SHERIFFDOM OF TAYSIDE, CENTRAL AND FIFE AT FALKIRK

[2026] FAI 44

FAL-B394-25

DETERMINATION

BY

SHERIFF SG COLLINS KC

UNDER THE INQUIRIES INTO FATAL ACCIDENTS AND SUDDEN DEATHS ETC (SCOTLAND) ACT 2016

into the death of

DAVID HOWSEGO

FALKIRK, 6 August 2026

Determination

The sheriff, having considered the information presented at the inquiry, determines in terms of section 26 of the Inquiries into Fatal Accidents and Sudden Deaths etc (Scotland) Act 2016 that:

In terms of section 26(2)(a): David Howsego, date of birth 14 April 2019 ("David"), was pronounced dead at Victoria Hospital, Kirkcaldy, at 0929 hours on 7 June 2019.

In terms of section 26(2)(b): David's death was not the result of an accident.

In terms of section 26(2)(c): the cause or causes of David's death cannot be ascertained.

In terms of section 26(2)(d): David's death was not the result of an accident.

In terms of section 26(2)(e): there are no reasonable precautions which (i) could reasonably have been taken, and (ii) had they been taken, might realistically have resulted in the death, or any accident resulting in the death, being avoided.

In terms of section 26(2)(f): there are no defects in any system of working which contributed to the death or any accident resulting in the death.

In terms of section 26(2)(g): other than the findings in fact set out below, there are no other facts relevant to the circumstances of the death which it is necessary or appropriate to record under this subsection.

Recommendations

In terms of section 26(1)(b): there are no recommendations made as regards reasonable precautions, improvement or introduction of a system of working, or the taking of any other steps, which might realistically prevent other deaths in similar circumstances.

NOTE

Introduction

[1] An inquiry was held into the death of David Howsego under the Inquiries into Fatal Accidents and Sudden Deaths etc (Scotland) Act 2016 ("the 2016 Act"). His death was reported to the Crown Office and Procurator Fiscal Service on or around 7 June 2019. A first notice of the inquiry was received on 29 October 2025. Preliminary hearings were held on 29 December 2025 and 2 March 2026. An evidential hearing was held on 9 April 2026. This was restricted to considering evidence relevant to trying to establish the cause of David's death, and hearing submissions on whether it was necessary or appropriate to hear further evidence in the light of this.

[2] At the evidential hearing a joint minute agreed between the participants was read into the record. Oral evidence was then led from the following witnesses: Aimie Davidson, Deon Howsego (David's mother), Dawn Penman and Sally Ann Collis (both consultant pathologists). The PFD then moved for a warrant to apprehend Aiden Hynd, the former partner of Deon Howsego, and to continue the inquiry to a further hearing for this purpose. Submissions were then made by representatives as to what finding the inquiry should make as regards the cause of David's death, and whether it was necessary or appropriate in the light of this to hear further evidence in order to conclude the inquiry. I then reserved my decision.

[3] The Crown was represented in the inquiry by Mr Nandan Goel, Procurator Fiscal Depute ("the PFD"). Deon Howsego, was represented by Mr Black, advocate. Fife Council, Ms Linda Shereet, and Ms Lesley Stevenson, social workers, were represented

by Ms Anderson, solicitor. Fife Health Board were represented by Ms Donachie, solicitor.

Legal framework

[4] This inquiry was held under section 1 of the 2016 Act. The purpose of a fatal accident inquiry is statutory. It is to establish the circumstances of the death and consider what steps (if any) might be taken to prevent other deaths in similar circumstances: section 1(3). It was not the purpose of the inquiry to establish civil or criminal liability: section 1(4). The PFD represented the public interest in the inquiry.

[5] The inquiry procedure was governed by the Act of Sederunt (Fatal Accident Inquiry) Rules 2017 ("the 2017 Rules"). These rules provide, in particular, that (a) an inquiry is to be inquisitorial, not adversarial, (b) is to be progressed expeditiously and efficiently, with as few delays as possible, (c) that taking account of its nature and complexity, the procedure is to be as flexible as possible, and the manner in which information is presented is to be as efficient as possible, and (d) that all participants are to be able to participate effectively in furthering the purpose of the inquiry: see 2017 Rules, Rule 2.2. These principles are to be taken into account by the sheriff in interpreting the Rules and in making any orders: Rule 2.3. The sheriff may make any order necessary to further the purpose of the inquiry: Rule 2.6. The procedure at preliminary hearings and the hearing of the inquiry is to be as ordered by the sheriff: Rules 3.8, 5.1.

[6] As soon as possible after the conclusion of the evidence and submissions in the inquiry, the sheriff must make a determination setting out findings on (a) where and when the death occurred, (b) when and where any accident resulting in the death occurred, (c) the cause or causes of the death, (d) the cause or causes of any accident resulting in the death, (e) any precautions which (i) could reasonably have been taken, and (ii) had they been taken, might realistically have resulted in the death or any accident resulting in the death being avoided, (f) any defects in any system of working which contributed to the death or any accident resulting in the death, and (g) any other facts which are relevant to the circumstances of the death: 2016 Act, section 26(1)(a), (2).

[7] The sheriff must also make such recommendations (if any) as are considered appropriate as to (a) the taking of reasonable precautions, (b) the making of improvements to any system of working, (c) the introduction of any system of working, and (d) the taking of any other steps, which might realistically prevent other deaths in similar circumstances: 2016 Act, section 26(1)(b), (4).

Facts

David's birth

[8] David was born to Deon Howsego (born 3 March 2001) on 14 April 2019 ("Deon"). Colin Boyle is the putative biological father of David. Aiden Hynd was the partner of Deon at the time of David's birth ("Aiden").

[9] David was born at the Victoria Hospital, Kirkcaldy. He was born prematurely at 37 weeks, 4 days. He weighed 2300 grams at birth. He had a cleft palate, no uvula, a tongue tie, and associated difficulties with feeding arising therefrom.

[10] David remained in hospital after birth due to his cleft palate and the associated issues with feeding arising therefrom. There were also concerns about smoking during the pregnancy.

Social work involvement with David's mother prior to his birth

[11] Deon has one other child (born 2017) who was removed from her care at 5 weeks old. She had monthly supervised contact with that child. At a Looked After Child Review in respect of that child on 10 December 2018, Deon advised that she had a 19 week scan and that her unborn baby (David) was assessed to have a cleft palate. It was noted that further assessment was required as to Deon's ability to care for her unborn baby.

[12] During pregnancy Deon contracted influenza and pneumonia and records show a suspected early rupture of the membranes in January 2019. This was later established not to be the case.

[13] Deon's relationship with Colin Boyle broke down prior to David's birth. Deon mentioned to a health visitor an incident of physical assault by him, alleged to have occurred in October 2018. This incident does not appear to have been reported by Deon to the police. The health visitor's record of this discussion is undated.

[14] Deon commenced her relationship with Aiden whilst pregnant with David.

[15] In October 2018, police attended at Deon's home address on two occasions due to reports of antisocial behaviour. It was noted that she was pregnant, and as a result Police Scotland referred her to Family Health Services within the NHS.

