Police Investigations & Review Commissioner

PIRC/00585/15 | August 2017

Report of a Complaint Handling Review in relation to Police Scotland

Index

1. Role of the PIRC

Sections 34 and 35 of the Police, Public Order and Criminal Justice (Scotland) Act 2006 ("the Act") provide that the Police Investigations and Review Commissioner ("the PIRC") may examine the manner in which particular kinds of complaints are dealt with by Police Scotland and the Scottish Police Authority. Through agreements with UK police bodies operating in Scotland, the PIRC may also examine the manner in which these bodies deal with complaints. The PIRC cannot review complaints of criminal behaviour against police officers or police staff, or complaints made by persons serving, or who have served with the police, about the terms and conditions of their service.

In performing this review function, the PIRC obtains information from the police body which dealt with the complaint. This information is considered together with information provided by the person who made the complaint ("the applicant"). An assessment is then made as to whether in all the circumstances the complaint was dealt with to a reasonable standard. Among the factors taken into account when making this assessment are the following:

- whether sufficient enquiries into the complaint have been carried out by the policing body;
- whether the policing body's response to the complaint is supported by all material information available;
- whether in dealing with the complaint the policing body has adhered to all relevant policies, procedures and legal provisions;
- whether the policing body's response to the complaint is adequately reasoned; and
- where the complaint has resulted in the policing body identifying measures necessary to improve its service, whether these measures are adequate and have been implemented.

2. Key findings

The complaints in this case arose from the applicant's concerns over a lack of investigation into "*suspicious*" deaths within a specific NHS Board area.

Six complaints were reviewed, namely:

1. that Police Scotland obtained no independent evidence during its review of the reported incidents;
2. that the evidence provided by Police Scotland did not enable prosecutors to make a valid decision and was not in accordance with prosecution principles;
3. that Police Scotland's review was only a paper exercise;

4. that Police Scotland mistakenly looked only for criminal intent and not criminal negligence;
5. that Police Scotland did not follow the Scottish Work-Related Deaths Protocol; and
6. that Police Scotland did not use the Enforcement Management Model.

It was found that one complaint was dealt with to a reasonable standard and five were not. Five recommendations were made in this connection.

3. Background

The applicant is a former psychiatric nurse who was previously employed by the NHS Board relevant to this case. In February 2011, the applicant made a request under Freedom of Information legislation to the NHS Board, for copies of all Critical Incident Reports (CIRs) and Significant Adverse Event Reports (SAERs) completed by the NHS Board since January 2005.

Dissatisfied with the response he received from the NHS Board, the applicant then referred the matter to the Scottish Information Commissioner (SIC). In February 2012, the SIC issued a response to the applicant stating that their decision against the NHS Board "*involves perhaps the most serious catalogue of failings … within the scope of a request that the Commissioner has ever had to deal with…* [and] *constitutes a significant failure of records management*" and further stated that "*Given the nature of the information… the information failings may point to wider governance issues which have to be addressed*".

As a result of the SIC's decision in his case, in April 2013 the applicant made allegations of "*criminal negligence*" against the NHS Board to Police Scotland. The applicant specifically referred to the large number of critical incidents and significant adverse events within hospitals in the NHS Board's area, and pointed to the records management failures established by the SIC as evidence that lessons had not been learned by the NHS Board, i.e. the relevant CIRs and SAERs had not been shared due to management failings, which had contributed to deaths that otherwise would have been avoidable.

In November 2013, a report on the 56 incidents identified by the applicant was submitted by Detective Inspector A to the Crown Office and Procurator Fiscal Service (COPFS). As the negligence alleged by the applicant was rooted in breaches of Health and Safety legislation, COPFS in turn shared the report with the Health and Safety Executive (HSE). COPFS ultimately came to the decision that no further action or investigation was required.

