# AP revised v2 logo.jpg

**Inter-related investigations, reviews and other processes**

Processes, which may need to be considered in addition to a Learning Review include:

## Adverse Events (Significant Adverse Events NHS)

In collaboration with NHS boards, Healthcare Improvement Scotland has led the development of the National Framework: **Learning from Adverse events through Reporting and Review: A National Framework for Scotland (Third edition 2018).**

As per the mental Welfare Commission report *recommendation Left alone – the end of life support and treatment of Mr. JL (July 2014)*, processes should make reference to this document.

An adverse event is defined as an event that could have caused (a near miss), or did result in, harm to people or groups of people. The National Framework describes 3 categories of reviews for significant adverse events and a senior manager or Director is assigned to ensure the review is undertaken at the appropriate level**.**

Category I**:** Events that may have contributed to or resulted in permanent harm, for example death, intervention required to sustain life, severe financial loss (£>1m), ongoing national adverse publicity

Category II: Events that may have contributed to or resulted in temporary harm, for example initial or prolonged treatment, intervention or monitoring required, temporary loss of service, significant financial loss, adverse local publicity

Category III: Events that had the potential to cause harm but i) an error did not result, ii) an error did not reach the person iii) an error reached the person but did not result in harm (near misses).

The management of adverse events should incorporate the following six stages

1. Risk assessment and prevention
2. Identification and immediate actions following an adverse event, including consideration of duty of candour
3. Initial reporting and notification
4. Assessment and categorisation, including consideration of duty of candour
5. Review and analysis
6. Improvement planning and monitoring

The report outlining the findings, conclusions and recommendations from the review should be presented through local NHS management structures. The third edition of the framework was produced following the implementation of the statutory organisational Duty of Candour legislation in Scotland on 1 April 2018.

## Criminal Investigations (CI)

Within Scotland the core functions and jurisdiction of the police are specified by the Police and Fire Reform (Scotland) Act 2012. This includes a duty to protect life and property. The police are an independent investigative and reporting agency to the Crown Office and Procurator Fiscal Service (COPFS). The police have a duty to investigate both crimes/offences and also any sudden and unexplained deaths.

## Crimes and offences

The paramount consideration in any decision or arrangement in respect of learning reviews taking place alongside other investigations is the need to protect adults from harm. In some instances this will be achieved by the successful prosecution of those who pose a threat to adults, in conjunction with securing improvements in systems that exist to prevent adults being exposed to harm.

Should the police receive information, by whatever means, that a crime or offence has been committed, they are duty-bound to investigate that occurrence. Principally the role of the police is to establish the following:

* 1. Whether or not a crime or offence has been committed;
	2. Whether there is sufficient evidence to support a criminal charge;
	3. Whether there is sufficient evidence to justify the detention and/or arrest of the alleged offender; and thereafter to
	4. Submit a report to the Procurator Fiscal

Where allegations of physical, sexual and emotional abuse are made involving adults, the police consider, in collaboration with other agencies the following before initiating the investigation. Reports of Adults at Risk of Harm being received under the Adult Support and Protection (Scotland) Act 2007 include physical harm, conduct which causes psychological harm (e.g. by causing fear, alarm or distress, unlawful conduct (e.g. Theft) or conduct which causes self-harm:

* The immediate safety and wellbeing of the adult at risk
* The need for medical attention, immediate or otherwise
* The opportunity of access to the victim and to other adults by the alleged perpetrator
* The relationship of the alleged offender to the victim
* The proximity in time over which the alleged abuse has occurred
* The need to remove the adult or other adult from the home to a place of safety, although this will only take place after discussion between the supervisor on duty in both the police and the relevant Social Work Departments
* The need to obtain and preserve evidence

After consideration of the above, which should ascertain the risks and needs of the adult, the investigation, will begin. In many such cases a Senior Investigation Officer (SIO) will be appointed to oversee the investigation.

In matters where a serious crime or offence has been committed, the investigation will usually be conducted by specially trained officers of the Criminal Investigation Department.

The evidence of the crime or offence will be gathered in a variety of ways such as the obtaining of statements from witnesses who have knowledge of the events under investigation, the gathering of forensic evidence such as DNA, fingerprints, hairs, fibres, etc. and the interviewing of those person(s) suspected of being responsible.

