

Discretionary FAIs

Discretionary FAIs in the public interest are central to this petition. In his opening statement to the Justice Committee on 5th May 2015 Lord Cullen made it clear that, *“The essential idea, however, is that a fatal accident inquiry is held in the public interest and everything must be responsive to that.”* So FAIs are essential in order to satisfy public interest. The discretionary element of the FAI act should be seen as a means of extending the coverage of the act, from ‘industrial accidents’, to the inclusion of sudden deaths of the type expressed in COPFS, [‘Deaths and the Procurator Fiscal 2008’](#). It should not be seen as a ‘let out’ for not holding one. Wording in 2016 act is different from that used in 1974 version, with regards to emphasis.

In the Super Puma deliberation issued by Sheriff Principal Derek Pyle on 13th March 2014 it states, from Carmichael, that *“The whole object of an impartial inquiry is to get to the truth, to **expose fault where fault is proven to exist [my emphasis]**, and in all cases to see to it so far as humanly possible that the same mistake, whether it arise through fault or any other reason, is not made in the future. **The public interest, in whose names inquiries are held, requires and deserves no less” [my emphasis]**. Sheriff Principal Pyle points out that *“It is an opportunity for the whole circumstances of an accident to be aired in public. Witnesses are examined and cross-examined under oath and documents are considered and scrutinised. And any party interested in the circumstances is free to come to his or her own conclusion on the evidence.....It is also an opportunity for an independent judge to come to his or her own conclusions on the evidence.”**

Legislative Intent

This petition is driven by my exposure to a number of comparative cases in Scotland and England, mainly involving military deaths, where clearly the ‘legislative intent’, outlined in the submissions from the Law Society, COPFS and the Government has not always been adhered to. This is best illustrated by one case involving the collision of two aircraft over the Moray Firth in 2012 (three deaths) where the following anomalies in the system were exposed, some of which display a significant amount of commonality with the Kennedy and Black case.

- (1) Military personnel not considered as employees or in occupation; therefore not mandatory.
- (2) Crown Counsel’s interpretation of ‘public interest’ wrongly pre-empted the scope of the issues that could be addressed at any FAI and, by implication, the scope of the findings that might be made following an FAI; as in the Kennedy and Black Case. Claiming that *“After thorough consideration of the circumstances of the case, Crown Counsel have concluded that all the relevant issues have been comprehensively examined in the course of the Military Aviation Authority report and could not have been better considered in any FAI.”*

- (3) Article 2 not complied with, despite Lord Cullen recommendation and COPFS's own 'handbook' (See below).
- (4) Documentation covering Crown Counsel's 'independent' investigation of the case not available to the family.
- (5) Families not consulted, or alternative causes considered prior to decision making.
- (6) Twenty items of new evidence rejected by Crown Counsel, following a meeting with Head of SFIU. Minutes of meeting not available, neither is the Head of SFIU's presentation to Crown Counsel.
- (7) Confidential documentation (new evidence under 2016 act) handed over to an unauthorised third party (MoD) for comments. This amounted to the 'guilty party's' opinion forming the basis for evidence rejection. Associated correspondence withheld.
- (8) Request to have the original decision reviewed in accordance with the Family Charter rejected on grounds that it had taken place during consideration of new evidence.
- (9) Request made for confirmation that those who reviewed the case were different from those involved the original decision was answered with a statement that *"The original investigation was reported to Crown Counsel, the most senior lawyers in COPFS"*. Meaningful answer avoided.

Changes were introduced in the 2009 Coroners and Justice Act to facilitate the transfer of the inquiry process from England to Scotland for bodies returned from abroad, and in doing so ease the burden on family members with regards to travelling time. In reality this has not happened, probably because families know that an inquest in England is guaranteed, whereas an FAI in Scotland is only discretionary; a fact pointed out in my evidence to the Justice Committee in May 2015. (See cases for Cpl Joshua Hoole from Lockerbie and Pte Conor McPherson from Paisley). Furthermore, it seems ironic that in the case of L/Cpl Joseph Spencer, killed on Tain firing range in Nov 2016, the sure way to guarantee an independent inquiry was by having his body transferred to Hampshire, where an inquest was convened immediately. The decision whether or not to hold an FAI in Scotland is still 'in progress' with the Crown Office after three years. Perhaps sending bodies to England and Wales is the answer for families who doubt that the FAI process will swing into action.

