FACULTY OF ADVOCATES

Response to Scottish Parliament's Consultation

2025 Fatal Accident Inquiry Review

1. **Please summarise your experience of, or interest in, the Fatal Accident Inquiry system.**

   Members of the Faculty of Advocates ("Faculty", i.e. advocates in practice at the Scottish bar), at all levels of professional experience, are regularly instructed to represent parties at Fatal Accident Inquiries ("FAIs"). Members have experience of representing all categories of interested party at FAIs: including families and employers of deceased persons, the Crown, professional persons such as GPs who are involved, the Scottish Ministers (including the Scottish Prison Service) and health boards, in FAIs.

2. **In your view, what is a Fatal Accident Inquiry for and do they achieve that?**

   An FAI is a form of public examination of the circumstances of certain deaths, which occurred in Scotland, in the public interest. Fundamentally, it has two purposes: (a) to learn lessons from a death so as to improve matters for the future; and (b) where it is engaged, to meet the duty under Article 2 of the European Convention on Human Rights for an effective investigation of a death.

   FAIs are designed to result in findings made following the leading of evidence by the Crown (and often, though not necessarily, other parties), by a sheriff on the matters set out in section 26 of the Inquiries into Fatal Accidents and Sudden Deaths etc. (Scotland) Act 2016 asp 2 (Scottish Act) ("the 2016 Act"). The sheriff can make recommendations to prevent similar deaths happening in the future. Under the 2016 Act, all determinations are now published on the Scottish Courts and Tribunals Service's ("SCTS") website.

   The Act of Sederunt (Fatal Accident Inquiry Rules) 2017 ("the 2017 Rules") now provide the basis upon which the jurisdiction of the sheriff to hold an FAI is to be

exercised. They set down various principles which must be taken into account in every FAI: rule 2.2. These include that, unlike criminal or civil proceedings which are adversarial in nature, FAIs are to be an inquisitorial process where the sheriff's role is to establish the facts surrounding the death, rather than to apportion blame or to find fault. They are intended to be progressed expeditiously and efficiently with as few delays as possible. Our experience is that in fact, there are often considerable delays (including delays in excess of five years) in FAI processes. The procedure is to be flexible and the manner in which information is to be presented is to be as efficient as possible, with all participants to be able to participate effectively.

As has been observed by the editors of Macphail, *Sheriff Court Practice* (4th Ed.), unlike many other areas of law in which the sheriff exercises a statutory jurisdiction, there is very little case law on the interpretation of the provisions relating to the sheriff's wide and flexible power to regulate the procedure of FAIs; no doubt because in the vast majority of cases the sheriff's findings will raise few, if any, points of law and are not made the subject of any mode of appeal. We have observed an increasing problem with sheriffs diverging on the proper meaning and application of the 2016 Act. We understand that the Inner House will hear an appeal in October which arises from that problem.

For the reasons more fully set out in the below submission, the Faculty of Advocates is of the view that, in many cases, the FAI system does not satisfactorily achieve the purposes for which it is intended.

3. In your view, what does not work well in the system and what would make it better?

A number of aspects of the current system of FAIs could be improved. Three particular aspects are worthy of note.

First, we have direct experience of considerable delays in the bringing and ultimate resolution of FAIs. In his determination of 21 August 2025 following an FAI investigating the deaths of Sonny Campbell and Cailyn Newlands[1], Sheriff Cameron observed as follows:

"*The issue of delay in holding this inquiry was a concern to all parties and to the court. The children's deaths occurred on 6 December 2016, with the Crown being notified of both deaths only days later. The Notice from the Crown of an inquiry into Sonny and Cailyn's deaths is dated 15 January 2024. That delay will have undoubtedly taken its toll on the children's families (and it is recognised by the court that the delay will also have impacted*

[1] [2025] FAI 37

on the medical clinicians involved). As at the date of the hearing on submissions no explanation had been given by the Crown for such a delay."

