Law Society of Scotland

Written Evidence

2025 Fatal Accident Inquiry Review

September 2025

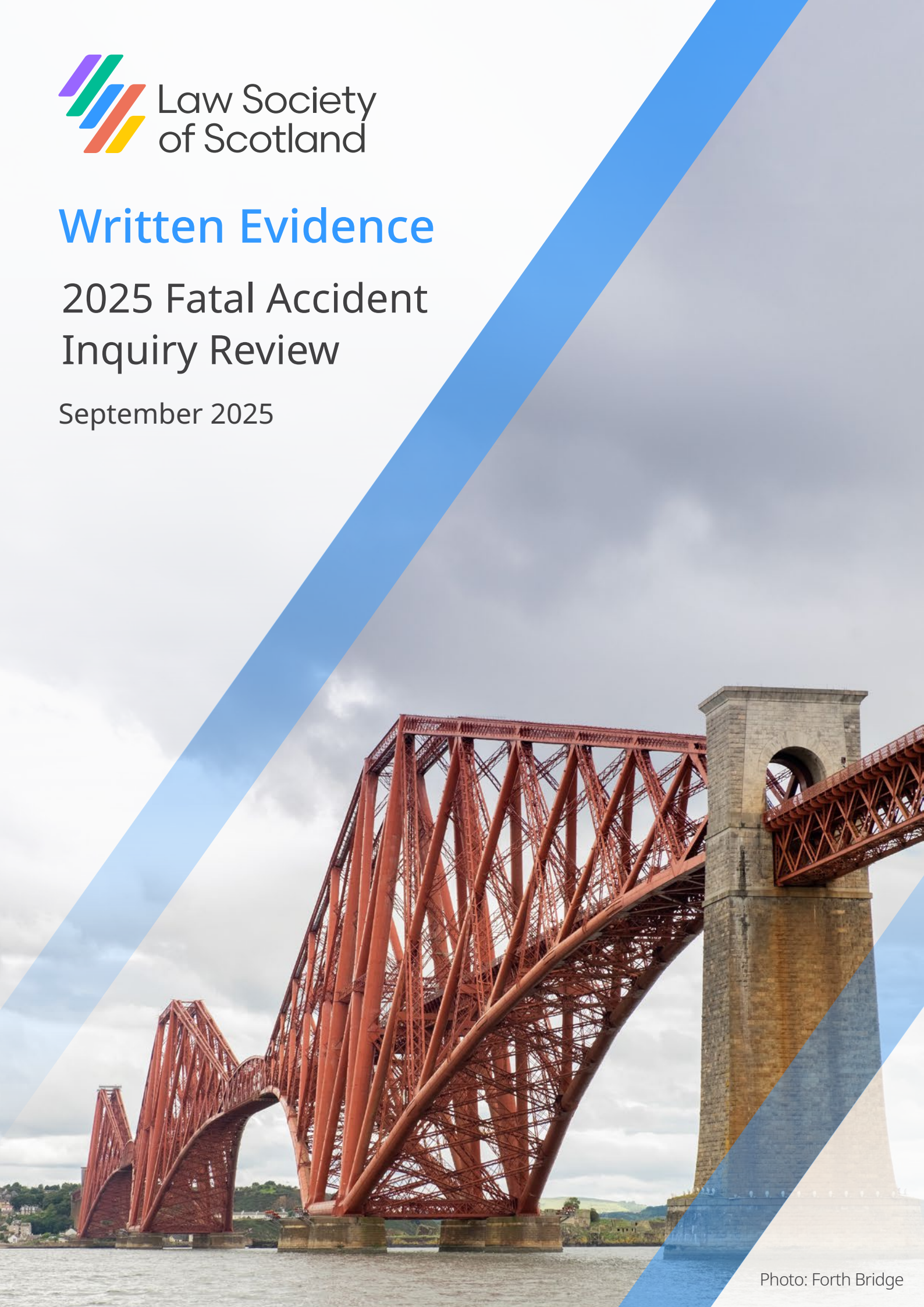

Photo: Forth Bridge

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Introduction

The Law Society of Scotland is the professional body for over 13,000 Scottish solicitors.

We are a regulator that sets and enforces standards for the solicitor profession which helps people in need and supports business in Scotland, the UK and overseas. We support solicitors and drive change to ensure Scotland has a strong, successful and diverse legal profession. We represent our members and wider society when speaking out on human rights and the rule of law. We also seek to influence changes to legislation and the operation of our justice system as part of our work towards a fairer and more just society.

