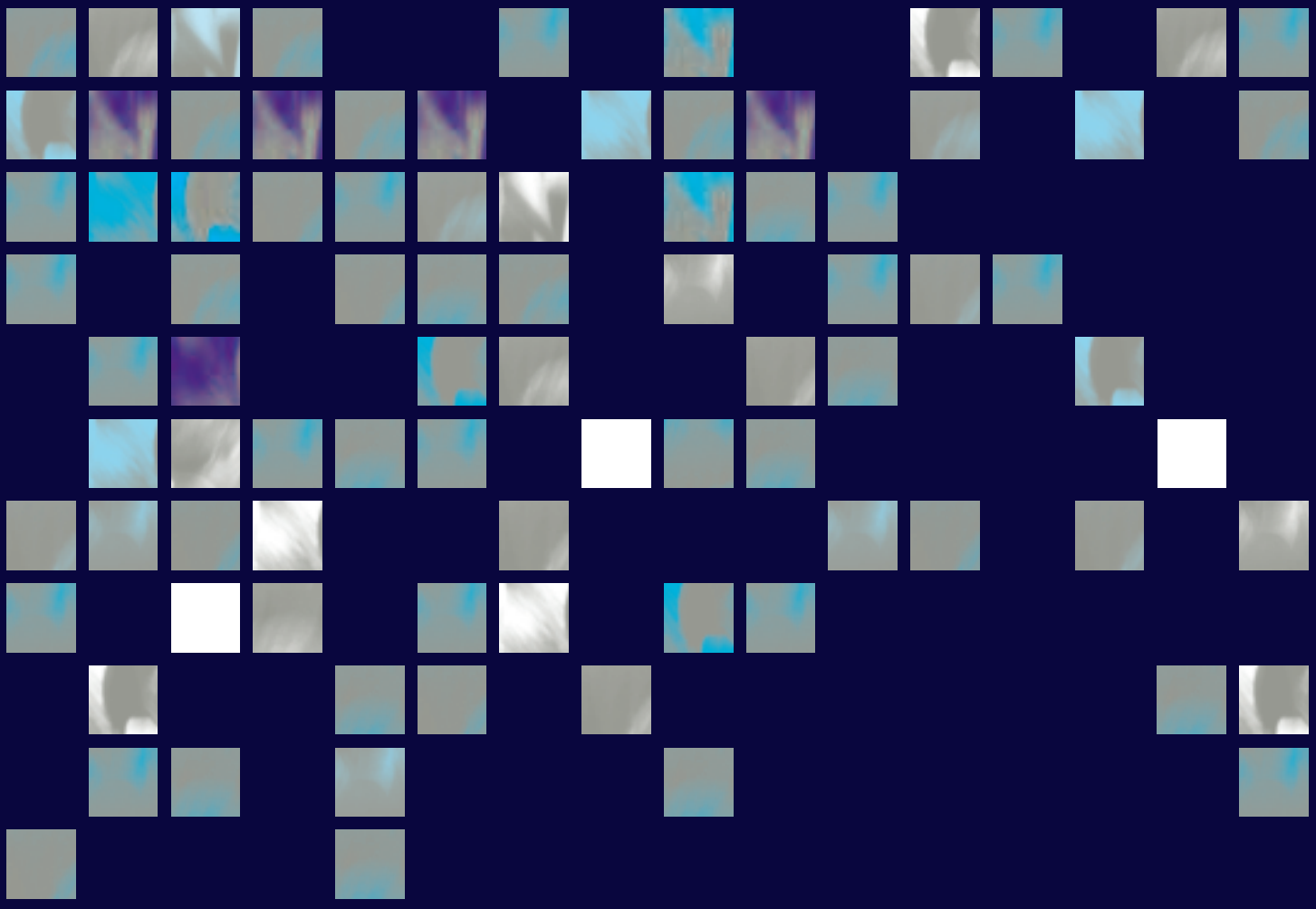
> "In a case where this (a post mortem) is fundamentally required by the law of the land an exception can be made."