[16] On 19 October 2018 Fife Council Social Work Team were contacted for the first time by Police Scotland who informed them of Deon's pregnancy. A child well-being meeting was arranged by the family health midwife to take place on 30 January 2019. This was attended by Fife Council Social Work, Deon, Aiden, a support worker from Fife Gingerbread and the family health midwife for NHS.

[17] A Child Protection Case Conference was held by the social work department of Fife Council on 18 March 2019. The conference was attended by Police Scotland, Fife Council Social Work, family health midwife, foetal medicine midwife, cleft lip and palate nurse, housing access officer, Fife Gingerbread, Deon and her sister. The outcome of the conference was a decision to place David's name on the Fife Council Child Protection Register.

[18] On 9 April 2019, an entry was recorded noting a recommendation by Fife Council Social Work that David be accommodated with foster carers at the point of discharge from hospital. As at this date, Deon had not yet decided if she would sign an agreement under section 25 of the Children (Scotland) Act 1995 to facilitate this. It was noted that if Deon did not sign the section 25 agreement, then a Child Protection Order (CPO) would have to be applied for.

Social work involvement with Deon and David after his discharge from hospital

[19] On 24 April 2019 a joint discharge planning meeting and a core group meeting took place. In advance of this meeting Deon signed the section 25 paperwork. David was subsequently discharged from hospital to foster carers on 29 April 2019.

[20] It was agreed with social workers that following David's discharge from hospital Deon and Aiden would have 4 to 5 hours of daily contact with him at the foster carer's residence.

[21] On 9 May 2019 it was agreed that Deon could have contact with David at her home address too. She had unsupervised contact with David at home address on Monday 13 May and Friday 17 May 2019, from 10.00am to 3.00pm. Social workers visited to assess her at home with David. These home visits were in addition to the supervised contact at the foster carers' home, which took place on Tuesday 14 May, Wednesday 15 May, and Thursday 16 May 2019.

[22] Social work records relative to these visits note that Deon was attuned to David and his needs and responding to his cues. Both Deon and Aiden were noted to be interacting well with David. It was agreed that Deon should have an overnight stay with David at her home address on 20 May 2019.

[23] During a visit to Deon and David on 20 May 2019 Deon informed the social worker of her desire for David to remain in her care with immediate effect. The social worker discussed this with Deon and recommended that she did not revoke her agreement under section 25, but continue with the scheduled plan, which was for Deon

to have more overnight stays with David at her home to allow for a period of adjustment.

[24] On 21 May 2019 Deon contacted Fife Council Social Work by telephone to inform them of her decision to discontinue the section 25 agreement. Social work records show Deon being advised against it. It was recorded that there was no basis for a Child Protection Order to be applied for and additional visits would be carried out and a more comprehensive plan put in place.

[25] Between 22 May and 7 June 2019 Deon and David were visited by a number of agencies to check on David's progress. In particular they were visited by social workers and the health visitor. Deon and David were seen by social workers on 22 May, 23 May, 24 May, 27 May, 28 May, 29 May, 30 May, 3 June, 4 June and 6 June 2019. They were seen on 27 May and 6 June 2019 by the health visitor.

[26] On Thursday, 23 May 2019 Deon missed a scheduled health visitor appointment. She spoke to the health visitor on the phone the same day to rearrange the visit for Monday, 27 May 2019. This rescheduled visit took place.

[27] On 24 May 2019 Deon took David to accident and emergency with suspected eczema. As a result of being at the hospital a scheduled social work appointment could not go ahead. Deon contacted the social worker by phone to inform them of this and to rearrange the appointment to 27 May 2019. This rescheduled visit took place.

[28] On 29 May 2019 Deon missed a GP appointment for David. This appointment was not rescheduled. The GP contacted the health visitor to inform them. They in turn

contacted social work who made contact with Deon. The social worker termed this as a "significant concern".

[29] Social workers noted that Deon's residence required cleaning and organising on a number of visits. Deon was advised on how to maintain a clean environment for David.

[30] At the Child Protection Core Group meeting held on 28 May 2019 it was agreed that David would remain on the child protection register. The minute of the meeting notes that:

> "Those present agreed that services would continue to support David at home, it was early days and there were worries about engagement and feeding however there was no view expressed about David being removed from his mother's care at this stage. However, the expectation was that a referral would be made to the reporter should the engagement not improve and be sustained - this will be discussed at the RCPCC (Review Child Protection Case Conference) on 11 June 2019. However should the situation deteriorate prior to then further discussions will take place with regard to the care offered to David by his mother and partner and alternatives that may be required."

[31] Actions were then put in place including that professionals were to remain in contact with each other, social work was to visit at least weekly, health was to follow up with Deon on feeding and the change of David's milk with guidance to be given on feeding instructions, and a discussion was to take place with Deon and Aiden about meaningfully engaging with staff and what might happen if they failed to comply.

The events of 6 and 7 June 2019

[32] Aimie Davidson ("Aimie") was a good friend of Deon. She was 16 years old. She visited Deon in her home almost every day in the period when David was living

there after 20 May 2019. To her inexperienced eyes, David mostly appeared healthy and happy. She saw Deon caring for David, feeding him, changing his nappy, and picking him up when he cried.

[33] On the evening of 6 June 2019 Deon, Aiden and David were in Deon's home. Aimie was also present. They were all in the living room. Deon, Aiden and Aimie were watching television and smoking cannabis.

[34] At around 0200 hours on the morning of 7 June 2019 Deon and Aiden decided to go to bed. Deon took David with her to the bedroom. Aimie remained in the living room. Around 0215 hours Deon called through to Aimie and asked her to come and look after David for a while as she was tired.

[35] Aimie came into Deon's bedroom. In the room was a double bed and a bouncy child's chair beside it. Deon and Aiden were in the bed. Deon was holding David. She gave him to Aimie who took him back to the living room.

[36] At around 0400 hours Aimie took David back through to the bedroom. David was crying and she was unable to settle him. She thought that either David's nappy needed changing or he needed to be fed a bottle of milk.

[37] Deon and Aiden were both in bed, awake. Aimie asked them for a nappy and to make a bottle of milk for David. Deon said that she and Aiden would just keep David with them in the bedroom. Aimie handed David over to Deon and went back to the living room and fell asleep.

[38] Some time later Aimie was woken by Aiden. He had come into the living room shouting and screaming. He was crying. He said "Aimie you need to come. David's

dead". Aimie went through to the bedroom. Deon had David in her arms. She was standing up at the bed, also shouting and screaming.

[39] David's skin was purple in colour and he was not breathing. There was some fresh blood round his mouth and on the bed.

[40] Deon took David and went to her upstairs neighbour for help. Aimie went too. None of them knew what to do. Aimie phoned for an ambulance at around 0838 hours. She was told by the call handler to do CPR on David. Deon attempted to do CPR but without success.