Our Criminal Law and Civil Justice Committees welcome the opportunity to consider and respond to the 2025 Fatal Accident Inquiry Review call for evidence[1]. The Committees have the following comments to put forward for consideration.

Call for views questions

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

We represent solicitors, who (along with advocates) appear on behalf of parties at Fatal Accident Inquiries (FAIs). Our approach to policy issues is directed by our statutory aims under the Solicitors (Scotland) Act 1980, namely to represent the interests of the solicitors' profession in Scotland and the interest of the public in relation to that profession, and by the regulatory objectives of the Regulation of Legal Services (Scotland) Act 2025.

Our Civil Justice and Criminal Law Committees respond effectively to law reform proposals with impacts in both areas of law. In addition, both Committees seek to support solicitors practicing in criminal and civil courts.

This particular response was informed by comments and views provided by Committee members with relevant experience in FAIs. We also received comments from our wider membership with interest and experience in the subject. Some of the comments were provided by members who have investigated deaths as Procurators Fiscal, as well as by solicitors in private practice.

We believe that a satisfactory system for the investigation of fatal accidents is vital - both for the families of the deceased and for wider society - as it provides a mechanism for identifying failures and driving improvements in health and safety standards.

[1] 2025 Fatal Accident Inquiry Review – call for evidence – gov.scot

Further, Article 2 of the European Convention on Human Rights imposes an obligation on state to investigate deaths occurring in custody or detention (*Salman v Turkey (2002) 34 EHRR 425*). In our view, the FAI is an essential part of the way in which the state fulfils that obligation.

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

The purpose of an FAI is to establish the full circumstances of the death and whether there were any failings in a system or any reasonable precautions which could or should have been taken which might (on the balance of probabilities) have meant the death would have been avoided; and to make recommendations to prevent similar incidents in the future. All of this will be determined on the basis of evidence.

Members of the profession who regularly appear at FAIs have expressed concerns about how the system is working at the moment, including lengthy delays in the commencement of FAIs and difficulties in obtaining information, particularly when a criminal prosecution is contemplated.

It is acknowledged that individual Procurators Fiscal are able to keep families well informed about process and progress of enquiries but in our view the lengthy delays in the commencement of FAIs prevents them being conducted efficiently, and risks undermining their effectiveness.

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

We consider that the FAI system faces chronic delays that impact in its efficiency and, potentially, effectiveness. Frequently, FAIs take years to conclude, with the risk that important evidence can be lost due to passage of time, with witnesses unable to retain a detailed recollection of historic events. In addition, delays may result in the findings at the conclusion of the inquiry becoming less relevant as recommended changes may already have been made, or superseded.

Concerns about delays in FAIs go beyond the efficient conduct on the inquiries. Fundamentally, FAIs are conducted a considerable time after the events. This situation causes that the opportunity to learn lessons and make improvements is undermined.

The delays in the system produce that frequently, FAIs cannot achieve their statutory purpose, especially given the parameters set by section 26(2) of the Inquiries into Fatal Accidents and Sudden Deaths etc. (Scotland) Act 2016. We are aware that some Sheriffs have to underline, in making their determinations and more generally, what an inquiry is not about. That is a longstanding issue which has persisted despite reforms to both legislation and practice and does tend to point towards the need for greater awareness and/or transparency.

One of the factors that contributes to these delays is the mandatory nature of certain FAIs. In circumstances where the family of the deceased person do not feel that a FAI is necessary and if an Inquiry does not appear to be in the public interest, for instance in the case of a death in custody from natural causes, we believe that a simplified process would contribute to the efficiency of the system. Currently, such FAIs are relatively streamlined with evidence agreed insofar as possible and with the Sheriff having the opportunity to direct further investigations if they have concerns. In the interest of transparency and consistency, there would be a benefit in such a procedure being set down in rules or a practice direction.

A further factor that contributes to the delays in the system is the allocation and use of current resources. It is critical that the system is provided with sufficient resources and funding to operate.

A further cause of delay is the length of time it takes to decide whether or not the circumstances of the death would merit a prosecution and then, if a prosecution is initiated, for that to take place. If the decision as to whether to prosecute could be made earlier, the process could be expedited and FAIs could potentially be scheduled for much earlier than is the case at present.

Some of our members have reported difficulties in obtaining necessary documentation and evidence from the COPFS and other external bodies involved. However, members that have worked as Procurators Fiscal have indicated that in FAIs, the Crown and the Police do not have the same authority that they have in criminal cases. There are no enforcement powers that allow fiscals to require information from external bodies in a specific time frame, producing frequent delays in recovering the documentation required.