In general it can be seen that the Department has moved considerably from the low watermark of the investigation of the death of Surjit Singh Chhokar. Ethnic, cultural, religious and faith issues are now taken into account in investigating deaths and, where possible, families' wishes complied with. In the event however of a conflict the needs of the law and proper investigation of deaths has to be paramount but wherever possible the wishes of the family do appear to be taken into consideration.

It is noticeable in the returns to our questionnaires arising from an examination of 400 individual deaths there were no respondents who complained of a lack of sensitivity in this area.

CHAPTER 9

Conclusions and Recommendations



The role of the Procurator Fiscal in the investigation of certain deaths is an important one and not widely understood by the public. Much of the work is "behind the scenes" as opposed to the much more public face of Crown Office and the Procurator Fiscal Service in the prosecution of crime.

Despite this we found no evidence that this aspect of the work was treated in a second class or secondary way. Indeed it tended to be senior staff who dealt with the work. Traditionally District Procurators Fiscal handled the work personally or the work was carried out by discrete death units.

Having said that training did emerge as an issue both in how to deal with the bereaved where two-thirds of staff indicated there was no training available and also in actually doing the work in accordance with the instructions to staff contained in the new Chapter 12 of the Crown Office Book of Regulations.

It was intended that training would follow the production of the new chapter and pilots were held. Unfortunately the roll out of the training was stalled during the preparation of our report and we were unable to assess it at first hand. We are conscious of heavy demands on training for staff across a wide range of issues including High Court Reform, Summary Justice Reform, Vulnerable Witness Reform and Disclosure all of which have arrived in a short period of time. However we do recommend that as soon as possible:

Training on the investigation of deaths (including training on how to deal with the recently bereaved) should be rolled out as soon as possible.

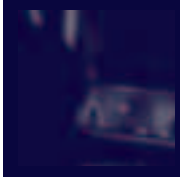
It was interesting to note that Procurators Fiscal contributed to outside training on deaths and on the role of the Procurator Fiscal but there was little external input into Fiscal training. This is something which could be addressed in the current training programme. We understand the new programme will include input from CRUSE Bereavement Care and other external input.

The guidance available to staff on investigation of deaths (accessible through the Departmental Intranet) is, in our opinion, comprehensive and strikes the correct balance between giving too much and too little information. There was some criticism, however, of the absence of an adequate search facility.

In the actual investigation of deaths we found evidence of good practice (outlined in Chapter 3) and sensitivity in dealing with nearest relatives although we mention some areas which we felt could be strengthened.

The feedback we obtained from contact with users of the system was generally positive. There was some indication of underuse of Departmental leaflets but on the arguably crucial question of whether users had received all the information they required 84% said they had done so. Also almost all who replied to our questionnaires said they were treated with courtesy and respect.

We did receive some comments on the operation of Victim Information and Advice, some positive, some less so. Only 4 of the respondents to our survey mentioned Victim Information and Advice specifically. However, the categories of death which Victim Information and Advice deal with are limited and we were sampling all categories of death so that result is not entirely unexpected. There was support for the whole concept of Victim Information and Advice from some sources. The management structure of Victim Information and Advice was changed during the preparation of our report



and is now assimilated into the “mainstream”. This should avoid possible confusion in the minds of some bereaved persons on receiving letters from the Procurator Fiscal and separate letters from Victim Information and Advice.

We were fortunate in getting very extensive input from pathologists and other medical personnel. All 4 university based Forensic Pathology Departments (Aberdeen, Dundee, Edinburgh and Glasgow) contributed their views as did a host of others. This revealed some areas of good practice such as the project based at the Western General Hospital, Edinburgh where there is a high success rate in obtaining authorisation for brains to be used for research purposes.

One statistic which stands out in our report is the considerable reduction in the number of hospital post mortems not instructed by the Procurator Fiscal which have taken place since the Alder Hey scandal in England (down approximately 40% in 5 years). This was accompanied by a similar drop in the number of organs retained.

In contrast the number of post mortems instructed by Procurators Fiscal was relatively steady. This tends to show that the proper investigation of death has not been influenced by recent events. Organ retention, however, at Procurator Fiscal post mortems is now a rare event.

We note the work of the Scottish Executive Review Group on Retention of Organs at Post Mortem chaired by Professor Sheila McLean which led to the Human Tissue (Scotland) Act 2006.