The applicant subsequently became aware of a further case involving the NHS Board where an HSE investigation had resulted in the NHS Board being prosecuted under the Health & Safety at Work etc Act 1974 ("the HSW Act"). The applicant identified that he had not been supplied with a copy of the report relevant to this particular case in the response to his request for information, despite the circumstances of the incident being within the parameters of his request.

As a result, in September 2014 the applicant contacted the Area Procurator Fiscal requesting that the case into his original allegations be re-opened as some evidence, e.g. relevant critical incident reports

which had not been provided to him, had not been included in the material originally considered by COPFS.

Between September 2014 and November 2015, the applicant continued to make submissions by email to COPFS and Scottish Ministers alleging that the NHS Board was potentially in breach of the HSW Act and/or the Corporate Manslaughter & Corporate Homicide Act 2007 ("the Corporate Homicide Act"). The applicant insisted that the matter be investigated and stated that the previous report submitted to COPFS by Detective Inspector A had been inadequate and had failed to take cognisance of the relevant Health & Safety legislation.

In May 2016, the applicant made a formal complaint about the police alleging a failure to appropriately investigate the allegations the applicant had made against the NHS Board. The applicant's complaints were allocated to Detective Inspector D for enquiry. A letter dated 3 October 2016 responding to the applicant's complaints was issued by Detective Chief Inspector C.

4. The Review

Complaint 1: Failure to obtain "independent evidence"

The applicant complained that Police Scotland "*obtained no independent evidence into* [the] *many deaths*" and pointed to the fact that Detective Inspector A had based his findings on "*the reports of the main suspect, the NHS Board*". In his application to the PIRC, the applicant specified that he was unhappy that Police Scotland had relied on "'*second hand' evidence from non-independent third parties*" and had not interviewed any of the parties involved in either the original 56 critical incidents or on the NHS Board.

Police Handling of Complaint 1

In his letter to the applicant, Detective Chief Inspector C wrote:

> "*In response to this complaint I can advise that the review conducted by* [Detective Inspector A] *was concluded in November 2013 whereby he compiled and submitted a full report to the Crown Office and Procurator Fiscal Service via his line management. The purpose of this report was to allow the points you had raised to be considered by the Crown Office and Procurator Fiscal Service to allow them to consider providing further instruction or direction in relation to the incidents. …*
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> *As you will be aware, from correspondence sent to you from the Crown Office and Procurator Service* [sic] *on the 9 April 2014, the matter was referred by them to the Health and Safety Executive on the 24 January 2014 for advice and comment to allow them to fully consider the points you had raised. The Crown Office and Procurator Fiscal Service advised that on receipt of the advice and comment from Health and Safety Executive a comprehensive report was prepared for Crown Counsel, who have the responsibility for considering matters of such complexity and of particular public concern. From the aforementioned correspondence it is clear that Crown Office have noted the*

> *undoubted failings by* [the NHS Board] *however they have concluded that they have determined that there is no evidence that the actions of the Board amounted to a criminal offence. Crucially within this letter you were advised that the Crown Office was advising* [Detective Inspector A] *that no further investigation was to be carried out in relation to this matter. Given that* [Detective Inspector A] *has been advised that no further investigation was to be undertaken by the Crown Office and Procurator Fiscal Service the police involvement and review these incidents on behalf of the Crown was complete. Having reviewed the evidence available in respect of this area of complaint I do not uphold your complaint in relation to this. …*
>
> *In some investigations Police Scotland require assistance from other investigative agencies who offer specialisms in their fields. These agencies can either be accessed through direct contact with Police Scotland or through instruction from the Crown Office and Procurator Fiscal Service. In the case of the matters you raised with* [Detective Inspector A] *it is evident that there was independent opinion and scrutiny, in relation to the issues you raised, provided by the Health and Safety Executive and Healthcare Improvement Scotland with an independent overview and audit being provided by* [professional audit company]*. I would therefore suggest that there had been consideration of other areas of independent evidence with this being signposted to the Crown Office and Procurator Fiscal Service when* [Detective Inspector A] *submitted his report…".*

Complaint 2: Evidence did not enable prosecution

The applicant complained that the evidence contained in the report provided by Police Scotland to COPFS was not sufficient for prosecutors to make a "*valid decision*" as to whether or not to instigate criminal proceedings. The applicant believes that the actions of Police Scotland in this respect were not in accordance with prosecution principles.