Upon conclusion of the investigation the police will prepare a report of the circumstances and this will be submitted to the Procurator Fiscal. Decisions will also be made as to whether the accused should remain in police custody pending his/her appearance in court, whether they should be released on an undertaking which may specify certain restrictions/provisions or whether they should be released pending report and summons.

In the event of an adult fatality or a case of serious harm which may be subject to a learning review, it is essential for the APC, Police Scotland and COPFS to confirm the likely processes of review and investigation to which the case is likely to be subjected (e.g. learning review, criminal investigation,

Fatal Accident Inquiry (FAI), Health and Safety investigation, Scottish Fire and Rescue Service investigation).

At the earliest possible opportunity, where it is identified that a learning review may be appropriate, the Convenor of the APC or designated member should contact Police Scotland to confirm:

* Whether a death report or criminal case has been reported to COPFS; or
* That there is evidence of a crime having been committed although no report has been submitted to COPFS

Consideration should be given to arrangements that allow reviews of systems critical to the welfare of adults to get underway, in the context of the need to secure and preserve the integrity of best evidence within criminal and other investigations.

If agreed by Police Scotland and COPFS, a learning review may involve the reviewer interviewing members of staff of the relevant authorities who may have had engagement with the adult, as well as people who may be considered as having a significant part in the life of the adult. The material generated from this activity, including interview notes, is likely to contain information which is of relevance to any potential criminal proceedings or FAI.

Police Scotland has a duty to reveal the existence of relevant information to COPFS and all such information must be made available to the Reporting Officer/SIO as soon as possible for consideration. To allow Police Scotland to fulfil this duty, in these circumstances close collaboration between the Lead Reviewer and the SIO will be required.

The timing of different processes will be determined by the particular circumstances of individual cases. It should not be necessary to postpone the initiation of a learning review until the conclusion of criminal proceedings or FAI but care must be taken that the learning review does not prejudice or put in jeopardy either of these proceedings. Therefore, in some instances, a learning review process may have to be adjourned after an initial review of critical systems until the conclusion of aspects of the criminal or other investigations. Alternatively, it may be possible to take information from a limited number of witnesses at first.

Criminal cases and FAIs can take a long time to resolve and there may be some circumstances where the APC, in carrying out its duties to conduct the learning review, considers it would not be appropriate to wait to gather all possible learning about how best to safeguard adults. If, prior to charge or conclusion of a trial or FAI, those engaged in the learning review wish to undertake interviews with people who are either witnesses, suspects or who have been charged with a criminal offence or potential witnesses in a FAI, this should be agreed beforehand with Police Scotland and COPFS.

Where there is an FAI, or potential for one, and where no criminal proceedings are anticipated, the conclusions of the learning review may assist the decision-making and such interviews should be encouraged.

Where there are criminal proceedings anticipated or ongoing and COPFS are giving consideration as to whether witnesses can be interviewed as part of the learning review process, the following are some of the factors which may be taken into account:

* The risk around the rehearsal of evidence in advance of trial
* The vulnerability of witnesses
* The risk of any confusion about two processes
* The impact of information being in the public domain

It is good practice that carers and significant family members are interviewed or otherwise engaged during the learning review process to seek any learning from them. The APC, COPFS and, where appropriate, the police officer leading the investigation, or their representative, must discuss the

timing and scope of such interviews or other engagement. While there may be no need to delay learning review interviews pending the outcome of criminal proceedings or FAI, a balance must be achieved between the need to capture relevant data and learning in order to protect adults and the investigation of a death or prosecution of a criminal case in the public interest.

The best timing of such interviews will differ depending on the circumstances and features of the case and as such arrangements should be made on a case-by-case basis.

Persons conducting learning review interviews must be conversant with rules of evidence and competent in the management of investigative processes running in tandem with criminal investigations.

In circumstances where there is an ongoing criminal investigation, prosecution or death investigation, the APC must seek permission from COPFS before publishing learning from a learning review.

Publication may need to be delayed if it is likely to prejudice an ongoing criminal investigation, prosecution or death investigation.

