# Citizen Participation and Public Petitions Committee

1st Meeting, 2024 (Session 6), Wednesday 24 January 2024

# PE1948: Improve the way that unexplained deaths are dealt with

Petitioner Alex O'Kane

Petition summary

Calling on the Scottish Parliament to urge the Scottish Government to encourage Police Scotland to review their practices for dealing with unexplained deaths from initial recovery through to the support that is

offered to family members.

Webpage <a href="https://petitions.parliament.scot/petitions/PE1948">https://petitions.parliament.scot/petitions/PE1948</a>

#### Introduction

- 1. The Committee last considered this petition at its meeting on <u>19 April 2023</u>. At that meeting, the Committee agreed to write to Police Scotland.
- 2. The petition summary is included in **Annexe A** and the Official Report of the Committee's last consideration of this petition is at **Annexe B**.
- 3. The Committee has received a new response from Police Scotland which is set out at **Annexe C**.
- 4. Written submissions received prior to the Committee's last consideration can be found on the <u>petition's webpage</u>.
- 5. Further background information about this petition can be found in the <u>SPICe</u> <u>briefing</u> for this petition.
- 6. The Scottish Government's initial position on this petition can be found on the <u>petition's webpage</u>.
- 7. Every petition collects signatures while it remains under consideration. At the time of writing, 839 signatures have been received on this petition.

## Action

The Committee is invited to consider what action it wishes to take on this petition.

#### **Clerk to the Committee**

#### Annexe A

# PE1948: Improve the way that unexplained deaths are dealt with

#### Petitioner

Alex O'Kane

## **Date lodged**

8 August 2022

## Petition summary

Calling on the Scottish Parliament to urge the Scottish Government to encourage Police Scotland to review their practices for dealing with unexplained deaths from initial recovery through to the support that is offered to family members.

## Previous action

I have written to the Chief Constable of Police Scotland and MSPs raising concerns about the current approach to unexplained deaths and the lack of support for those impacted. I have arranged a number of TV interviews and newspaper articles to highlight the way that families who have lost a loved ones to an unexplained death are treated. I have gathered over 20,500 signatures from members of the public asking for changes to the way that Police Scotland approach and deal with unexplained deaths.

## **Background information**

Unexplained deaths are far too common in Scotland and whilst I accept that in some cases the medical conclusion cannot be determined, I would urge Police Scotland to improve its policy when a body is initially discovered. This is a vital window of time when decisions are made and evidence can either be secured or lost forever.

Whilst representing a family who had lost a loved one to an unexplained death, I discovered that Police Scotland did not conduct door to door enquiries at relevant locations nor did they formally appeal for witnesses after a body was discovered. I believe this should be good practice and become policy when a body is discovered with no clear cause of death.

As an unexplained death case is not considered as a crime - the same level of resources are not invested to support the person's family, nor is victim support involved.

Unexplained deaths leave many families without answers and in some cases without justice, so it's vital for the Police to have a good line of communication open with the families and to be as transparent, helpful and empathetic as possible.

#### Annexe B

# Extract from the Official Report of last consideration of PE1948 on 19 April 2023

**The Convener:** PE1948, which was lodged by Alex O'Kane, calls on the Scottish Parliament to urge the Scottish Government to encourage Police Scotland to review its practices for dealing with unexplained deaths, from initial recovery through to the support that is offered to family members.

I am sure that members will recall that, on 22 February, we heard evidence—it was very difficult evidence to hear—from Stephanie Bonner in relation to the experience that she had in investigating the death of her 19-year-old son, Rhys, and her concerns about the way in which the police handled the issue, and the presumptions and assumptions that were made, based on her son's age and where he lived, which left her in the intolerable position of having to conduct her own inquiries in an attempt to establish answers.

On the issue of support to families, Stephanie shared the fact that she did not feel that she was supported by Police Scotland. She felt that she was met with nothing more than a wall of silence following her initiation of a complaint. She called for unexplained deaths to be treated as a matter for immediate investigation. She believed that it should be a standard expectation that a proactive approach will be taken, that doors will be knocked on and that family liaison officers will be embedded in the process.