Police Handling of Complaint 2

In his letter to the applicant, Detective Chief Inspector C wrote:

> "*The evidence placed before the Crown Office and Procurator Fiscal Service in the form of* [Detective Inspector A]*'s report was considered along with the Healthcare Improvement Scotland Independent Review into the Management of Significant Adverse Events, the audit carried out by* [professional audit company] *and the information supplied as a result of the Health and Safety Executive review that was instructed by the Crown Office and Procurator Fiscal Service. I am of the opinion that the review of the matters raised by you have been conducted by a multitude of agencies all of whom have reviewed the matter from their own specialised areas resulting in an appropriate decision being reached.*
>
> *In many cases police enquiries, such as complex medical cases including deaths and cases where there are potential breaches of Health and Safety legislation, are directed by the Crown Office and Procurator Fiscal Service. In this case direction was sought*

there [sic] *was a clear decision that* [Detective Inspector A] *was not to conduct any further enquiry as there was no identified criminality to investigate.*

Based on the information to hand I am satisfied that there was a clear sufficiency of information presented to the Crown Office and Procurator Fiscal Service by [Detective Inspector A] *to allow them to make an informed decision on the matters referred which they did".*

Consideration of Complaints 1 and 2

As Complaints 1 and 2 are closely related, their handling has been considered jointly in this review.

The applicant's allegations are rooted in two distinct pieces of legislation, namely the HSW Act and the Corporate Homicide Act. Breaches of the former are dealt with by the HSE, whilst breaches of the latter are investigated by the relevant policing body, in this case Police Scotland.

The applicant's main contention appears to be that each of the 56 original incidents potentially involved breaches of the HSW Act which were not reported or investigated at the time and that the NHS Board's subsequent failure to keep accurate records and disseminate learning from the relevant CIRs and SAERs compiled following these incidents potentially led to further avoidable deaths and therefore a breach of the Corporate Homicide Act.

In the report submitted to COPFS, Detective Inspector A enclosed copies of the statements provided by the applicant, a DVD made by the applicant explaining his concerns, a copy of the report compiled in 2012 by Healthcare Improvement Scotland into the Management of Significant Adverse events in the NHS Board area in question and a copy of the NHS Board's own Improvement Plan for the Review of Significant Adverse Events. It is evident therefore that "*independent*" evidence was, as asserted by Detective Chief Inspector C, "*signposted*" to COPFS within the report.

Detective Inspector A also made clear in his report that its purpose was to "*brief*" COPFS on the "*background, commentary on the current position and seek a meeting to allow for dialogue and direction to the Police Service*". Therefore, the report does not appear to have been designed to convey the findings of an investigation, but rather – as asserted by Detective Chief Inspector C – *"to allow the points* [the applicant] *had raised to be considered by* [COPFS] *to allow them to consider providing further instruction or direction"*.

The applicant has acknowledged that the 56 critical incidents relate initially to breaches of the HSW Act and thus any investigation instructed in this regard would be the responsibility of the HSE and not Police Scotland. The briefing prepared by Detective Inspector A was ultimately shared with the HSE and the HSE identified that no action was required. It is therefore evident that potential breaches of the HSW Act were considered by the relevant agency on the basis of the information submitted, as has been explained to the applicant by Detective Chief Inspector C.