[41] Police and paramedics later arrived. David was taken by the paramedics to Victoria Hospital in Kirkcaldy. His life was pronounced extinct there at 0929 hours on 7 June 2019.

Post-mortem examination

[42] A post-mortem examination was carried out on 11 June 2019 by Dr Dawn Penman, consultant paediatric and perinatal pathologist and Dr Sally Anne Collis, consultant forensic pathologist. They produced a final report dated 15 April 2020. They certified the cause of David's death as "unascertained".

[43] No clinical or pathological signs to identify the cause of David's death were detected during his post-mortem examination.

[44] David was found to be a small baby, with his height (51.9 centimetres) and weight (3900 grams) at time of death. This placed him around the 9th percentile, adjusted to reflect prematurity of his birth.

[45] At the time of his death David had a rash on his body, most prominent on his chest and abdomen. This rash could have been scabies, but despite analysis could not be confirmed as such. The cause of it is unknown. David also had nappy rash around his groin area, which is not uncommon in small infants.

[46] There were no other signs found by the pathologists which might have indicated a lack of parental care.

[47] David's death could have been due to Sudden Unexpected Death in Infancy ("SUDI"), though equally it could have been due in part or wholly to co-sleeping. Both were possible. Pathologically it is not possible to say that one was more probable than the other.

[48] SUDI is not a diagnosis, nor a cause of death. Rather it is a label to describe the death of an infant where there are no clinical or pathological signs on post-mortem examination to enable a cause of death to be established.

[49] There are a number of non-modifiable and modifiable factors which are associated with increased frequency of SUDI. Non-modifiable factors include young age, weight, male gender, and background medical conditions (including cleft palate). Modifiable factors include smoking, drug and alcohol use in the household and/or the child sharing a bed with an adult.

[50] The association between such factors and SUDI does not mean that they cause an infant to suddenly die. It means that if an infant suddenly dies and the cause of death cannot be explained there is a statistically higher chance that one or more of these factors will be present.

[51] Co-sleeping is not a diagnosis, nor a cause of death. Rather it is a label used to describe the death of an infant where, due to it sleeping in a bed with a parent or parents, it has been accidentally asphyxiated.

[52] Accidental asphyxiation in co-sleeping can arise because the infants breathing is accidentally obstructed by movement over their nose and mouth of an adult's body or arm, bedding, or other object. The infant will lack the learned reflex and muscular ability to remove or move away from the obstruction. The adult may be asleep and so unaware that they are causing the obstruction.

[53] Where an infant dies due to asphyxia, it is possible that on post-mortem examination there will be signs of external petechiae on the skin, petechial haemorrhage in the eyes, or haemorrhage in the lungs.

[54] There were no signs of external petechiae on David's skin, petechial haemorrhage in his eyes, or haemorrhage in his lungs.

[55] But while the presence of such signs will point towards asphyxia as the cause of death, the absence of them cannot rule it out. That is because the degree of physical or mechanical obstruction required to stop a very young child from breathing is less than in the case of an adult. Accordingly the pressures generated by the child to overcome the obstruction may be insufficient to cause haemorrhaging.

[56] Although David had a cleft palate, and no uvula, these did not place him at higher risk of asphyxia.

[57] Although blood was seen around David's mouth at the time of death, this is nearly always present in cases of infant death due to hypoxia from any cause. It does

not indicate that the infant has been injured. It does not establish nor make more probable that death resulted from asphyxia than that it falls to be categorised as SUDI.

[58] The cause of David's death cannot be ascertained. It is as likely to have been from natural as from unnatural causes.

Discussion

[59] This was a discretionary inquiry under section 4 of the 2016 Act, not a mandatory inquiry under section 2. Accordingly it was only held because the Lord Advocate considered that David's death occurred in circumstances giving rise to serious public concern and that it was in the public interest for an inquiry to be held into the circumstances of it: section 4(1). Yet although David died on 7 June 2019, the Crown did not apply for a first order until 29 October 2025, nearly 6½ years later. At a meeting in chambers on 7 November 2025, under Rule 3.2(2) of the 2017 Rules, I queried why, if there was such concern and public interest in holding an inquiry, there had been such a long delay in initiating it. No good explanation was given, then (see paragraph 2 of the note to the order of 10 November 2025 - Appendix 1 to this determination) or at any later stage.

[60] At the meeting on 7 November 2025 I also expressed concern to the PFD concerning the evidence in relation to the cause of David's death, and the consequences that this might have for any findings or recommendations which the inquiry could or should make (see paragraphs 3 and 4 of the note of 10 November 2025). I repeated these concerns at the preliminary hearings on 29 December 2025 and 2 March 2026 (see the

notes to the orders following these hearings – Appendices 2 and 3). In the first place, the cause of David's death had been certified as "unascertained" in the post-mortem report of 15 April 2020. This was on the ground that given their findings the pathologists considered that death by accidental asphyxiation through co-sleeping, or by sudden unexplained death in infancy, were equally likely. No other possible cause of David's death could be identified by them. In the second place, it became apparent that the Crown had refused to grant immunity from prosecution to Deon or Aiden, notwithstanding that they were the only direct witnesses to the death. That had the almost inevitable consequence that they would decline to answer any questions at an inquiry regarding the circumstances of David's death: 2016 Act, sections 20(5), (6). This would mean that as a result of Crown's decision on immunity the court would likely be deprived of the only other sources of evidence which might assist it in deciding which of the two possible causes of death suggested by the pathologists was the more likely.

[61] The PFD accepted, from the time of the meeting on 7 November 2025, that if the cause of death really could not be ascertained, then there were obvious difficulties in making any findings under section 26(2)(e) or (f) of the 2016 Act, let alone recommendations under section 26(1)(b) and (4). He submitted then, as he did later, that findings could nonetheless be made under section 26(2)(g) in relation to the actions of Fife Council Social Work Department. I expressed my concern that attempting to do so might face a similar conceptual difficulty, but that in any event it might be difficult to understand the appropriateness of doing so, particularly at more than 6 years removed from the death, and in circumstances where no clear reason had been provided by the

Crown for the delay (again, see the note to the first order of 10 November 2025, paragraphs 2, 4).

[62] At the preliminary hearing on 2 March 2026, and notwithstanding these concerns, the PFD moved the court to fix a hearing on all issues in the inquiry, of 1½ to 2 weeks duration. He maintained that the court could and should inquire into the actions of Fife Council's Social Work Department even if the cause of David's death could not be ascertained. I refused that motion. I considered that the most expeditious and efficient way to progress the inquiry (cf 2017 Rules, Rule 2.2(2), (3)) was to fix a 1-day hearing initially, restricted to hearing all the evidence bearing on the cause of David's death, and then to invite submissions on further procedure. I considered, without deciding the issue, that if the cause of David's death could not be ascertained there was at least a real question as to whether it would then be appropriate in the public interest to proceed to inquire into the actions of the social work department. If it was, then a further evidential hearing could be arranged. But if not, then the inquiry could more quickly concluded, and with a considerable saving in court time and cost, all participants in the inquiry being publicly funded (see order of preliminary hearing of 2 March 2026, at paragraphs 6a and f - Appendix 3).