Some concern was expressed to us by various medical contacts that the reduction in the number of hospital post mortems was causing problems for research and training. This was attributed to a number of factors and may well now have “bottomed out”. This is outwith our remit but may be of interest elsewhere. What did emerge, however, was that the results of Fiscal post mortems were not always fed back to the appropriate medical authorities or at least not quickly enough. Accordingly we recommend that:

In Fiscal post mortems consideration should be given to the early release of the results (and copies of the report where appropriate) to the appropriate medical authorities.

On the question of organ retention we found that systems were generally in place to advise the Procurator Fiscal when an organ had to be retained for diagnostic purposes. There were some unfortunate examples of how the system had broken down where the Procurator Fiscal had not been advised of retention and given the small overall number of such cases there might have been cause for concern. However, the systems in the locations in question have been strengthened and we would not expect a repetition.

Liaison between the various Forensic Pathology providers and local Procurators Fiscal seemed generally good. Some concern was expressed about the role of the Procurator Fiscal at the scene of a suspicious death and at the subsequent post mortem. Clearly this can have an impact on subsequent liaison with nearest relatives etc. The Procurator Fiscal is legally in charge of the investigation and selects the appropriate experts, etc. Presence at the scene and at the post mortem can be beneficial, subject to appropriate safeguards. There are protocols for this but we recommend that:

The existing protocols be highlighted for on-call staff to ensure the minimum number of people actually attend at the scene of a crime and actually in the mortuary during the course of a dissection.

The overwhelming weight of evidence we received from the pathologists was that retention of organs was now very rare and there had been a considerable change in practice in recent years. However, it was stressed that retention would take place if this was necessary for the proper investigation of the death especially in suspicious cases.

The number of Forensic Pathologists in Scotland is very small and we received some evidence that feedback to Forensic Pathologists on their reports and the effectiveness of their evidence in court was negligible. Accordingly we recommend that:

The Department gives consideration as to how feedback can be given to Forensic Pathologists on the contents of post mortem reports and on the use of their evidence in court.

We also received a suggestion that there should be a national forum for Forensic Pathologists where issues of mutual interest could be discussed. As the Crown Office negotiates contracts with all these suppliers and is the common link it seems appropriate that Crown Office facilitate the creation of such a forum and accordingly we recommend that:

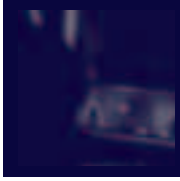
The Crown Office host a forum for Forensic Pathologists where issues of mutual interest could be discussed.

This forum could discuss issues such as the feedback referred to and could also consider some issues which were raised in the course of our enquiries. For example we received mixed input on the question of maternal deaths and whether these should routinely be referred to the Procurator Fiscal. We do not feel qualified to take a view on this but feel it would merit further discussion and accordingly we recommend that:

The Crown Office and the relevant medical authorities take forward discussion on the reporting of maternal deaths to the Procurator Fiscal.

Organ retention was a theme which ran through several chapters of our report. We looked at the guidance to Procurators Fiscal and carried out an audit of Fiscal Offices between January and November 2006. We found that organs had been retained on 22 occasions. These included short term retention where in the majority of cases the organ was returned to the body prior to its release, this was done to give an indication of what organs did require to be retained even for short periods, normally the brain. The results are in Chapter 6 but the overall picture is of high compliance by Procurators Fiscal with their instructions on this highly sensitive issue. The few problems we did encounter had been mistakes in Pathology Departments about informing the Procurator Fiscal about retention. These seem unlikely now.

We did, however, have difficulty in tracking down relevant cases because of the absence of recording of such on the Crown Office IT system. Given its importance, not to mention risk factor, we would recommend that:



Consideration be given to recording retention (and ultimate method of disposal) of organs on the IT system.

We also looked at organ donation and were advised that the opportunity for such in Fiscal deaths was relatively small. Nevertheless, we received evidence from various sources that, in appropriate cases, Procurators Fiscal facilitated the donation of organs including, as a recent example, large scale donation in a homicide case. While evidence has to be preserved for possible criminal proceedings consideration was being given to release where appropriate. We came across three specific examples of donation and were advised of one other.