## Fatal Accident Inquiry

A Fatal Accident Inquiry is a court hearing which publically makes inquiries into the circumstances of a death. It will be presided over by a sheriff and will usually be held in the sheriff court. If the death occurred as a result of an accident while the deceased was in the course of employment or where the person who died was at the time of death in legal custody, for example in prison or police custody, an FAI is mandatory. The Lord Advocate has discretion to instruct an FAI in other cases where it appears to be in the public interest that an Inquiry should be held into the circumstances of the death.

The purpose of a Fatal Accident Inquiry is to ascertain the circumstances surrounding the death and to identify any issues of public concern or safety and to prevent further deaths or injuries. The Procurator Fiscal has responsibility for calling witnesses and leading evidence at an FAI, although other interested parties may also be represented and question witnesses.

At the end of a Fatal Accident Inquiry, a Sheriff will make a determination. The determination will set out:

* Where and when the death occurred
* The cause of death
* Any precautions whereby the death might have been avoided
* Any defect in systems which caused or contributed to the death
* Any other facts which are relevant to the circumstances of the death

The court has no power to make any findings as to fault or to apportion blame between individuals. The Sheriff has the power to make recommendations as to steps which ought to be taken to prevent a death occurring in similar circumstances in future. While there is no compulsion on any person or organisation to take such steps it would be unusual for such a recommendation to be disregarded.

## MAPPA Significant Case Review

The fundamental purpose of MAPPA is public protection and managing the risk of serious harm posed by certain groups of offenders. It Is understood that the responsible authorities and their partners involved in the management of offenders cannot eliminate risk – they can only do their best to minimise that risk.

It is recognised that, on occasions, offenders managed under the MAPPA will commit, or attempt to commit, further serious crimes and, when this happens, the MAPPA processes must be examined to, firstly, ensure that the actions or processes employed by the responsible authorities are not flawed

and, secondly, where it has been identified that practice could have been strengthened, plans are put in place promptly to do so.

There are five stages to a MAPPA Significant Case Review:

1. Identification and notification of relevant cases
2. Information gathering
3. Decision to proceed, or not to a Significant Case Review
4. Significant Case Review process
5. Report and publication

The criteria for undertaking a Significant Case Review in MAPPA is:

* + When an offender managed under MAPPA at any level, is charged with an offence that has resulted in the death or serious harm to another person, or an offence listed in schedule 3 of the Sexual Offences Act 2003;
	+ Significant concern has been raised about professional and/or service involvement, or lack of involvement, in respect of the management of an offender under MAPPA at any level;
	+ Where it appears that a registered sex offender being managed under MAPPA is killed or seriously injured as a direct result of his/her status as a registered sex offender;
	+ Where an offender currently being managed under MAPPA has died or been seriously injured in circumstances likely to generate significant public concern.

## Offences Obstruction

Section 49 of the Adult Support and Protection (Scotland) Act 2007 provides that it is an offence to prevent or obstruct any person from doing anything they are authorised or entitled to do under the act. It is also an offence to refuse, without reasonable excuse, to comply with a request to provide information made under section 10 (examination of records etc.). However, if the adult at risk prevents or obstructs a person, or refuses to comply with a request to provide access to any records, then the adult will not have committed an offence.

A person found guilty of these offences is liable on summary conviction to:

* + A fine not exceeding level 3 on the standard scale; and/or
	+ Imprisonment for a term not exceeding 3 months.

## Offences by corporate bodies etc.

Where it is proven that an offence under Part 1 of the Act was committed with the consent or connivance of, or was attributable to any neglect on the part of a “relevant person”, or a person purporting to act in that capacity, that person as well as the body corporate, partnership or unincorporated association is also guilty of an offence. A “relevant person” for the purposes of this section means:

* + A director, manager, secretary or other similar officer of a body corporate such as limited company, a plc, or a company established by a charter or by Act if Parliament;
	+ A member, where the affairs of the body are managed by its members;
	+ An officer or member of the council;
	+ A partner in a Scottish Partnership; or
	+ A person who is concerned in the management or control of an unincorporated association other than a Scottish Partnership.