[63] The evidential hearing was ultimately (re)fixed for 9 April 2026 to suit witness availability. By that time the participants had helpfully agreed and signed a lengthy joint minute of agreement in terms of Rule 4.10 of the 2017 Rules. This was read into the record by the PFD at the outset of the hearing. Aside from the basic facts of the times and dates of David's birth and death, the minutes agrees the circumstances of Deon's

involvement with Fife Council Social Work Department prior to and after David's birth and during his short life. Some of what is agreed is simply the content of the social work records. However there is sufficient to show that Fife Council had been involved with Deon since 2017, that they were aware of her pregnancy, that they had significant concerns for her ability to care for David after his birth, and that they would have sought a CPO if she had not signed a section 25 agreement to facilitate his discharge from hospital to foster carers on 29 April 2019. It is also agreed that the records, at least, indicate that when Deon revoked the section 25 agreement on 20 May 2019 consideration was given to applying for a CPO, but that it was not considered that there were sufficient grounds to do so. Instead, a plan of almost daily visits by social workers and health workers was proposed, and apparently then carried out. While Deon missed a GP appointment on 29 May 2019, there were other agreed facts indicating that she was engaged with social work services in relation to care of David.

[64] I do not regard Rule 4.10 minutes of agreements as binding on a fatal accident inquiry (see for example, the determinations of the inquiries into the deaths of *Katie Allan and William Brown* [2025] FAI 6 at paragraph 23; and *Shea John Ryan* [2025] FAI 31 at paragraph 30), as they would be binding on the court in a civil action (see for example *B* v *Authority Reporter for Edinburgh* 2012 SC 23 at paragraph 14). Their purpose in an inquiry, and the nature of the proceedings, are quite different. But in this case I was content to accept the facts agreed in the minute in relation to Fife Council Social Work Department's involvement with Deon and David, and have largely incorporated these into the findings in fact set out above.

[65] Collectively, these findings present a picture in which social work clearly had reasons to be concerned about Deon's ability to care for David after 19 April 2019, and in which it took a number of actions in relation to those concerns. There is enough to indicate that at times prior to David's death there was a judgment call for social workers to make as to whether to apply to the court for a CPO. Conceivably, making such an application might have been a reasonable precaution for the purposes of section 26(2)(e) of the 2016 Act, even so the social workers could not have been said to have been negligent in failing to apply. That is because section 26(2)(e) is concerned with what could have been done, not what ought or should have been done: *Duncan* v *Lord Advocate* 2026 SC 30, paragraphs 57 to 63. But a finding under section 26(2)(e) requires not only that there was a reasonable precaution which could have been taken, but that had it been taken it might realistically have resulted in the death being avoided. That requires, in the present case, a causal connection between the failure to seek a CPO, and David's death. In the first place such a causal connection would require a finding that, if a CPO had been applied for, it would have been granted. In the second place, it would require a finding that David did not die from natural causes, or it would not have mattered whether or not he was in Deon's care at the time of his death. This second finding (in particular) would have to be made on a balance of probabilities, not whether there was a realistic possibility of it: see the determination of the inquiry into the death of *Jack Mackenzie* [2025] FAI 24 at paragraphs 162 to 166.

[66] Against the background of the agreed facts, the inquiry heard first from Aimie Davidson, a friend of Deon who had been in the house at the time that David had

died. Ms Davidson was only 16 years old at the time. I consider that she did her best to tell the truth, but inevitably the passage of time had impaired her memory of events. In the main she was willing to adopt the statement which she had given to the police shortly after David's death. And the findings in fact which I have made in relation to the events of the night of 6 June and morning of 7 June 2019 are largely derived from her evidence. There were other things she said which I did not feel able to make findings about. She said that following David's death both Deon and Aiden had blamed each other for it. However the reasons for these allegations were unclear, and at least some of what she had heard was obviously through neighbourhood gossip.

[67] Thereafter Deon was called to give evidence. She appeared fragile and nervous. I sought to reassure her and encourage her regarding the purpose of the inquiry. But I also sought to make clear, as I had to, that she was not required to answer any question which might incriminate her. She gave her name and other basic details, and was respectful to the court, but refused to answer any questions thereafter. As her counsel confirmed, this was done on his advice. This was entirely predictable, standing the refusal of the Crown to grant her immunity from prosecution in relation to David's death. In particular Deon refused to confirm that she had given the statement to the police which had been produced by the Crown, let alone to adopt it. Its contents were not agreed, no attempt was made to lead evidence from the police officer who took it, and no motion was made to have it entered into the evidence by any other manner by virtue of Rule 4.1(4) of the 2017 Rules. Its contents were therefore not put in evidence in the inquiry. Even if Deon's statement had been put in evidence, there would have been

obvious questions about the extent to which it could be relied on in the absence of her oral evidence.

[68] The next witness was Dr Dawn Penman. Dr Penman is a consultant paediatric pathologist of around 17 years' experience. She has conducted many hundreds of post-mortems on children, at the request of both hospitals and the Crown. Along with her colleague Dr Sally Anne Collis she had carried out the post-mortem on David on 11 June 2019. They produced a final report dated 15 April 2020. They certified the cause of David's death as "unascertained". Dr Penman explained that no clinical or pathological signs to identify the cause of David's death were detected during his post-mortem examination. Dr Penman's opinion, then and now, was that David's death could have been due to SUDI, though equally it could have been due in part or wholly to co-sleeping. Both were possible. Pathologically it was not possible to say that one was more probable than the other.

[69] Dr Penman explained that SUDI is not a diagnosis, nor a cause of death. Rather it is a label to describe the death of an infant where there are no clinical or pathological signs on post-mortem examination to enable a cause of death to be established. She also explained that co-sleeping is not a diagnosis, nor a cause of death. Rather it is a label used to describe the death of an infant where, due to it sleeping in a bed with a parent or parents, it has been accidentally asphyxiated by part of the parent's body while asleep or by bedding. There were no signs of external petechiae on David's skin, petechial haemorrhage in his eyes, or haemorrhage in his lungs. The presence of such signs would indicate asphyxia as the cause of death, but Dr Penman explained that the

absence of such signs in a young child did not rule it out. Although David had a cleft palate, and no uvula, these did not place him at higher risk of asphyxia. Although blood was seen around David's mouth at the time of death, Dr Penman said that this is nearly always present in cases of infant death due to hypoxia from any cause. It did not indicate that David had been injured. It did not establish nor make more probable that death resulted from asphyxia than that it fell to be categorised as SUDI.

[70] Dr Penman was an excellent witness. Her experience and expertise was evident, as was her grasp of the details of the case. She properly resisted invitations to offer opinions outwith her field of expertise. She was able to explain and clarify many details of her report, and why she had reached the conclusion as to cause of death which she did. She did not deviate from that conclusion. In her opinion, on the pathological signs found, accidental asphyxiation as a result of co-sleeping and SUDI were equally likely causes of David's death. It was not pathologically possible to say, even on balance of probabilities, that one was more likely than the other. I had no hesitation in accepting Dr Penman's evidence and have made findings in fact accordingly.

