Health and Safety Division Thematic Report

Executive Summary

April 2013

The Scottish Government
Riaghaltas na h-Alba

HEALTH AND SAFETY DIVISION THEMATIC REPORT

EXECUTIVE SUMMARY

1. The selection of the Health and Safety Division as a topic for inspection was made in the context of growing specialism within the Crown Office and Procurator Fiscal Service (especially following the move to Federation working with function based work rather than geographical responsibility).

2. Scotland's current and previous Law Officers have been active in promoting greater specialisation and the Health and Safety Division seemed a suitable candidate to be made into a specialist unit. Accordingly the specialist Health and Safety Division was established in 2009. This mirrored greater specialisation on the part of defence lawyers especially in this field.

3. The major conclusion is that the work completed by the division is done to a high standard and favourably commented on by many contributors to our report. The existence of the unit made for early meaningful discussions and good liaison with Health and Safety Executive and other reporting agencies.

4. The apparent focus of the division is to obtain pleas of guilty, produce agreed narratives of events for court (commented favourably on by various sheriffs to whom we spoke) and thus potentially save court time. This also has the benefit of saving time and inconvenience to witnesses.

5. The downside of this policy was, however, that few cases went to trial and the development of the law in Scotland in this area (and the experience of those in the unit) suffered as a result. The presumption appears to be to initially regard cases as suitable only of proceeding on indictment and we felt there could be better targeting of the simpler cases which could proceed in the summary courts rather than join a queue. An effective 'triage' system would be of benefit.

6. Our major concern was the delay in concluding cases, several of which were several years old and the 'time to clear' figure of current work was increasing rather than decreasing. There has been growing public concern about delays in this field.

7. We found there was some confusion about the type of case the new Health and Safety Division would take on board with potential confusing overlap with in particular the recently created Scottish Fatalities Investigation Unit.

8. Additionally the IT system was not configured to 'direct' health and safety cases to the unit and management information was sketchy. All of this contributed to lack of clarity, double handling and our biggest concern – delay in processing the cases. The normal IT and management tracking devices were largely absent with too much reliance on internal spreadsheets which were not always up to date.

9. We also found staff turnover to be a matter of concern. This was high which we feel exacerbated the problem about delay. Many of the cases are complex and staff leaving mid-case led to inefficiency and delay as new members had to go over the same ground. Additionally the perfectly worthy attempt to create local geographical centres to deal with local cases was largely abandoned because of the need to give priority to certain types of cases irrespective of where the staff were located.

10. We took the view (and so recommend) that greater use could be made of existing staff especially those at fairly senior grades. Increased delegation to these staff of crucial decision making would speed up the process and improve the job satisfaction of those involved. Although praise worthy in concept the need for all cases to be channelled into a single decision point inevitably led to delay and in some cases meant action could no longer be taken because of the time taken to approve of decisions.

11. The perception of the unit by outside agencies including the Health and Safety Executive is generally very good. No-one doubts the commitment of those involved. However, delay was a major cause of concern for some especially victims and next of kin. The Victim Information and Advice Officer in Health and Safety Division did a very good job of keeping them informed but it was too frequently on the basis of no real progress.

12. We make 38 recommendations mainly intended to speed up disposal of cases with better use of existing resources and with better management information and tracking.

RECOMMENDATIONS

RECOMMENDATION 1

We recommend that a written remit of HSD work is prepared and promoted throughout COPFS by being made available through the "Intranet" and also to the reporting agencies. This should clarify which cases will be dealt with by HSD, which are dealt with by SFIU, which are to remain within the Federations for prosecution and how agreement about these issues are to be dealt with in "borderline cases". In particular this protocol should agree the division of duties in relation to deaths so all tasks are covered.

RECOMMENDATION 2

We recommend that the case marking guidelines, the knowledge bank and any other reference or guidance should be amended to direct appropriate cases to HSD. This should be clearly cross referenced to the remit recommended above. Instruction and guidance about how these cases should be marked should also be included.

RECOMMENDATION 3

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

RECOMMENDATION 4

We recommend that more training and guidance be provided to specialist agencies on how to send reports via the Specialist Reporting Agency (SRA) website to COPFS.

RECOMMENDATION 5

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

RECOMMENDATION 6

We recommend that, where criminal cases are reported by multiple agencies, all reports for the incident should be rolled up in FOS to allow a single case reference number to be used and all case documents to be found within the one case reference in FOS, SOS and PROMIS.

RECOMMENDATION 7

We recommend that HSD use their existing FOS report tray and office code. This would allow cases identified as being for HSD to automatically flow.