However, the applicant has also alleged that the NHS Board's actions were in breach of the Corporate Homicide Act. On 29 May 2017, the PIRC sought clarification from COPFS as to whether it had

considered this specific allegation. Mr E of the COPFS Health & Safety Division replied to the PIRC on 8 June 2017. He confirmed that, in assessing Detective Inspector A's briefing paper in respect of the applicant's allegations, Crown Counsel gave consideration as to whether or not the circumstances described could amount to a breach of the Corporate Homicide Act, found that there was no evidence that the actions of the NHS Board amounted to a criminal offence and concluded that the Corporate Homicide Act could not apply.

Detective Chief Inspector C states in his response that that the evidence presented to COPFS was sufficient to allow it to make an informed decision. The applicant contends precisely the opposite. Notwithstanding the conclusion that would ultimately be drawn by COPFS, the applicant's position is that additional evidence, other than the reports compiled by external agencies, should have been sought by Police Scotland in relation to his allegations.

In an email to Detective Inspector D on 12 September 2016, the applicant raised concerns that Police Scotland did not interview any of the parties involved in any of the original 56 critical incidents, writing that it "*seems apparent that directors… should have been at the least interviewed under caution with regard to the serious and criminal allegations*". It is considered that these particular concerns have not been adequately addressed in Detective Chief Inspector C's response.

In addition, in a statement taken by Detective Sergeant B on 30 April 2013, the applicant raised concerns that the learning and action plans of the CIRs had been *"produced retrospectively, meaning there was no learning from these critical incidents, which could have resulted in the death or serious harm of a patient".* On the basis of the papers provided, no enquiry appears to have been carried out by Police Scotland in this connection.

For those reasons, it is concluded that this complaint was not dealt with to a reasonable standard. It is recommended that a further response be sent to the applicant explaining precisely why Police Scotland did not deem it necessary to investigate or seek to obtain any "*independent evidence*" before referring the matter to COPFS. The response should specifically address why no interviews were conducted by Police Scotland with potential suspects or witnesses in connection with the applicant's allegations and why no enquiry appears to have been carried out in relation to the applicant's concern about the retrospective production of documents.

Complaint 3: Limited to "paper exercise"

The applicant complained that Police Scotland "*only did a paper exercise*" and argued that this was "*not the approach to investigating potential homicides*" under the HSW Act or the Corporate Homicide Act.

Complaint 4: "Criminal negligence" not applied

The applicant complained that Police Scotland "*were looking for criminal intent*" which was "*completely the wrong criteria… they should be doing criminal negligence*."

Police Handling of Complaints 3 and 4

Detective Chief Inspector C treated Complaints 3 and 4 as one complaint and responded as follows:

> *"I have examined* [Detective Inspector A]*'s review of the incidents and the subsequent report to the Crown Office and Procurator Fiscal Service which you refer to as a 'paper exercise'. I am of the opinion that the content and style of this report was both acceptable and appropriate in the format and style and it clearly laid out the incidents which had to be considered. When this report was taken into consideration along with the Healthcare Improvement Scotland Independent Review into the Management of Significant Adverse Events, the audit carried out by* [professional audit company] *and the advice received by the Health and Safety Executive I am satisfied that there was a sufficiency of information presented to the Crown Office and Procurator Fiscal Service to allow them to make an informed decision on the matter.*
>
> *It is evident from correspondence from the Crown Office and Procurator Fiscal Service that they are satisfied that no criminality existed within the issues you have raised".*

Consideration of Complaint 3

As discussed in the consideration of Complaints 1 and 2, the report submitted to COPFS by Detective Inspector A was intended as a briefing on the circumstances reported by the applicant, inviting the instruction for further investigation, as opposed to being the findings of an investigation.