[71] The final witness led was Dr Sally Anne Collis. Given that she was junior to Dr Penman at the post-mortem, and that Dr Penman had addressed the issues in their report in detail, Dr Collis' evidence was in shorter compass. In substance however she too confirmed that she still adhered to the conclusion in the report, that the cause of David's death could not be ascertained. She confirmed that her opinion remained that co-sleeping and SUDI were equally likely, and it was not possible even to say that

co-sleeping was 51% to 49% more probable. Again, I had no hesitation in accepting Dr Collis evidence, although in substance she added little to Dr Penman's evidence.

[72] Thereafter the PFD proved me to grant a warrant for Aiden's apprehension, and to adjourn the inquiry to enable him to be apprehended. Aiden had not sought to become a participant in the inquiry. However he had been cited to appear at the hearing on 9 April 2026. Having then failed to attend, he was contacted by phone by a member of staff from the PFD's office. Aiden was said to have said that he had run out of money and had no valid bus pass. There was no vouching for the truth of this statement. Aiden had not been given immunity from prosecution in relation to David's death. It was not known whether he had sought any legal advice in connection with giving evidence to the enquiry. If not, the PFD accepted that he would have to be given the opportunity to do so. He also accepted that any responsible lawyer would advise him to refuse to answer any questions which might incriminate him. It was accepted that the inquiry would also have to advise him of this right. The PFD therefore accepted that it was very likely that even if forced to attend Aiden would refuse to answer any questions, but submitted that this could not be known until they had been asked. However even if he did refuse to answer, this would not affect the Crown's position in the inquiry.

[73] Mr Black, on Deon's behalf, indicated that he was essentially neutral on the Crown motion for a warrant. He accepted that was a matter for the discretion of the court. He also agreed, in effect, that in the circumstances the only reasonable legal advice which could be given to Aiden would be to refuse to answer any questions for

risk of incriminating himself. That was the advice that he had given to Deon, and she had acted on it when called to give evidence earlier in the day. Accordingly the practical effect of granting a warrant and continuing the enquiry for the purpose of securing Aiden's attendance would likely be that matters would not be taken any further forward. Ms Anderson, solicitor, for Fife Council, associated herself with Mr Black's submissions. Ms Donachie, solicitor for Fife Health Board, had nothing to add to what had already been said.

[74] I refused the Crown motion for a warrant for Aiden. If such a warrant had been granted, and he had been compelled to appear before the inquiry, then given the Crown's refusal to accord him immunity from prosecution in connection with David's death it was highly likely that he would refuse to answer any questions, as Deon had earlier done. He would have to be given the opportunity to obtain legal advice in relation to that, and any responsible legal advice would be to the effect that he should say nothing. As Mr Black submitted, granting a warrant and adjourning in order to execute it would therefore likely not advance matters. There had already been a very lengthy and unexplained delay by the Crown in bringing the inquiry. I was satisfied that the further delay that would inevitably be involved in granting and executing a warrant, for no likely practical benefit, would not be in accordance with the inquiry principles, and in particular the need to progress it as expeditiously and efficiently as possible: 2017 Rules, Rule 2.2(2), (3).

Submissions

[75] I therefore invited the participants, as per the procedure which I had outlined at the outset, to make submissions (i) on what finding the inquiry should make as regards the cause of David's death for the purpose of section 26(2)(c) of the 2016 Act, and (ii) what the further procedure in the inquiry should be in the light of this.

[76] In this regard the PFD submitted that the pathologists could not differentiate between SUDI and co-sleeping. He therefore invited the inquiry to find that the cause of David's death was unascertained for the purpose of section 26(2)(c) of the 2016 Act. However he submitted that the inquiry should hear further evidence regarding alleged failures by Fife Council Social Work Department in relation to the care of David prior to his death. He submitted that it was in the public interest to do so, and that the Crown had initiated the inquiry for this purpose.

[77] The PFD accepted that even if this further evidence was led, the inquiry would not be in a position to make any findings under sections 26(2)(e) or (f), nor to make any recommendations under section 26(1)(b). However it would be able to make finding under section 26(2)(g). The Crown anticipated inviting the inquiry to make three findings under this subsection: (i) that Fife Council should have had a multiagency discussion as to whether to apply for a CPO immediately after Deon revoked the section 25 agreement on 20 May 2019; (ii) that Fife Council should at the same time have reviewed their 6 month plan for Deon to ease into taking care of David; and (iii) that having decided on 9 April 2019 to apply for a CPO if Deon did not sign a section 25

agreement prior to David's discharge from hospital, Fife Council then failed to apply for a CPO when Deon later revoked the section 25 agreement on 20 May 2019.

[78] The PFD submitted that in relation to these matters he wanted to explore what he said were discrepancies in Fife Council's social work records, and in particular to investigate a backdated entry (relating to whether consideration was indeed given to applying for a CPO) which was not made until after David's death. The PFD did not dispute that his proposed findings all related to particular actions or inactions by particular social workers in the particular circumstances of David's case, rather than raising any more general issues of practice or procedure by Fife Council. He estimated that a further week and a half of court time would be required.

[79] Mr Black submitted that in the light of the evidence it was inevitable that the inquiry would conclude that the cause of death was unascertained. The pathological findings, at best, were indicative of hypoxia. But they could not point one way or the other as to whether the death was because of asphyxia caused by co-sleeping, or fell to be categorised as SUDI. The factual evidence which the court had did not enable a more considered view of these matters, given the position which the Crown had taken (in not according immunity from prosecution to Deon and Aiden).

[80] As to future procedure, Mr Black questioned whether there was any significant public interest in hearing evidence about Fife Council's social work practices and decision making some 7 years ago. There could be no benefit to the public as regards preventing deaths in the future where the Crown came to court with no positive submission as to recommendations which ought to be made. The findings which were

sought under section 26(2)(g) would only apply to this case, and would set up no recommendation that could be carried forward.

[81] Insofar as the Crown proposed to investigate whether social workers should have considered applying for a CPO, Mr Black submitted that it should be remembered what it had agreed at paragraphs 19, 20 and 24 of the joint minute. These paragraphs agreed records which showed that active consideration had been given to whether to apply for a CPO after Deon had revoked the section 25 agreement, that it was decided that there were no good grounds to do so, and that increased visits were directed and carried out as an alternative. The Crown position amounted to a speculative inquiry with a view to saying that the social workers just got it wrong. But even if a CPO had been applied for, it was not clear that it would have been granted. And in any event, it was not possible to say that even if granted a CPO would have affected the outcome - because the cause of David's death was unascertained. So the Crown position led nowhere. There was no compelling reason why the court should hear a further week or more of evidence where the Crown sought no recommendations which would now benefit the public. The court should make formal findings and leave the matter there.