RECOMMENDATION 8

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

RECOMMENDATION 9

We recommend that, as soon as forum is decided upon, the case should be re-marked in FOS to bring it under the umbrella of MI Book and to allow central and local monitoring of all work in HSD. Every stage of the life of the case should be recorded within the database.

RECOMMENDATION 10

We recommend that use of spreadsheets as sole records ceases and that use is made of existing national systems (PROMIS) to record, monitor and manage the work. A decision should be made about which spreadsheets are to be used for internal purposes and all others should be deleted from the shared drive to avoid confusion. Thereafter that remaining spreadsheet should be kept up to date and accurate.

RECOMMENDATION 11

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

RECOMMENDATION 12

We recommend that if the 'Case Load' document is to be retained it must contain ALL relevant cases, updated at regular intervals for it to be really meaningful. The case load document should be available for all and be on the shared drive.

RECOMMENDATION 13

We recommend reporting agencies submit all documents such as statements and productions electronically into the case directory to allow disclosure on the website, using the Disclosure Manual Client (secure disclosure website) as do all other mainstream units.

RECOMMENDATION 14

We recommend that full discussions take place with all reporting agencies as soon as possible to allow a training programme on disclosure schedules to be arranged as a priority.

RECOMMENDATION 15

We recommend further training of specialist agencies to ensure their reports and statements meet the needs of the prosecutors and to minimise the need for precognition. This would speed up the preparation process and bring the HSD more into line with all mainstream units.

RECOMMENDATION 16

We recommend that at all stages the system should be fully updated to allow fruitful interrogation of the system by any enquirer and also to allow Management Information Division (MID) to provide automatic information about the stage and state of case preparation with a view to flagging up any potential problems in time to prevent delays and risks to reputation re old cases.

RECOMMENDATION 17

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

RECOMMENDATION 18

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

RECOMMENDATION 19

We recommend that internal targets are put in place to avoid cases becoming too old, both for meaningful prosecution and for any ensuing civil case. It may be that individual targets could be attached to each case, based on complexity, to allow for a realistic preparation time. A target should also be extended to cases as they are reported for CCI.

RECOMMENDATION 20

We recommend that wherever possible information required for processing a civil claim is passed to representatives of victims and next of kin as soon as possible to allow them to raise a civil action within the three year civil time bar.

RECOMMENDATION 21

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

RECOMMENDATION 22

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

RECOMMENDATION 23

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

RECOMMENDATION 24

We recommend that in order to avoid a bottleneck Principal Deputes are given more autonomy to make decisions about forum, charges and agreed narratives and acceptable pleas leaving the Head of Unit freer to train reporting agencies, improve reports and concentrate on the initial stages of investigation with HSE and the other reporting agencies.

RECOMMENDATION 25

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

RECOMMENDATION 26

We recommend that work is allocated geographically wherever possible.

RECOMMENDATION 27

We recommend that when cases are sent to Crown Office there should be an accompanying letter or email indicating the complexity of the decision for Crown Counsel and giving a target or an indication of urgency. This information should be recorded both within HSD and Crown Office as part of an audit trail and as an aid to monitor progress of and manage work.

RECOMMENDATION 28

We recommend that two Crown Counsel should be appointed on a "staggered" basis to prevent lengthy periods where no Crown Counsel is available due to other work commitments.

RECOMMENDATION 29

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

RECOMMENDATION 30

We recommend that the level of staffing of Fiscal Officers should not be allowed to fall from the agreed level of three for any period in excess of four weeks without cover from some other source.

RECOMMENDATION 31

We recommend that there should be an agreed complement of Legal and Precognition staff. Where staff members do leave the unit they should be replaced within an agreed short period with a minimum agreed handover, to allow work to carry on more fluently than at present, thus avoiding delays.

RECOMMENDATION 32

We recommend that there should always be an agreed period for Legal and Precognition staff to remain within the unit. There should perhaps be a short trial period to allow the staff to determine whether the work will suit them.

RECOMMENDATION 33

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

RECOMMENDATION 34

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

RECOMMENDATION 35

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

RECOMMENDATION 36

We recommend more formal and informal training in health and safety law for staff on a regular basis, particularly for new members of staff. A prepared pack would be very useful.

RECOMMENDATION 37

We recommend training for those with an interest in joining the unit in the future. This would build up a bank of staff to cover quickly when team members leave. It would also provide a bank of knowledge when large cases are reported and additional support and resources are required.

RECOMMENDATION 38

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

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ISBN: 978-1-78256-494-2 (web only)

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Produced for the Scottish Government by APS Group Scotland
DPPAS14138 (04/13)

Published by the Scottish Government, April 2013