Notwithstanding, it is considered that Detective Chief Inspector C's response to the applicant is inadequate. While the response refers to the *"format and style"* of Detective Inspector A's report, these do not appear to be core to the applicant's complaint, which was that the approach taken by Detective Inspector A was not appropriate in respect of *"investigating potential homicides"*. In order to fully address the applicant's complaint, Detective Chief Inspector C should have explained precisely why Detective Inspector A's report was deemed appropriate in the circumstances, e.g. by outlining its purpose and detailing why an investigation into "*potential homicides*" was not considered necessary before papers were submitted to COPFS. In this connection, Detective Chief Inspector C ought also to have explained to the applicant the legislative provisions of the offences specified, e.g. what would need to have been proven in order to establish that breaches of the relevant legislation had occurred.

As it is considered that Detective Chief Inspector C's response to the applicant is inadequate, it is concluded that this complaint was not dealt with to a reasonable standard. It is recommended that a further response be sent to the applicant explaining precisely why Detective Inspector A's report was deemed sufficient to address the applicant's allegation of *"potential homicides"*, with reference made to the relevant provisions of the HSW Act and the Corporate Homicide Act.

Consideration of Complaint 4

As part of his enquiry into the applicant's complaint, Detective Inspector D obtained guidance from Mr E of the COPFS Health & Safety Division regarding any criminality which could potentially be identified in

the applicant's allegations against the NHS Board. According to Detective Inspector D, Mr E stated that criminal negligence was not a crime unless statute made it one and added that this was not the case in these circumstances.

In his response, Detective Chief Inspector C states that it is evident from correspondence from COPFS that they are satisfied that no criminality existed. However, in order to address the applicant's complaint, an explanation should have been provided as to the extent of the enquiries made with COPFS, and also as to precisely why "*criminal negligence*" was not considered a relevant criteria for assessment in the circumstances, with reference to the legislation cited by the applicant.

As the explanation provided to the applicant in respect of these points is insufficient, it is considered that the response is inadequate. Accordingly, it is concluded that this complaint was not dealt with to a reasonable standard.

It is recommended that a further response be provided to the applicant detailing the enquiries made with COPFS and explaining precisely why "*criminal negligence*" was not considered a relevant criteria for assessment in the circumstances, with reference made to the relevant provisions of the HSW Act and the Corporate Homicide Act. Police Scotland may find it useful to liaise further with COPFS in order to adequately address this matter.

As Complaints 3 and 4 are distinct allegations which could have been upheld or not upheld independently of each other, it is recommended also that Police Scotland record them as separate complaints about the police.

Complaint 5: Protocol not followed

The HSE's Work-Related Deaths protocol is a document endorsed by the police and COPFS which details the framework for liaison between these organisations when investigating a work-related death occurring in Scotland. The applicant complained that Police Scotland did not follow this protocol, which would have entailed Police Scotland, COPFS and HSE becoming involved as soon as any death occurred.

Police Handling of Complaint 5

This complaint was not addressed in Detective Chief Inspector C's letter to the applicant.

Consideration of Complaint 5

Paragraph 6.5.10 of Police Scotland's Standard Operating Procedure on Complaints About the Police ("the Complaints SOP") provides that a "*clear understanding*" must be reached between the enquiry officer of Police Scotland and the complainer about precisely what matters are to be investigated. This is generally established by summarising a list of agreed complaints at the end of the complainer's statement, which is then recorded on a 'Heads of Complaint' form and signed by the complainer.

In the applicant's case, Detective Inspector D has noted on the complaint record that he did not obtain a statement of complaint from the applicant as the applicant had provided Police Scotland with a document detailing six points of complaint and this document was then signed by the applicant and Detective Inspector D in lieu of a completed Heads of Complaint form. This particular complaint was included in the list provided by the applicant and there is no indication that any explanation was given to the applicant by Detective Inspector D as to why the complaint would not be considered or responded to by Police Scotland. It is therefore unclear why this complaint has not been addressed in Detective Chief Inspector C's response.

As the complaint has not been responded to, it is concluded that this complaint was not dealt with to a reasonable standard. It is recommended that this issue now be recorded as a complaint about the police and a response sent to the applicant addressing the matter in line with the Complaints SOP.