Article 2 Compliance

According to Lord Cullen, in his 2009 FAI review *"Lord Hope of Craighead pointed out that the European Court of Human Rights had made it clear that an FAI was a means of carrying out an investigation which would satisfy article 2. The same should apply to a public inquiry into the circumstances in which a death occurred. Lord Cullen went on to say, "that the practical difference which article 2 makes is that it may require an FAI or a public inquiry where neither would otherwise have been held. This therefore has implications for the exercise by the Lord Advocate of his or her discretion as to the holding of an FAI".*

The above interpretation is also reflected in para 41.1.3 of the COPFS manual on Fatal Accident Inquiries and Disclosures, in which it states, *"It is also important to note that a FAI may be required in order to satisfy obligations under Article 2 of the*

European Convention. In the case of R (on the application of Goodson) v HM Coroner for Bedfordshire and Luton Coroner ([2006] 1 WLR 432 (at 450)) the Court held that: "Where State agents potentially bore responsibility for the death, including potential liability in negligence, the events relating to the death should be subject to an effective investigation."

Overview of Current System

In a recent article posted in the Scottish Legal News the HM Chief Inspector of Prosecution's review of the FAI regime found that three years on from the last thematic report, there has been a "lack of progress in many areas" and that FAIs are characterised by "lengthy intervals of unexplained delays" and "periods of inactivity" which "have the potential to devalue the purpose of the FAI".

The article goes on to say "There are serious structural barriers impeding progress. The Justice Secretary and Lord Advocate are failing in their public duties if they don't consider all options for improvement – that means investigating whether these inquiries need to be removed from the Crown Office as is the case in England, Wales and Northern Ireland."

In the Clutha FAI Sheriff Turnbull noted it was "surprising" that it took two years from the 2015 publication of the Air Accidents Investigation Branch (AAIB) report on the crash to confirm that there would be no criminal proceedings. He added: "It took far too long to lodge a notice of inquiry in this case."

It maybe that part of this problem is because the work is contained within the Crown Office and Procurator Fiscal Service, as opposed to an independent coronal system like that used in England, Wales and Northern Ireland. Such a system can limit bureaucracy, increase oversight and accountability and ultimately generate greater efficiency which, as you may know, is direly needed in Scotland. Self regulation does not work.

The Way Forward

Having worked with the English system as a technical adviser, during Nimrod inquest in 2008 I am of the opinion that the Crown Office is not equipped, or qualified on technical issues, to deal with the FAI process and is a 'bottle-neck' to progress. A separate coronal type system, where the Lord Advocate is not 'all powerful', has to be the answer. Decisions made by a Sheriff on whether or not to proceed with an FAI, following a preliminary hearing, would generate several outlets and bypass the single one. A bit like having a water bucket with several holes in the bottom rather than one, the bucket empties much quicker. The Lord Advocate could operate in an advisory role, similar to the Chief Coroner in England/Wales.

Such a system would be the ideal outcome for my petition. Families would have an opportunity to put their views to the sheriff without having to go through a costly Judicial Review process. It would also mean that the phrase, "not in the public interest to hold an FAI", often seen as a means of blocking an FAI, could become a thing of the past.

The statement made in the final four paragraphs of the Law Society of Scotland's submission is misleading, in my opinion. The coroner is more equivalent to a sheriff, not COPFS. Also, the reference to discontinuing an investigation is incomplete. Section 4 of the 2009 Coroners and Justice act goes on to say the 'discontinuation' does not apply if the coroner suspects that the deceased (a) died a violent or unnatural death, or (b) died whilst in custody or otherwise state detention. This is not similar to the Scottish position.

A revised system, working outside that Crown Office, would be a means of ensuring transparency and restoring confidence in an investigative process that is long overdue for change. In 2015 I had the current FAI act modified to make it mandatory for all military deaths to be investigated under the act. I believe that came about because Parliament was not aware of anomalies in the system that were taking place under their noses, until they were pointed out in oral evidence to the Justice Committee. That was just the start. I am hoping that other changes can be made.

Discretionary decisions are currently made behind closed doors. Crown Counsel/COPFS reports are not published.