[82] Ms Anderson, for Fife Council, echoed and adopted Mr Black's submissions. The inquiry should find that the cause of David's death was unascertained. Given the Crown decision to refuse immunity from prosecution to Deon, the only evidence about cause of death came from the pathologists. And their evidence was that there was an equal probability that David's death was from natural causes, that is, SUDI.

[83] This was critical, submitted Ms Anderson. In other inquiries sheriffs had made findings notwithstanding that the precise cause of death had been unascertained. Reference was made to the determinations of the inquiries into the deaths of *Declan Hainey* [2014] FAI 25, *Doris Margaret Gilchrist* [2017] FAI 8, and *Yvonne Anne Robson* [2023] FAI 20, all produced and relied on by the Crown. But in all of these cases, submitted Ms Anderson, it was clear that the death was not due to natural causes. The vast majority of deaths from natural causes did not lead to (non-mandatory) Fatal Accident Inquiries being convened. That was because a natural death, being unavoidable, was unlikely and incapable of leading to substantive findings, for example, under section 26(2)(e), as to reasonable precautions by which it could have been avoided. That was also the position in the present case, as on the evidence of the pathologists the court could not say on balance of probabilities that David's death was unnatural.

[84] So, submitted Ms Anderson, Mr Black had been correct to say that the case ultimately led nowhere as regards being able to make a determination to assist the public interest. And it was of concern that so much court time was being incurred, with all parties funded from the public purse, so many years after the death, when it was unclear what benefit to the public interest could be derived. The Crown did not seek recommendations to be made. It did not even seek to establish a causal link between the alleged failure to seek a CPO and the death, that is, it did not seek to show that if granted a CPO would have prevented David's death. Nor could it, on the evidence as to cause of death. It was a matter for the court to determine further procedure as deemed

appropriate and necessary. It should reach formal findings and issue a determination without the need to hear further evidence.

[85] Ms Donachie, for Fife Health Board, who had a watching brief only, had no submissions to make.

[86] In response, the PFD referred to the determination of the inquiry into the death of *Robert Allan* [2023] FAI 32, for the proposition that there was no requirement for facts under section 26(2)(g) to have a causal connection with the death, as this provision was wider in scope and applied to any matter legitimately being examined in an inquiry where it appeared to be in the public interest. He submitted that there were serious contradictions in the social work records, not mere inaccuracies. As regards the cause of David's death, he then sought to refer to statements of other witnesses. However these witnesses had not been called by the Crown, and the content of their statements had not been agreed. Accordingly the PFD accepted that these statements were not evidence before the inquiry. Finally the PFD pointed out that the entry in the social work records referred to by Mr Black, and agreed in paragraph 20 of the joint minute, was the backdated entry the veracity of which he had questioned earlier.

Conclusions

[87] It will likely be a rare case where a fatal accident inquiry is truly unable to make a finding as to the cause or causes of death for the purposes of section 26(2)(c) of the 2016 Act. That the pathologists have concluded that cause of death cannot be ascertained based on post-mortem examination is not unheard of, but is not conclusive.

As Dr Penman explained, her opinion is and must be based solely on the pathology. But in most cases there will also be some other evidence as to the facts and circumstances of the death which will enable the court to say, on balance of probabilities, that it was likely caused by one mechanism or another. In particular, there will generally be evidence sufficient to at least enable the inquiry to positively conclude that the death was not from natural causes. For if that cannot be done, then it is hard, as Ms Anderson submitted, to see a good basis for a discretionary fatal accident inquiry under section 4 of the 2016 Act. Put another way, it is hard to see why it would be in the public interest to inquire into the circumstances of a death from natural causes. That would be to fail to properly recognise one of the statutory purposes of a fatal accident inquiry, which is to consider what steps (if any) might be taken to prevent other deaths in similar circumstances: 2016 Act, section 1(3)(b). But if it cannot be established that the death was not from natural causes, then it is hard to see that any such steps could properly be identified.

[88] In that context I have considered the various determinations in other fatal accident inquiries lodged by the Crown and on which reliance was placed in the course of submissions. As each inquiry will, to a large extent, turn on its facts, limited assistance can be gained from them. And insofar as the sheriffs do bear to state matters of general principle - and with all due respect - their views are not binding on me any more than mine are on them. As a matter of generality, however, I accept Ms Anderson's submission that an important difference between this case, and those of *Declan Hainey*, *Doris Margaret Gilchrist*, and *Yvonne Anne Robson*, is that in none of those

cases was the sheriff unable to find that the death was not from natural causes. The causes of the deaths were found to be wholly or partially unascertained, but it was clear from the determinations as a whole that they resulted from a cause or causes which, although they could not be precisely identified, could not have been natural. There was thus a public interest in inquiring into the circumstances and considering what if any steps might be taken to prevent other deaths in similar circumstances.

[89] Accordingly in the determination relating to the death of *Declan Hainey*, although the precise mechanism of death could not be ascertained, the sheriff was satisfied that "prolonged neglect" on the part of his mother was "at least a contributory factor" to it. The sheriff rejected the submission that she was, in effect, bound by the terms of the post-mortem to find the cause of death to be wholly unascertained. This was because she had other evidence sufficient to satisfy her that it was not (see the sheriff's note, "Preliminary Matters", paragraph 1). She might perhaps equally have found (for the purpose of what would now be section 26(2)(c) of the 2016 Act) that prolonged neglect, having made a material contribution to the death, was therefore either the "cause or causes" of it. Such a reading of section 26(2)(c) would have emphasised a broad approach to causation, in keeping with seeking to achieve the statutory purpose of a fatal accident inquiry already mentioned. But in any event it is clear from the whole determination that the sheriff was satisfied that the death had been unnatural, that there were reasonable precautions by which it might realistically have been avoided, and that there were systemic defects in social work practice which contributed to it. That was not the Crown's position in the present case.

[90] Similar issues arose in relation to the determination of the inquiry into the death of *Doris Margaret Gilchrist*. In relation to the cause of death, the sheriff found that it "was unascertained but hot water scalding was a significant contributory factor". The position was that Ms Gilchrist had a severe learning disability, was blind, and required 24/7 care. She was left alone by a carer in a bath for around 30 minutes, and then found dead, with the hot tap running. Although the pathologists certified the cause of death as unascertained, their evidence was that it was most likely by scalding, there being post-mortem evidence of this. The only other possible causes - drowning and an epileptic seizure - were rejected by the sheriff (see his conclusions at paragraphs 14 and 15). As he also found that Ms Gilchrist could not have operated the tap herself, he determined, in substance, that her death was unnatural, leading to inquiry into whether the carer had left the hot tap running, or it had been faulty. Again, on a broad approach to causation for the purpose of (what is now) section 26(2)(c) of the 2016 Act, it might perhaps have been said that to find that water scalding was a "significant contributory factor" to the death was in substance to find that it was at least one of the "causes" of it. But in any event the sheriff was clearly persuaded that there was sufficient causal connection between the death and both reasonable precautions and systemic defects to enable him to make non formal findings. It is also noteworthy that this was another case where the Crown refused to grant Ms Gilchrist's carer immunity from prosecution, and she refused to answer any questions at the inquiry. But unlike in the present case there was sufficient other evidence available to enable the sheriff to make the finding on causation that he did.