Complaint 6: Enforcement Management Model not used

The applicant complained that Police Scotland did not use the 'Enforcement Management Model' (EMM) in deciding whether or not any action should be taken in respect of any of the deaths.

Police Handling of Complaint 6

In his letter to the applicant, Detective Chief Inspector C wrote:

> "*The Enforcement Management Model is a tool that is used by the Health and Safety Executive for the purposes of assisting Health and Safety Executive Inspectors make decisions regarding processes rather than a tool would* [sic] *assist in a police criminal investigation of a reported crime. Police Scotland officers are not trained in this model and do not use this model in criminal investigations.*
>
> *It is clear from the correspondence you received from Crown Office and Procurator Fiscal Service on the 9 April 2014 that this matter was referred to the Health and Safety Executive to review the circumstances of the matters you raised. I am unable to confirm whether the Enforcement Management Model was used in their review and would suggest that if you require further clarification on this you contact the Health and Safety Executive.*
>
> *Having considered this issue and considered your suggestion that the use of the Enforcement Management Model should have been a consideration for the police I am firmly of the opinion that it would have provided no additional investigative options to* [Detective Inspector A] *which would have impacted on the result of the review undertaken. In addition the Crown Office and Procurator Fiscal Service have also commented that they do not use the Enforcement Management Model and would have no expectations that this would be used by the police during an investigation".*

Consideration of Complaint 6

As asserted by Detective Chief Inspector C, the EMM is a system used by HSE inspectors to facilitate enforcement decisions in accordance with the HSE's Enforcement Policy. The system is not designed to be utilised for decision-making purposes by any other agencies, as the HSE is responsible under the HSW Act for making arrangements for the enforcement of health and safety legislation.

As part of his enquiry into the applicant's complaint, Detective Inspector D obtained confirmation from Mr E that COPFS did not use the EMM as a tool and furthermore did not expect Police Scotland to utilise the EMM either. Detective Chief Inspector C has explained this to the applicant and is correct to refer the applicant to the HSE to query whether the EMM was utilised in its assessment of the circumstances reported by Detective Inspector A.

On the basis of the foregoing, it is concluded that this complaint was dealt with to a reasonable standard. No further action is required of Police Scotland in this connection.

5. Conclusions

Complaints 1 and 2:

It is concluded that these complaints were not dealt with to a reasonable standard. It is recommended that a further response be sent to the applicant explaining precisely why Police Scotland did not deem it necessary to investigate or seek to obtain any "*independent evidence*" before referring the matter to COPFS. The response should specifically address why no interviews were conducted by Police Scotland with potential suspects or witnesses in connection with the applicant's allegations and why no enquiry appears to have been carried out in relation to the applicant's concern about the retrospective production of documents.

Complaint 3:

It is concluded that this complaint was not dealt with to a reasonable standard. It is recommended that a further response be sent to the applicant explaining precisely why Detective Inspector A's report was deemed sufficient to address the applicant's allegation of *"potential homicides"*, with reference made to the relevant provisions of the HSW Act and the Corporate Homicide Act.

Complaint 4:

It is concluded that this complaint was not dealt with to a reasonable standard. It is recommended that a further response be provided to the applicant detailing the enquiries made with COPFS and explaining precisely why "*criminal negligence*" was not considered a relevant criteria for assessment in the circumstances, with reference made to the relevant provisions of the HSW Act and the Corporate Homicide Act.

As Complaints 3 and 4 are distinct allegations which could have been upheld or not upheld independently of each other, it is recommended also that Police Scotland record them as separate complaints about the police.

Complaint 5:

It is concluded that this complaint was not dealt with to a reasonable standard. It is recommended that this issue now be recorded as a complaint about the police and a response sent to the applicant addressing the matter in line with the Complaints SOP.

Complaint 6:

It is concluded that this complaint was dealt with to a reasonable standard. No further action is required of Police Scotland in this connection.

Kate Frame
Commissioner