We try to take a "risk-based" approach to our work and it became obvious that road traffic deaths stood out as an area which caused public concern.

We examine in Chapter 7 the number of road deaths in Scotland and compare this to the number of homicides (about 3 times as many road deaths). The existing law is examined and input was received from a number of relatives of those killed in road traffic collisions.

Although the number of prosecutions for the major offence of causing death by dangerous driving (Section 1 of the Road Traffic Act 1998) is relatively small the capacity of these for adverse comment if they go astray is considerable.

We did receive some complaints about acceptance of reduced pleas in such cases and a failure to explain or at least explain quickly to nearest relatives what had happened at the court hearing. Accordingly we recommend that as a general principle:

A reduced plea to a Section 1 charge under the Road Traffic Act 1988 should only ever be accepted where there has been a significant change in circumstances and not without the circumstances being first explained to the relatives or other contact person.

Some of the complaints levelled at Fiscals in this area had more to do with the state of the law itself. The wide gap between contraventions of Section 1 of the Road Traffic Act where the death is relevant and Section 3 where it is not is highlighted. We mention the new offence of causing death by careless driving and await with interest the implementation of this new offence.

Finally we look at diversity issues in Chapter 8. As we do office inspections in tandem with thematic reports we took the opportunity to examine deaths where racial or cultural issues were involved. This covered 34 offices over a 12-month period. We found many examples of good practice and sensitivity in dealing with such deaths. It was clear that Procurators Fiscal were striking the correct balance between proper investigation of a death on the one hand and complying with the wishes of the family of the deceased on the other. No complaints were received by us on this topic in our questionnaires.

We did, however, experience some difficulty (as with organ retention) in tracking such cases as they are not flagged on the Crown Office IT system. We appreciate this might be difficult to do but we would recommend that:

Crown Office give consideration to placing an IT flag on a death where it appears that the deceased's family may have specific cultural or religious needs.

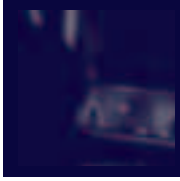
This could possibly be best done in conjunction with the Police who are the main reporters of sudden deaths to the Procurator Fiscal and who should be obtaining this information in the first place.

One area we were unable to examine but which could have a big impact for nearest relatives and others is the pilot Victim Statement Scheme in Scotland. A pilot Victim Statement Scheme commenced in Scotland in November 2003 and concluded in November 2005 and operated in 3 sites – Ayr, Edinburgh and Kilmarnock – in relation to certain offences only.

It gave the victims of the prescribed offences an opportunity to make a statement about the effect of the crime on them personally. The statement in question was obtained by the prosecutor and then presented to the Sheriff or Judge.

At the time of completion of our report consideration was being given to whether or not this scheme should be rolled out in Scotland as a permanent feature. It has been used in other jurisdictions including England and has attracted considerable media interest particularly in relation to road traffic deaths and homicide deaths.

In general, subject to the various factors we mention throughout our report, we found that deaths were investigated properly and in a sensitive fashion. As ever the quality of the staff carrying out the work was crucial to good service delivery. The roll out of the training programme on deaths should help to raise awareness and facilitate the provision of a good service.



Recommendations

1. Training on the investigation of deaths (including training on how to deal with the recently bereaved) should be rolled out as soon as possible.

2. In Fiscal post mortems consideration be given to the early release of the results (and copies of the report where appropriate) to the appropriate medical authorities.

3. The existing protocols be highlighted for on-call staff to ensure the minimum number of people actually attend at the scene of a crime and actually in the mortuary during the course of a dissection.

4. The Department gives consideration as to how feedback can be given to Forensic Pathologists on the contents of post mortem reports and on the use of their evidence in court.

5. The Crown Office host a forum for Forensic Pathologists where issues of mutual interest could be discussed.

6. The Crown Office and the relevant medical authorities take forward discussion on the reporting of maternal deaths to the Procurator Fiscal.

7. Consideration be given to recording retention (and ultimate method of disposal) of organs on the IT system.

8. A reduced plea to a Section 1 charge under the Road Traffic Act 1988 should only ever be accepted where there has been a significant change in circumstances and not without the circumstances being first explained to the relatives or other contact person.

