SPSO decision report

Case: **201302427, Crown Office and Procurator Fiscal Service**
Sector: Scottish Government and devolved administration
Subject: policy/administration
Outcome: some upheld, recommendations

Summary

Mr C's wife (Mrs C) died in April 2011, and the Procurator Fiscal (PF) investigated her death. They decided that they needed to retain some of Mrs C's organs for tests to establish the cause of her death, and told Mr C this by letter. Mr C did not wish to finalise his wife's funeral arrangements until he knew that her organs had been returned. When the funeral directors contacted the mortuary they found that the organs had been returned – they told Mr C this and the funeral then took place.

Between 2011 and 2013 the PF instructed a number of medical experts to confirm the cause of Mrs C's death, during which time her death certificate was amended in light of clinical opinion. A final conclusion was reached in early 2013, and the family met with the PF and a medical expert in June 2013 to discuss his conclusions. The family were told the death certificate had to be amended again and that the PF would arrange this.

By December 2013 the family had heard nothing, and Mr C complained to the Crown Office and Procurator Fiscal Service (COPFS). The death certificate was amended in January 2014, but Mr C did not receive a response to his complaint until he followed it up a few weeks later. Meanwhile, he received information from National Records of Scotland that indicated COPFS had supplied them with incorrect information. Mr C raised this with COPFS, who apologised immediately.

We investigated Mr C's complaints and found that COPFS had not told him that Mrs C's organs had been returned; the time taken to decide the cause of Mrs C's death and to arrange for her death certificate to be altered was unreasonable; COPFS sent an incorrect document to Mr C's solicitor and referred incorrectly to Mrs C in correspondence, so we upheld Mr C's complaints about all of these matters.

Although we did not uphold some of Mr C's complaints relating to a specific meeting with COPFS, we did make some recommendations about how such sensitive meetings should be recorded in future. We also did not uphold Mr C's complaint about an enquiry he made to COPFS in 2011 as, due to the passage of time, we did not have any evidence to consider this point.

Recommendations

We recommended that COPFS:

- advise relatives when an organ examination is complete and seek instruction regarding the disposal of the organ as part of their procedure for organ retention;
- devise and implement procedures for the identification, contracting, monitoring, etc of medical experts and provide us with copies of these and evidence of their implementation;
- devise and implement procedures for the regular updating of relatives when a death is being investigated;
- take steps to ensure that minutes of sensitive meetings, such as that held with Mrs C's family, are properly taken and, where requested, circulated to all attendees before being finalised and clearly record, where appropriate, the role of attendees where

- apologise to Mr C that a document was generated and provided to his solicitor incorrectly referring to a case against his late wife;
- devise and implement a receipt for specific use in death investigation cases, to ensure that inappropriate criminal case disclosure receipts are not provided to grieving relatives or their representatives;
- take steps to ensure that when notes or minutes are taken of sensitive meetings, such as that held with Mrs C’s family, such notes should clearly record whether any actions were agreed;
- ensure that amendments to death certificates are undertaken in a timely manner and that responsible officers are automatically reminded of the need to progress such arrangements; and
- alert staff to the repeated reference to Mrs C as Mr C's mother in COPFS correspondence, remind staff of the sensitivity of such communications and the effects that such errors can have on grieving relatives.