[91] In the determination relating to the death of *Yvonne Anne Robson* the sheriff found in terms of section 26(2)(c) of the 2016 Act simply that "the cause of death… [was] unascertained". He found that Ms Robson suffered from severe mental illness with suicidal ideation and was admitted to and treated in hospital. She attempted suicide and was given further treatment. She was later given a day pass, and drove herself away from the hospital. Her car was later found on fire, and her body was in the driver's seat. Given the extent of fire damage it was not possible to determine the cause of the fire, but there was evidence that the most probable cause was self-ignition. The post-mortem report concluded that the cause of Ms Robson's death was unascertained. This is not further discussed (possibly out of sensitivity to her relatives), but it seems plausible that the pathologists' finding was a consequence of the severely burnt state of Ms Robson's body at the time of examination, and the consequent inability to determine the precise mechanism of death. But it is clear from considering the whole determination that the sheriff must have been satisfied that it was a death by suicide. I would respectfully suggest that he would have been entitled to make a section 26(2)(c) finding to this effect, even if the precise mechanism of death could not be determined. In any event the death was not natural, and there was an obvious public interest in considering how and why Ms Robson, given her mental illness, was able to absent herself from hospital and drive herself away on the day of her death.

[92] In the present case, by contrast, there was no dispute on the evidence that the cause or causes of David's death could not be ascertained. And it is also apparent that the inquiry could not, even on balance of probabilities, make a finding that the death

was other than a death from natural causes. That is because the only evidence led in relation to cause of death was from the pathologists, Drs Penman and Collis. As noted above, their opinion, based on their findings at post-mortem, was that it was equally likely that David's death was a SUDI - and therefore a death from natural causes - as it was from accidental asphyxiation resulting from co-sleeping. As also noted, the practical reason why this was the only evidence on cause of death was that the Crown chose to refuse to grant Deon and Aiden immunity from prosecution. By so doing, they made it inevitable that these witnesses would refuse to answer any questions regarding the circumstances of David's death. But for this, it is possible that the inquiry would - even in the light of what would likely have been unreliable evidence from both of Deon and Aiden seeking to blame the other and exculpate themselves - have been in a position to find that death from accidental asphyxiation was at least marginally more likely than death from natural causes. But standing the Crown's position, and unlike the situation in the determinations discussed above, there was simply no evidence to establish cause of death other than that of the pathologists. I have therefore made findings in fact accordingly.

[93] But the Crown position was that even if it could not be established that the cause of David's death was not from natural causes, it was still in the public interest to inquire into what Fife Council Social Work Department did or did not do in relation to caring for him when he was alive. In making this submission, the PFD expressly accepted that if further evidence was led about this the Crown still could not and would not be inviting the inquiry to make any findings under sections 26(2)(e) or (f) of the 2016 Act,

nor to make any recommendations under sections 26(1)(b) and (4). In other words, the Crown accepted that there were no precautions which could reasonably have been taken which might realistically have resulted in David's death being avoided. It accepted that there were no defects in any system of working which contributed to his death. And it accepted that there were no recommendations that the inquiry could make which might realistically prevent other deaths in similar circumstances. This was because none of the further evidence which the Crown proposed to lead would be sufficient to establish any causal connection between the actions and inactions of the social workers and David's death.

[94] All that was sought by the Crown therefore, by leading another week and a half of evidence regarding the actions of the social workers, was the making of three findings under section 26(2)(g) of the 2016 Act. In other words the Crown sought only that the inquiry should find, as facts relevant to the death but in no way causative of it, that individual social workers failed to properly consider, and then apply for, a Child Protection Order in respect of David prior to 6 June 2019 - and then sought to cover their backs by making a retrospective entry in their records. There is no doubt that a fatal accident inquiry could make such findings in a determination as matters ancillary to consideration of whether to make non formal findings and recommendations, and that relevancy, rather than a causal link, would be all that was required in order to do so. But the Crown's position was that the only purpose of further inquiry would be to make such findings. The consequence of this would be, in effect, to seek to use the inquiry process to obtain judicial findings criticising case specific actions of individual social

workers, taken more than 7 years ago, rather than seeking to learn lessons of general import to prevent future deaths in similar circumstances. But this would be to lose sight of the purpose of a fatal accident inquiry just referred to. If the evidence shows that a death resulted from mistakes made by an individual or individuals, then they may of course be criticised in the determination, whether by findings under section 26(2)(g) or otherwise. But this is incidental to the statutory purpose, not the purpose in itself. The purpose of a fatal accident inquiry is not to establish civil or criminal liability: section 1(4). But nor is a fatal accident inquiry a disciplinary hearing, or a professional regulatory investigation.

[95] It was not disputed that it was within the wide powers of the sheriff in a fatal accident inquiry to determine not only the procedure, but what evidence may be led, and the manner in which conclusions should be reached: see Rules 4.2 and 5.1 of the 2017 Rules. Lest it needed saying, therefore, while the court will of course accord respect to the Crown, and recognise the role of the PFD in seeking to represent the public interest, ultimately the court must have the last word on where this lies. Despite the flavour of some of the submissions of the PFD, the Crown does not have the right to lead all and any witnesses that it wishes to. If the sheriff considers that a proper determination may be made in the inquiry, without hearing from some or all of the witnesses whom the Crown would like to call, then it is within the sheriff's discretion to proceed in this way. This is always assuming that the sheriff is satisfied that it is not necessary or appropriate in the public interest to hear further evidence, that the purposes of the inquiry in section 1(3) of the 2016 Act have been sufficiently achieved,

and that the decision is in accordance with the inquiry principles in Rule 2.2 of the 2017 Rules.

[96] In the light of all these considerations I am satisfied that I should refuse the Crown motion to hear further evidence in the present case. I am satisfied that the circumstances of David's death have been sufficiently established by the evidence already led and agreed in the joint minute, all of which is reflected in the findings in fact set out above. I consider that the leading of the proposed further evidence would not lead to the making of non-formal findings in relation to any steps which might be taken to prevent other deaths in similar circumstances to David's. Given this, and also the very lengthy delay in bringing this inquiry to court, I do not consider that it is now necessary or appropriate in the public interest to continue the inquiry to hear further evidence for the limited purposes advanced by the PFD. And I am mindful of the substantial cost which would be incurred by a further week and a half of evidence, all of it funded from the public purse. I am therefore satisfied that the most expeditious and effective way to progress this inquiry, in accordance with the principles in Rule 2.2(2) of the 2017 Rules, is to make formal findings only, issue this determination, and so bring the inquiry to an end: cf 2016 Act, section 30(4).

Postscript

[97] Deon may not have been the best mother to David in his short life, but she was young and inexperienced, and there was no evidence before me to suggest that she did not love him. Nor was there evidence to establish, even on balance of probabilities, that

she was culpable for his death. It is as least as likely that his death was of natural causes, and in circumstances that will have been traumatic for her. She has my condolences.