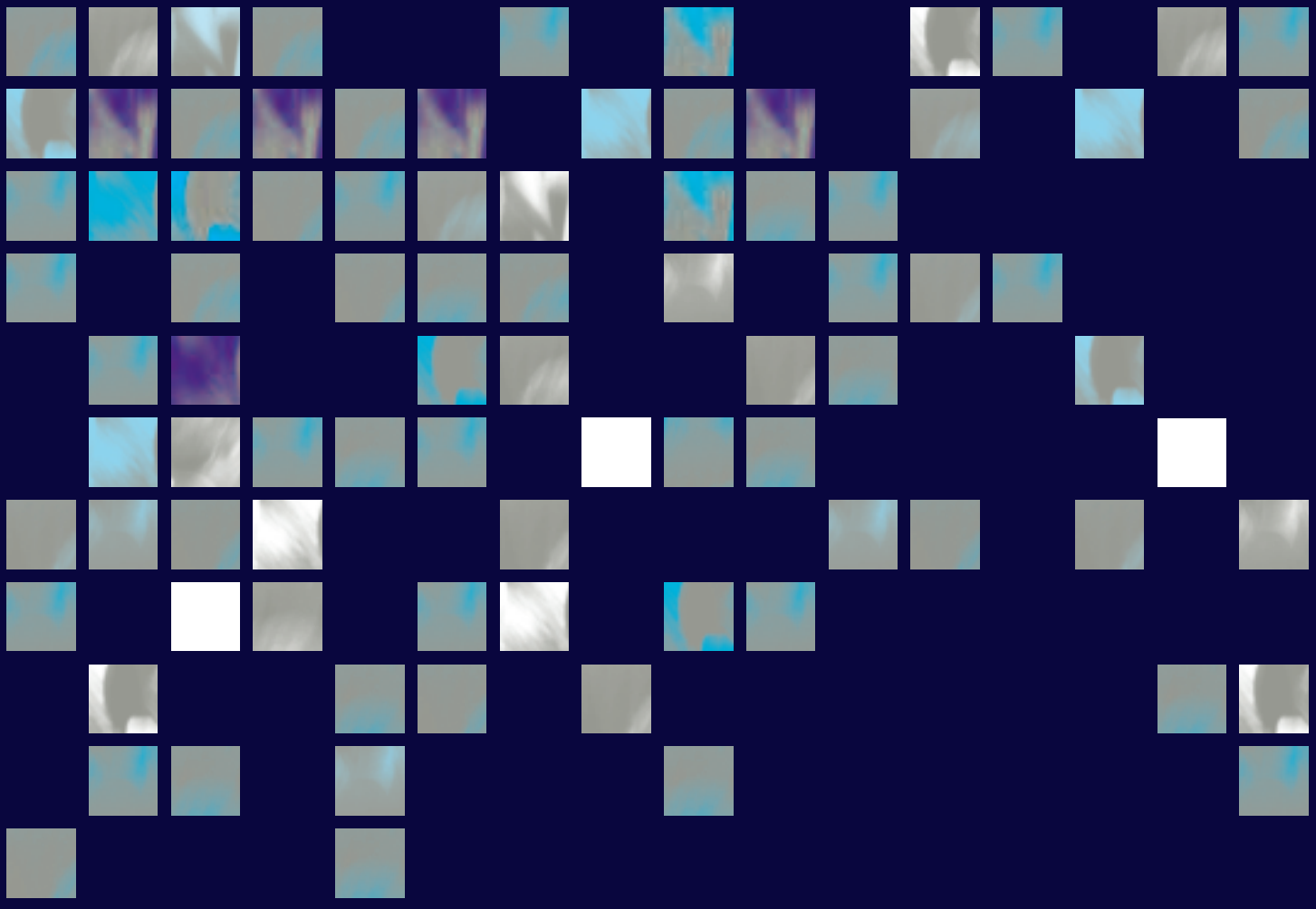
9. Crown Office give consideration to placing an IT flag on a death where it appears that the deceased's family may have specific cultural or religious needs.