Although we are unable to look into the specifics of Stephanie's experience, because that goes beyond the committee's remit, her evidence was definitely helpful in illustrating the issues that the petition raises. Now that members have had an opportunity to reflect on her evidence, are there any suggestions that they wish to make about what action we might take?

Alexander Stewart: As you identified, the evidence that we had from Stephanie Bonner was quite compelling. I think that there are areas that we can ask Police Scotland about in order to take forward the petition. It might be useful to find out how many complaints it has received about the way in which it has investigated unexplained deaths in the past five years, how many of those were upheld and what the main failings were that were identified in the complaints that were upheld.

It is important that we possibly also look at the review of the investigation of deaths, the national guidance that we have and the steps that are planned to ensure that updated guidance is fully implemented. As you identified, convener, many issues came out of the evidence session that we are not able to look into specifically, but I think that these areas would give us clarity about what Police Scotland are doing and how the police are moving forward to manage the process that was identified during the session.

**The Convener:** I would very much like the letter to be framed in the context of the evidence that we heard during the session, in particular, because I would like Police Scotland to be aware that we heard quite harrowing testimony that we found compelling and that is what underpins our questions. We are not just asking them because we feel that we should ask something; we are asking them because we really feel motivated to do so, given the experience that we heard about from Stephanie Bonner. Are we agreed?

Members indicated agreement.

#### Annexe C

# Police Scotland submission of 16 June 2023 PE1948/D: PE1948: Improve the way that unexplained deaths are dealt with

I write in reply to your email to Police Scotland dated 4 May 2023, seeking information on a number of points raised at the Citizen Participation and Public Petitions Committee in relation to petition PE1948: Improve the way that unexplained deaths are dealt with.

1. How many complaints Police Scotland has received about the way it has investigated unexplained deaths in the past 5 years; of those, how many were upheld; and of the complaints upheld, what the main failings identified were.

At this time the Professional Standards Department (PSD) database cannot be filtered to identify specific complaints relating to the Investigation of Unexplained Deaths. Complaints are recorded as per agreed categories, and this specific set of circumstances detailed by the Committee would be recorded under Quality of Service or Irregularity in Procedure categories. Identifying relevant complaints would involve a manual review of thousands of files in these categories, which has not been practically feasible.

PSD can however report that PSD Investigations (West) maintain an additional index of complaints covering these circumstances in the West command area only. This confirms that from April 2021 to current date, PSD West recorded 13 complaints relating to deaths, either unexplained or suicide. Further analysis into the circumstances of these has revealed that allegations involved a combination of dissatisfaction with the death investigation, disputing the cause of death (particularly suicide or drugs deaths) and police notification to next of kin (either time taken to notify or disputing who was deemed to be the appropriate next of kin). Of these, only one complaint (relating to the matter presented to CPPP) was referred to PIRC for a Complaint Handling Review.

I appreciate this only partially informs the request received, however I can further advise that future upgrades to the PSD database which are currently being progressed, the newly implemented National

Complaint Investigation Model, and potential further analytical support for PSD aims to improve our future recording and analysis capabilities, consistency across the nation and understanding of a wider range of themes, including these particular circumstances

2. When Police Scotland expects to complete its review of the Investigation of Death National Guidance, and what steps it plans to take to ensure the updated Guidance is fully implemented.

Having reviewed the PIRC report in relation to the death of Rhys Bonner, no recommendations were made in relation to the Investigation of Death National Guidance. The Investigation of Death National Guidance is regularly reviewed and updated, often due to specific matters being highlighted through various means. As with any changes made to the guidance, these are highlighted across the organisation by the publishing of internal Police Scotland memos, and via national, and divisional electronic transmissions and/or by face to face briefings by line managers.

The guidance is currently sitting with senior management for review prior to consultation.