An unincorporated association is the most common form of organisation within the independent and third sector in Scotland. It is a contractual relationship between the individual members of the

organisation, all of whom have agreed or “contracted” to come together for a particular charitable purpose, unlike an incorporated body the association has no existence or personality separate from its individual members.

## Post Mortem Examination

The Procurator Fiscal will instruct a Post Mortem Examination for all suspicious deaths; all deaths which remain unexplained after initial investigation; and in a number of other situations where there are concerns about the circumstances or cause of death.

## Serious Incident Review

A serious incident is defined as an incident involving: -

‘Harmful behaviour, of a violent or sexual nature, which is life ‘threatening and/or traumatic and from which recovery, whether physical or psychological, may reasonably be expected to be

difficult or impossible.’ (Framework for Risk Assessment Management and Evaluation: FRAME)

And includes:

* + An offender on statutory supervision or licence is charged with and/or recalled to custody on suspicion of an offence that has resulted in the death or serious harm of another person.
	+ The incident, or accumulation of incidents, gives rise to significant concerns about professional and/or service involvement or lack of involvement.
	+ An offender on supervision has died or been seriously injured in circumstances likely to generate significant public concern.

The purpose of a serious incident review is to ensure that local authorities and partner agencies identify areas for development and areas of good practice.

Following a serious incident, the Care Inspectorate must be notified of such within 5 working days. The Care Inspectorate will forward to Scottish Government Criminal Justice division. The local authority is then required to undertake a review of the serious incident and submit this to the Care Inspectorate within 3 months of the notification. The review can be completed in two ways: firstly, and initial analysis review is completed – this may be enough with the local authority concluding no further detailed review is required or; secondly following an initial analysis review a more comprehensive review is required.

The Care Inspectorate will then provide a written response to the review and the case will then either be closed or additional information sought.

## Sudden and Unexplained Deaths

All sudden and unexplained deaths must be reported to the Procurator Fiscal. The death is usually reported by a doctor (either a General Practitioner (GP) or a hospital doctor), by the police or a local Registrar of Births, Deaths and Marriages. Whether or not the cause of death is known, if a doctor is of the view that a death is not known or is not clear to a doctor, this is described as an “unexplained death”.

Once a person’s death is reported to the Procurator Fiscal, it is for the Procurator Fiscal to decide what further action, if any, will be taken. The Procurator Fiscal may decide that further investigation is required which may include, but is not limited to, the instruction of a post mortem examination to

determine the cause of death and/or instructing the police to carry out further enquiries and provide a report.

While some death investigations may conclude once a cause of death is known, others may require further detailed and sometimes lengthy investigation, for example, those involving complex technical and medical issues which may require the instruction of independent experts to provide an opinion. At the conclusion of the Procurator Fiscal’s investigation, it may be necessary for a Fatal Accident Inquiry (FAI) to be held.

Once a death has been reported to the Procurator Fiscal, the Procurator Fiscal has legal responsibility for the body, usually until a death certificate is issued by a doctor and given to the nearest relative. The Procurator Fiscal will usually surrender legal responsibility for the body once the nearest relative has the death certificate.

In a small number of cases, it may be necessary for the Procurator Fiscal to retain responsibility for the body for a longer period of time to allow for further investigations to be carried out into the circumstances. This happened with only a very small number of deaths, most likely where the death is thought to be suspicious. If this is necessary, nearest relatives will be advised by the Police or the Procurator Fiscal.

## Suspicious Deaths

Where there are circumstances surrounding the death which suggest that criminal conduct may have caused or contributed towards the death, this is described as a “suspicious death”. The Procurator Fiscal will instruct the Police to investigate the circumstances and consider whether criminal charges should be brought which may lead to a prosecution. All deaths where the circumstances are thought to be suspicious must be reported to the Procurator Fiscal.

In circumstances where the death is considered to be potentially suspicious, the Procurator Fiscal may direct that a two Doctor post mortem examination be carried out for corroboration purposes of the finding. This would be an essential element in the chain of evidence, particularly where criminal investigations and/or proceedings were to be instigated later.

Normally, a Senior Investigating Officer (SIO) will be appointed to investigate suspicious deaths and specially trained officers would carry out these investigations. These investigations may well identify criminality and also those who may be responsible and in these circumstances the police would follow their well-established investigative procedures. Good practice would always suggest that a Family Liaison Officer acts as the single point of contact between them and the police.