DEATH CASES

A Thematic Report on Liaison in **Death Cases** with Particular Reference to **Organ Retention**

ANNEX 1

List of Reference Group Members



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ANNEX 2

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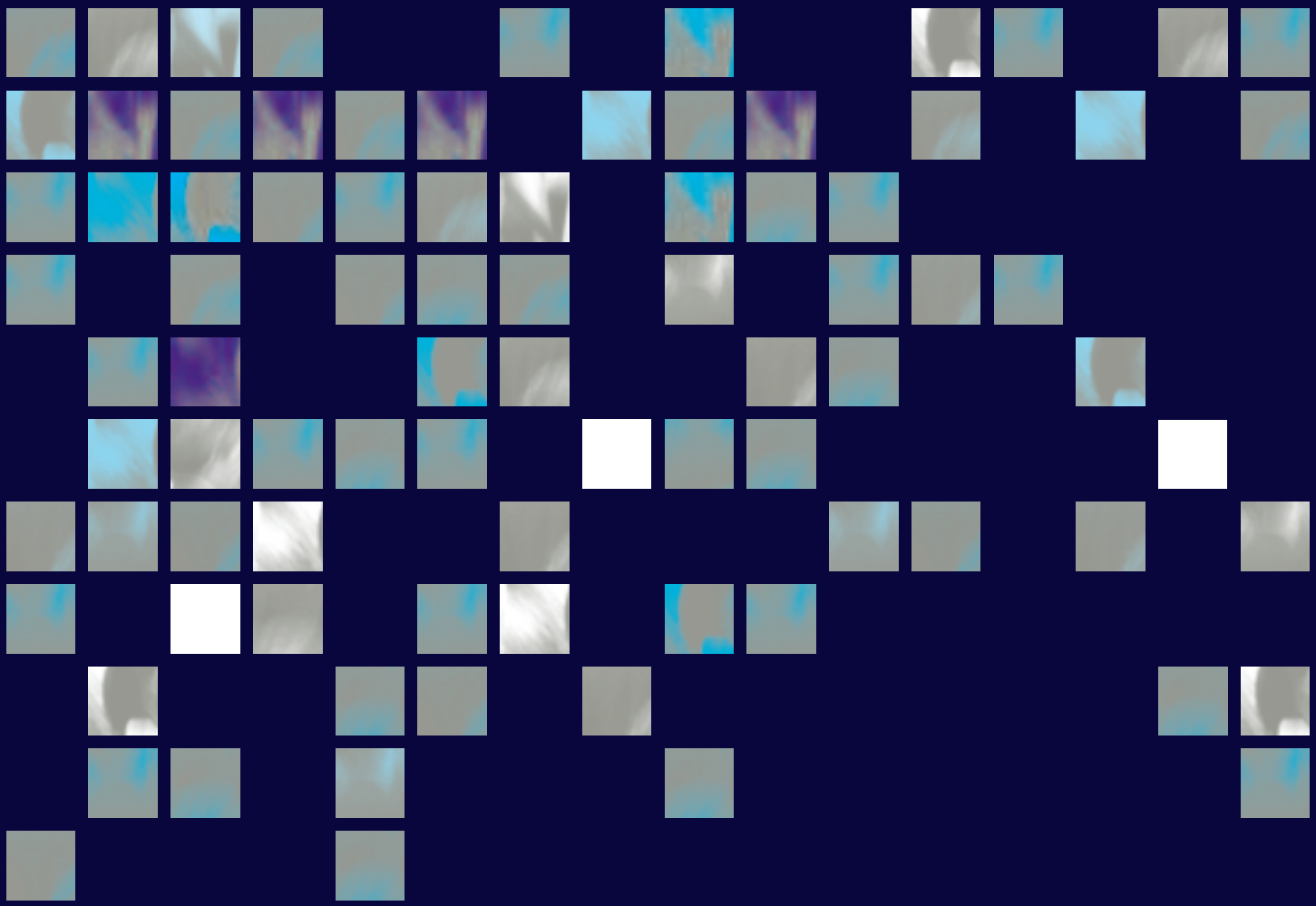

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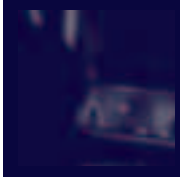

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