In our experience, significant delays are not uncommon. In preparing this submission, we have looked at the five most recent determinations published on the Scottish Court Service Website. It is recognised that this is not a robust method of assessing overall delays in the system, but it does confirm the anecdotal experience. The five most recent determinations (as at 5 September 2025) concern deaths in December 2018, January 2020, April 2020, January 2019 and July 2020. Delays of five years or more are therefore entirely unexceptional. That has a number of deleterious consequences. The passage of time inevitably degrades the quality of the evidence that is available. It also requires all involved in the death (not only relatives of the deceased but others such as medical professionals or colleagues who witnessed an accident) to revisit what are invariably difficult memories. That is a cause of stress and anxiety and it is obvious to those conducting these inquiries that it often has a material adverse effect on the health and wellbeing of those involved. The regular delays often mean that there is little learning gained from the FAI process as the relevant lessons have often been learned long before the FAI process begins. These sort of delays are irreconcilable with the stated aim of the Scottish Ministers that FAIs should take place expeditiously and efficiently with as few delays as possible. More importantly, they undermine the efficacy and utility of the FAI process.

Secondly, Faculty is concerned at the varying and often conflicting approaches taken by sheriffs to both the conduct of FAIs and the interpretation and application of the 2016 Act. There is no binding guidance on the interpretation and application of the 2016 Act. None of the earlier legislation was considered at appellate level either. We understand that the Inner House will, for the first time, hear an appeal that will require it to consider the interpretation and application of the 2016 Act. Whilst it is hoped that some clarity (and thus certainty) will result, it is unsatisfactory that the only way to achieve that is through collateral litigation.

The problem is illustrated by the recent decision of the Outer House (which is the subject of October's appeal): ***Duncan, Petitioner*** [2024] CSOH 114; 2025 S.L.T. 47. In that decision, the Lord Ordinary set out her interpretation of an important provision of the 2016 Act. In FAIs following that decision, that interpretation has been followed without comment (e.g. ***FAI into the death of Peter Carter*** [2025] FAI 21), not followed without comment (e.g. ***FAI into the deaths of Leo Lamont, Ellie McCormick and Mira-Belle Bosch*** [2025] FAI 15) and expressly not followed (the Sheriff accepting a submission that it was wrong: ***FAI into the deaths of Sonny Campbell and Caitlyn Newlands*** [2025] FAI 37). That level of uncertainty about the meaning and application of an important provision is untenable. But for an

appeal, that uncertainty would have remained. That is a seriously unsatisfactory situation.

The purpose of the inquisitorial process that is an FAI is not to establish guilt, fault or liability. It is for that very reason that FAIs are not usually held until a decision has been taken on whether there should be criminal proceedings. Findings in an FAI are not, however, without consequence. A finding, for example, that there was a reasonable precaution that a doctor could have taken which might realistically have avoided a death requires such a doctor to self-report to the General Medical Council. Whatever the 2016 Act says, it is judicial criticism (and that no doubt explains why clinicians are so often represented at FAIs).

Thirdly, an emerging trend has been observed which has seen an increasingly prosecutorial approach taken to FAIs by the Crown, notwithstanding, as has been noted above, the process is inquisitorial and is not intended to establish 'guilt' or 'fault'. Contrary to the statutory scheme, the Crown increasingly conduct an FAI seemingly looking for "fault" or "blame". Whilst it is of course important for the Crown to maintain the confidence of deceased's persons' families, given the funding now available for such families to be represented, the Faculty hopes that this trend will not continue.

4. In your view what works well in the system, and should be kept if changes are made?

In principle, Faculty do not take issue with the intended (important) function, arrangements and aspirations of the FAI system.

5. Do you have any comments to make on Fatal Accident Inquiry reporting?

This matter has been addressed at Answer 3, above, in relation to delays in reporting.

6. Do you have any sources of information that you would like to bring to our attention?

Not applicable.

7. Is there anything else that you would like us to know?

An efficient and properly resourced FAI system is important. Not only is it required to meet the State's obligations under Article 2 of the ECHR in some circumstances; it is important for securing public confidence following deaths which have caused public concern. The Faculty supports the system and supports the basic structure of the 2016 Act. Our concerns, set out above, are directed at the operation of the system and how, in our view, it can be improved to better achieve the important functions of an FAI.