Public bodies with responsibility for scrutiny and improvement support include:

## Care Inspectorate

The role of the Care Inspectorate is to regulate and inspect care, social work and child and adult protection services so that:

* + Vulnerable people are safe
	+ The quality of these services improves
	+ People know the standards they have a right to expect

The Care Inspectorate reports publicly on the quality of these services across Scotland. The Care Inspectorate has a duty to support improvement in care and social work services and promulgate good practice. The Care Inspectorate is strongly committed to supporting strategic partnerships such as adult protection committees in their continuous improvement by proving support and feedback

locally and by identifying and reporting on wider themes and learning which could improve practice nationally.

## The Health and Safety Executive

The [Health and Safety Executive](https://www.hse.gov.uk/enforce/index.htm) (“HSE”) is a statutory body established under section 10 of the Health and Safety at Work Act 1974. The Health and Safety Executive’s main statutory duties are to:

* + Propose and set necessary standards for health and safety performance, including submitting proposals to the relevant SoS for health and safety regulations and codes of practice;
	+ Secure compliance with these standards, including making appropriate arrangements for enforcement;
	+ Make such arrangements as it considers appropriate for the carrying out of research and the publication of the results of research and encouraging research by others;
	+ Make such arrangements as it considered appropriate for the provision of an information and advisory service, ensuring relevant groups are kept informed of and adequately advised on matters related to health and safety; and
	+ Provide Ministers on request with information and expert advice

Local authorities also have a role in enforcing health and safety legislation in some privately-owned care homes. The HSE and Scottish local authorities have signed an agreement with the Care Inspectorate. The agreement has been developed to assist staff by:

* + Promoting co-ordination of investigations, where appropriate, into incidents that have resulted in service user deaths or serious injuries, which could have been prevented
	+ Encouraging appropriate information to be shared in a timely manger
	+ Establishing and maintaining liaison arrangements

The [Care Inspectorate agreement](https://www.hse.gov.uk/scotland/pdf/liaison-agreement-0617.pdf) document can be found on the Health and Safety Executive website.

## Healthcare Improvement Scotland

[Healthcare Improvement Scotland](https://www.healthcareimprovementscotland.org/) (“HIS”) is an organisation with many parts and one purpose – better quality health and social care for everyone in Scotland. They have five key priorities. These are areas where they believe they can make the most impact and where they focus efforts and resources.

* + Enabling people to make informed decisions about their care and treatment
	+ Helping health and social care organisations to redesign and continuously improve services
	+ Provide evidence and share knowledge that enables people to get the best out of the services they use and helps services improve
	+ Provide quality assurance that gives people confidence in the services and supports providers to improve.
	+ Making the best use of resources, we aim to ensure every pound invested in our work adds value to the care people receive

HIS provides public assurance about the quality and safety of healthcare through the scrutiny of NHS hospitals and services, and independent healthcare services. HIS reports and published findings on performance and demonstrates accountability of these services to the people who use them. HIS also supports health and social care services to continuously improve and redesign services alongside the provision of evidence and sharing of knowledge. This makes a positive impact on the healthcare outcomes for patients, their families and the public, and feeds the improvement cycle by providing further evidence for improvement.

## Mental Welfare Commission for Scotland

Investigations by the  [Mental Welfare Commission for Scotland](https://www.mwcscot.org.uk/) focus on one person, but have lessons for many organisations. The Commission carries out investigations into deficiencies in an

individual’s care and treatment, particularly when it believes there are similar issues in other people’s care and where lessons can be learned for services throughout Scotland. Their work is specific to individuals with mental ill health, learning disability, and related conditions. (See section 11 Mental Health Care and Treatment (Scotland) Act 2003).

The Mental Welfare Commission should be notified of significant events that meet particular criteria. It is difficult to be prescriptive, as each and every circumstance will be different. The [criteria](https://www.mwcscot.org.uk/good-practice/notifying-commission) can be found on the Mental Welfare Commission website.

