



Fatal Accident Inquiry Review

Response to the Independent Review of Fatal Accident Inquiry's Call for Views.

September 2025

Who we are

Who Cares? Scotland is Scotland's only national independent membership organisation for Care Experienced people. Our mission is to secure a lifetime of equality, respect, and love for Care Experienced people in Scotland and we currently have around 2000 members.

At the heart of Who Cares? Scotland's work is the rights of Care Experienced people, and the power of their voices to bring about positive change. We provide individual, relationship-based independent advocacy, and a range of participation and connection opportunities for Care Experienced people across Scotland.

Every year, our advocacy workers support around 1,600 people with around 6,000 individual advocacy issues across all 32 Local Authorities in Scotland. As we take a human rights-based approach to our work, around 10,000 individual rights are logged every year in supporting these issues. We bring Care Experienced people together to connect and shape the world around them. Around 700 unique individuals come together every year to take part in around 800 of our activities across Scotland.

We work alongside Corporate Parents and various communities to broaden understanding and challenge stigma faced by Care Experienced people. We work with policy makers, leaders, and elected representatives locally and nationally to shape legislation, policy and practice. We do this collaboratively to build on the aspirations of The Promise and to secure positive change.

Summary

This consultation response provides an overview of statistics highlighting the increased mortality risk of Care Experienced children and young people and current duties on local authorities to investigate and report on these deaths.

Who Cares? Scotland is calling for:

 The Independent Review to assess whether a statutory duty to carry out a Fatal Accident Inquiry for every death of a child in care and young person eligible for aftercare would be an important and effective mechanism in identifying any patterns or practice contributing to these statistics and preventing future deaths.

Response to the consultation questions

Q1. Please summarise your experience of, or interest in, the Fatal Accident Inquiry system.

We are responding to this Call for Views to draw the Review's attention to the current overrepresentation of Care Experienced children and young people in Scotland's mortality statistics. We ask that the Review assess the role a statutory duty to carry out a Fatal Accident Inquiry (FAI) for these deaths could play in understanding this issue better and preventing future deaths.

Scotland has a higher mortality rate for under 18s than any other Western European country, with over 300 children and young people dying every year. The Care Inspectorate state that is estimated around a quarter of those deaths could be prevented. In England, FAIs are required when any child in care dies however Scotland does not have the same requirement. We are concerned that without a requirement to conduct a fatal accident inquiry, lessons and opportunities to offer justice to families and prevent future avoidable deaths are being lost.

While there exists a statutory requirement for local authorities to notify the Care Inspectorate and Scottish Government of such deaths, this data is not routinely or systematically analysed to produce recommendations or highlight patterns.² Although a learning review may be carried out as recommended by national guidance, this is not a mandatory process. A legal duty to carry out an FAI in these cases may help ensure accountability and a transparent systemwide commitment to learning and preventing future harm to Scotland's care experienced community.

Between April 2020 and March 2024, the Care Inspectorate received notification of the deaths of 30 looked after children and 56 young people who were in receipt of a continuing care placement or aftercare services.³ The majority of these deaths were young men aged 16–25, with over half reported as suspected suicides or drug-related. Investigative work by The Ferret echoes these findings, reporting that since 2021, 16 young people in the care system have taken their own lives or died from drug overdoses - the most common cause of death in this group.⁵ University of Glasgow research reported in 2021 that the mortality rate of Care

¹ https://www.careinspectorate.com/index.php/news/6331-reviewing-and-learning-from-the-deaths-ofchildren-and-young-people-in-scotland

² https://hub.careinspectorate.com/media/4370/national-guidance-when-a-child-or-young-persondies.pdf

³ https://www.healthcareimprovementscotland.scot/wp-content/uploads/2025/05/National-Hub-forreviewing-and-learning-from-the-deaths-of-children-and-young-people-data-release.pdf

⁴ https://www.healthcareimprovementscotland.scot/wp-content/uploads/2025/05/National-Hub-forreviewing-and-learning-from-the-deaths-of-children-and-young-people-data-release.pdf

⁵ https://theferret.scot/suicide-self-harm-cause-death-young-people-care/

Experienced children and young people was up to five times higher than the general population growing up without state involvement.⁶ These figures also echo what we know from our own informal networks across Scotland's Care Experienced community.

It is clear that there is an alarming rights issue here, which was also identified in 2023 by the UN Committee on the Rights of the Child following their inspection of the UK.⁷ On Article 6, the right to life, survival and development, the Committee's Concluding Observations recommended that the State Party:

- "(a) Urgently reduce infant and child mortality rates, including the reportedly high rates among boys in the overseas territories, and address the underlying determinants, especially poverty, discrimination and disability;
- (b) Conduct an independent inquiry into the unexpected deaths of children in alternative care, custody, mental health care and the military and ensure the regular collection and publication of disaggregated data on child deaths in all institutional settings;
- (c) Address the high rate of avoidable child deaths and strengthen efforts to prevent suicide and self-harming behaviour among children, including children in care, custody, health-care settings and immigration detention;".

One mother, Nina, is currently seeking a Fatal Accident Inquiry into the death by suicide of her Care Experienced son.⁸ According to The Ferret, her legal team has raised serious concerns about the circumstances surrounding his death and is awaiting a decision from the Crown Office following an ongoing investigation. The case highlights the distressing lack of clarity and accountability families often face after such tragedies, and reinforces the need for a consistent, mandatory process to examine the deaths of Care Experienced young people.

We ask the Review to assess whether a legal requirement to perform an FAI for every death of a looked after child or young person eligible for aftercare would be an important and effective mechanism in reducing these statistics. We believe this duty would increase accountability, the detection of systemic and personal factors that may have contributed to their deaths, and allow any recurring patterns or practice to be addressed in order to prevent failures from happening in future.

Should you wish to discuss the contents of this response, please contact: Policy and Public Affairs Team, policy@whocaresscotland.org.

⁶ https://www.gla.ac.uk/news/archiveofnews/2021/september/headline_811017_en.html

⁷ <u>UNCRC-Concluding-Observations.pdf</u> p6-7

 $^{^{8}\ \}underline{\text{https://theferret.scot/migrant-mother-cultural-bias-family-ripped-apart/}}$