

Professional Discipline and Regulation

February 2008

Proper Conduct of Fatal Accident Inquiries

Background

Sheriff Mitchell's recent determination into the death of Thomas Bolesworth raises some interesting points about the proper conduct of Fatal Accident Inquiries. Mr Bolesworth died on 6 January 2006 in the Intensive Care Unit of Glasgow Royal Infirmary subsequent to sustaining scalding injuries to about 38% of his body surface. The accident occurred on 30 December 2005 whilst he was working a butcher.

Determination

Sheriff Mitchell made only formal findings in his determination, namely the date, time, place and causes of death. He declined to make any findings in respect of reasonable precautions whereby the death might have been avoided or any defects in any system of working that contributed to the death. Instead, Sheriff Mitchell felt there were limitations as to what he could properly find at an inquiry held so long after the death and in a situation where the evidence led was deficient in several respects. Whilst he praised the procurator fiscal depute who conducted the inquiry, that depute had not been involved in the initial preparation stages. By the time he became involved, Sheriff Mitchell commented that it was impossible for him to do what had been left undone.

Firstly, Sheriff Mitchell criticised the decision by the procurator fiscal's deaths unit not to carry out a post mortem examination. He was of the view that this was a most unfortunate decision which resulted in the inquiry becoming more lengthy and expensive than it need otherwise have been. Without a post mortem examination it could not be known why Mr Bolesworth died.

Secondly, Sheriff Mitchell was critical of the absence of relevant evidence at the inquiry. The inquiry did not hear evidence from any police officer, ambulance personnel or nurse who might have spoken with Mr Bolesworth about what happened to him in the

meat preparation room at the time of his accident. Consequently, much of the evidence related to an examination of surrounding facts and circumstances from which an inference might be drawn as to how the accident occurred.

Thirdly, Sheriff Mitchell regretted the lack of proper investigation by the procurator fiscal's office in advance of the inquiry. At an early preliminary hearing, the procurator fiscal depute then dealing with the inquiry made it clear that he considered there might be responsibility for the accident attaching to the environmental health officer involved. However, Sheriff Mitchell felt that proper investigation and preparation should have revealed that it was quite inappropriate to criticise the environmental health officer. Her role was one of food hygiene inspection and not health and safety inspection. She had been exposed to considerable strain and stress as a result of a suggestion of potential culpability or inappropriate conduct which was without any foundation.

Finally, Sheriff Mitchell suggested that the Sheriff Court Rules Council should examine the issue of fair notice in Fatal Accident Inquiries. It was suggested by one of the parties during the inquiry that a line of medical questioning by the local authority had not been raised with the consultant in intensive treatment medicine. Sheriff Mitchell took the view that this was a fundamental issue in the conduct of a Fatal Accident Inquiry and should be examined.

Significance

Last year, Sheriff R A Davidson in Dundee Sheriff Court called on the Crown to devote more resources to the preparation and conduct of Fatal Accident Inquiries. Sheriff Mitchell has now done the same in Glasgow Sheriff Court. It remains to be seen whether the Crown will be able to take these recent criticisms on board or whether parliamentary intervention will be required. What is clear is that the present position is often unsatisfactory.

This Alert! is correct to the best of our knowledge and belief at the time of going to press. It is however written as a general guide, so it is recommended that specific professional advice is sought before any action is taken. We are required by law to protect personal data.

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If you have any questions on this decision or any other aspect of our regulatory work, please contact our professional discipline and regulation team:

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