In the Scottish Government review of arrangements for investigating the deaths of patients being treated for mental disorder [report](https://www.gov.scot/publications/review-arrangements-investigating-deaths-patients-being-treated-mental-disorder/pages/1/) (December 2018) Action 1 is:

The Scottish Government will ask the Mental Welfare Commission for Scotland to develop a system for investigating all deaths of patients who, at the time of death, were subject to an order under either the Mental Health (Care and Treatment) (Scotland) Act 2003 or Part VI of the Criminal Procedure (Scotland) Act 1995 (whether in hospital or in the community, including those who has their detention suspended).

This process should take account of the effectiveness of any investigations carried out by other agencies and should reflect the range of powers the Commission has to inspect medical records, carry out investigations, and hold inquiries (as set out in sections 11-12 and 16 of the 2003 Act). The design and testing of the new system should involve, and be informed by the views of carers, families and staff with direct experience of existing systems. It should include appropriate elements of public scrutiny and should involve staff, families and carers. The new system should have clear timescales for investigation, reporting and publication.

The commission is working to develop this system of reviews and further information and guidance will be issued to all stakeholders at an appropriate stage.

## The Office of the Public Guardian

The [Office of the Public Guardian (Scotland)](https://www.publicguardian-scotland.gov.uk/) (“OPG”) has statutory powers to supervise financial guardians, financial interveners and withdrawers, and powers to investigate them (and continuing attorneys) where there is a concern or risk of financial abuse.

The OPG aims to ensure that these appointed proxies act in the best interests of the adults with incapacity, and that they carry out their duties properly, within the scope of their powers. If there is a concern about how an appointed proxy is acting, an investigation may be undertaken, and the incapable adult’s property or financial affairs may be appropriately safeguarded from risk from abuse or misuse.

Anyone who has concerns that an adult’s funds/property are at a risk, can refer the matter to the OPG.They will need to provide evidence to support those concerns. Concerns might include:

* + The way in which an attorney, who has authority to manage an adult’s finances or property, is using that authority.
	+ An adult’s property or financial affairs appears to be at risk, perhaps because of the involvement of a third party who has no authority to manage the adult’s finances.

When investigating continuing attorneys, the Office of the Public Guardian only has a locus when the granter/adult has lost capacity; when a current and future risk has been identified (the Office of the

Public Guardian does not have a remit to investigate historical matters); and, where no proxy (joint attorney) has been appointed who could investigate and safeguard the estate.

## The Scottish Fire and Rescue Service (SFRS)

The [Scottish Fire & Rescue Service](https://www.firescotland.gov.uk/) (“SFRS”) is a national organisation delivering front-line services locally across three Service Delivery Areas (SDAs) in the North, West and East of the country. SFRS works in partnership to reduce the incidences of fire in Scotland and, continues to play a key role in prevention, to ensure the safety and wellbeing of Scotland’s communities.

The SFRS have a specialist fire investigations unit located in each SDA (Glasgow, Edinburgh and Aberdeen). The teams work exclusively on fire investigation. Their role allows them to build a comprehensive knowledge base, identify issues, track trends and understand the circumstances surrounding the fire event. The investigation process culminates in a detailed report that identifies the origin, cause and fire development. This information is shared across the organisation and partners (where appropriate) in order to learn from previous incidents and, improve community and firefighter safety. By jointly investigating fire incidents, the SFRS aim to reduce the instances of fire and reduce the number of fire deaths, injuries and trauma resulting from such incidents.

A multi-agency protocol to jointly investigate fires was introduced in 2013. This protocol commits SFRS, Police Scotland and Scottish Police Authority (SPA) Forensic Services to work together and share their specialist skills and expertise when dealing with certain levels of investigations. The protocol ensures that the approach to investigations is consistent across the organisations, and across the country.

## Scottish Social Services Council

The [Scottish Social Services Council](https://www.sssc.uk.com/) (“SSSC”) is the regulator for the social services workforce in Scotland. SSSC register social services workers, set standards for practice, conduct, training and education and support professional development. Where people fall below standards of practice and conduct they can investigate and take action.

The fitness to practice process of a professional regulator, such as SSSC, may be running in parallel with a Learning Review. Where there are issues with the conduct of workers who are registered with the SSSC, it would be helpful to keep them informed. This will support the coordination of activity between organisations and minimise duplication