Whilst it is appropriate that families are a focus of the system, it must also be recognised that others who have been directly impacted by the events such as witnesses or interested parties do no enjoy the same rights of access to information, particularly during the enquiries phase of the process -even when it takes a number of years- and where an inquiry is a discretionary. That lack of transparency causes significant difficulty and protracted uncertainty which is undesirable especially in the context of trauma-focussed advocacy.

We consider that the lack of time limits for the conduct of FAIs is also a cause of delay. At the moment, flexibility in timescales is essential as the Crown does not have the power to demand material in the way that the Crown does in criminal cases (see above); if the Crown had that power, then time limits -established either by statute or practice note- would be appropriate and would allow a more efficient service to be delivered. This could also be implemented with earlier disclosure of key information. Such a system would still have to be operated flexibly, with the court retaining the power to extend time limits on cause shown; but it may have the effect of resetting expectations and driving progress at all stages in the process. This can also contribute to reduce the delays when obtaining information from external bodies.

To assist with directing the Inquiry and with early sharing of information, it might be sensible to have an early preliminary hearing relatively quickly after the death to allow the sheriff to indicate areas of interest which she or he would expect to be addressed during the Inquiry and, if necessary, to make early preliminary observations.

Accelerating the process would allow relevant parties to have early access to any recommendations or findings, which might lead to health and safety improvements more speedily.

A further point is that there is insufficient enforcement of recommendations made at FAIs. While responses to recommendations are recorded on the Scottish Courts website, there are varying levels of response. A mechanism for review of implementation would ensure that recommendations are followed to drive improvements. We also suggest that, when appropriate, expert support is provided in the implementation and evaluation of recommendations.

We believe the system would operate more efficiently with either specialist FAI courts, or a few nominated sheriffs with a specific interest, experience, and training in this area. This would allow the opportunity for trauma informed training, and a deeper understanding of how best to engage with the family and, for instance, manage the impact of continuations and discharges of FAI diets.

We see some value also in considering a specialist team of Fiscal Deputes to deal with FAIs in combination with specialist Sheriff. This would enhance consistency and should also assist in accelerating the process.

As matters stand, FAIs tend to come far down the list of priorities in the management of court diaries. One possibility would be to make greater use of remote hearings in appropriate cases, which would remove the physical availability of a courtroom as a constraining factor. Remote hearings may work particularly well in a specialist courts model.

We also suggest to review alternative models to the FAI system with the purpose of identifying improvements that can be implemented into the Scottish system. For instance, the Coroners statistics 2024: England and Wales showed that the average time taken to complete an inquest was 31.2 weeks in 2024[2]. We are of the view that valuable lessons can be learnt from a comparative analysis of models that have addressed some of the issues that the FAI system is currently facing, such as the significant delays reported above.

In recent years, there has been challenges to the manner in which families have engaged with FAIs as a result of the removal of the right to legal aid but that has now been reversed. Engagement with families and their concerns is an important feature of the FAI process but it is something which needs to be dealt with more consistency and factored in an early stage in the process. Where a family

[2] Coroners statistics 2024: England and Wales – gov.uk

chooses not to participate, then that ought to limit their involvement in the process to some extent.

Finally, we consider that a wider education campaign on the scope of FAIs is required. This would assisting in setting reasonable expectations on FAIs and what realistically can be achieved.

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

We consider that the concept of minuting/agreeing evidence is sensible. It saves court and witness time.

We also consider that the general practice of requiring written submissions on the conclusion of evidence is helpful and should continue. This practice allow Sheriff to issue determinations more quickly once submissions are finalised.

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

We believe that it might be advantageous to have an annual report to parliament on matters such as the number of FAIs held, and how long they took between date of commencement and determination. This might include a possible report on recommendations and their implementation, increasing accountability and publicly available information on the system.

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

We do not have any information to share in response to this question.

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

We appreciate that the remit of the 2025 Fatal Accident Inquiry Review is limited to deaths that occurred in prison custody or police custody. This includes children and young people retained in a young offender institution, as indicated in Section 2(4)(a) of the Inquiries into Fatal Accidents and Sudden Deaths etc. (Scotland) Act 2016.

We consider that a review is also required into the deaths of children and young people that occurs in secure accommodations different from young offender institutions and other institutional care settings.

Some members have reported that it is unclear how these children and young people who tragically lose their lives in these state settings are included in the FAI framework or in national records.

We understand that the Non-Statutory Significant Case Review Process conduction in local authorities areas are often not publicly reported. We would

welcome some consideration on the crossover in public authorities' duties, including as Corporate Parents for vulnerable young people.

For further information, please contact:

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