APPENDIX 1: FIRST ORDER AND NOTE, 10 NOVEMBER 2025

The Sheriff having considered the First Notice in terms of rule 3.1 of the Act of Sederunt (Fatal Accident Inquiries Rules) 2017 dated 29 October 2025, and having had a discussion with the procurator fiscal depute in chambers pursuant to rule 3.2(2); Makes a First Order in terms of rule 3.2(1); Fixes a Preliminary Hearing in the Inquiry for 29 December 2025 at 10am within the Sheriff Court House at Falkirk, Sheriff Court House, Main Street, Falkirk, FK1 4AR; Considers that it is not appropriate to fix a date for the start of the Inquiry before this Preliminary Hearing; Finds that Deon Howsego and Colin Boyle are entitled to participate in the Inquiry in terms of section 11(1)(a) to (d) of the Inquiries into Fatal Accidents and Sudden Deaths Etc Act 2016; is Satisfied that the following persons may have an interest in the Inquiry in terms of section 11(1)(e), namely (i) Aiden Hynd (ii) Fife Council (iii) Jenni Potter, social worker, Fife Council (iv) Linda Sheret, Service Manager, Fife Council (v) Lesley Stevenson, Social Work Team Manager, Fife Council (vi) Jackie McLaughlan, social worker, Fife Council (vii) NHS Fife (viii) Zoe O' Neil, Health Visitor, NHS Fife (ix) Pauline McQueen, midwife, NHS Fife, (x) Rebecca Saunders, child protection midwife, NHS Fife (xi) Police Scotland, and (xii) Claire Richardson, police officer, Police Scotland; Directs the procurator fiscal depute to give notice of the Inquiry and of the date and place for the holding of the Preliminary Hearing to all said persons in terms of section 17 and rule 3.3; Further Directs that when giving notice as aforesaid that a copy of this First Order and Note should be appended to the Form 3.3A

Note:

1. In terms of rule 3.2(2) of the Act of Sederunt (Fatal Accident Inquiry Rules) 2017 I met with the procurator fiscal depute via Teams on 7 November 2025 to discuss the First Order and related issues. This note summarises the discussion.
2. I queried why it had taken more than six years since the death to apply for a First Order. I was told that there had been a criminal investigation following David Howsego's death, but that there had been no prosecution arising from it. Nor had there been any civil litigation. The decision to hold a FAI into the death is discretionary, and I assume it will have been carefully considered by the Lord Advocate. However I remain unclear as to the full reasons for the very lengthy delay.
3. In addition to the narrative set out in the First Notice I was told that it was the procurator fiscal depute's understanding was that on the night of 6 to 7 June 2019 David slept in the same bed as his mother and her partner, that when they awoke around 8.30am they found him unresponsive, that paramedics were called and arrived within a reasonable time, and that when they did so they certified David as dead. I was further told that a joint post mortem was carried out and that the cause of death was certified as unascertained. I was told that no further medical evidence had been obtained in relation to this.

4. I sought to understand the Crown position in relation to the cause of David's death, and its consequent approach to the matters on which determination is required under section 26 of the Act. As the procurator fiscal depute recognised, if the cause of death cannot be ascertained, then there are obvious difficulties in making any findings as to reasonable precautions (section 26(2)(e)) or systemic defects (section 26(2)(f)) by which it might have been avoided, let alone recommendations as to steps which might realistically prevent other deaths in similar circumstances (section 26(1)(b) and (4)). The Crown position appeared to be that other relevant facts could be made under section 26(2)(g). However I am concerned that attempting to do so would face a similar conceptual difficulty, and in any event it may be difficult to understand the appropriateness of doing so, particularly more than six years after the date of death.

5. These issues will have to be considered carefully at the preliminary hearing. It may be that a finding should be made in relation to cause of death prior to considering the scope of the Inquiry.

6. I queried with the procurator fiscal depute the persons on whom intimation of the inquiry should be made. Only David's parents are entitled to participate in terms of section 11(1)(a) – (d) of the Act and rule 3.3. But others may have an interest per section 11(1)(e). It seemed to me that those individuals most closely involved in David's care and treatment during his short life should be identified and intimation made on them. These included his mother's partner, the individual social workers, health care staff, and police officers (who participated in the relevant child protection conferences), in addition to the organisations for whom they worked. The procurator fiscal depute subsequently produced a list of the names of these individuals, which are therefore included in the First Order and should receive notice of the Inquiry and of the Preliminary Hearing. Conceivably the Inquiry might be invited to criticise one or more of these individuals, so they should be given the opportunity to participate should they wish to do so.

7. Given the timescales in rule 3.2, and my availability, the only practicable date identified for a preliminary hearing was Monday 29 December 2025. Further preliminary hearings may follow.

8. I instructed the procurator fiscal depute to produce and lodge a pen drive with all the currently available Crown witness statements and productions on it. Given the date of the preliminary hearing, and the Christmas holiday, this should be lodged with the court no later than close of business on 15 December 2025. The procurator fiscal depute is yet to produce a draft joint minute, but this too should be done and lodged by the same date.

9. Ailsa Ure has been assigned as the dedicated clerk to this inquiry, and all correspondence relating to it should in the first instance be addressed to her care of Falkirk Sheriff Clerk's office.

APPENDIX 2: ORDER OF PRELIMINARY HEARING AND NOTE, 29 DECEMBER 2025

The sheriff, having heard from parties, ex proprio motu, continues the preliminary hearing until 2 March 2025 at 10am within Falkirk Sheriff Court to enable further enquiries and preparation to be undertaken by parties, and to address the issues in the attached Note.

Note:

In a helpful discussion today the participants' representatives addressed the various matters set out in the various sub-paragraphs of rule 3.8 of the FAI Rules:

a. With the earlier assistance of the PFD I identified all the persons who I considered would have an interest in this inquiry, and set them out in the Note attached to the First Order. The PFD confirmed that all these persons had now received intimation. No other person who had or might have an interest was identified today.

b. In addition to the Crown, there are five persons who are to participate in the inquiry, all of whom were represented today: Deon Howsego, Fife Council, Ms Lesley Stevenson, Ms Linda Sheret, and Fife Health Board. The PFD advised that he had been contacted by Police Scotland who had indicated that they would not be participating. He further advised that there had been no response received from Aiden Hynd.

c. This is an inquiry into the death of David Howsego at the age of only seven weeks. Complexities arise in relation to the cause of his death and social work actions and practices in relation to his care.

d. Parties were agreed that if the inquiry were to proceed to hear all the witnesses currently listed by the Crown in its rule 3.7 Note then its likely duration would be one and a half to two weeks.

e. The PFD submitted that the two main disputed issues for the inquiry were (a) identification of the cause of David Howsego's death, and (b) whether Fife Council should earlier have sought a child protection order ('CPO') in respect of him. No other participant took issue with this. As regards (a) the PFD submitted that "to a reasonable degree" it was possible to ascertain the cause of death as being sudden unexpected death in infancy ('SUDI') with a contributory factor of co-sleeping (ie accidental suffocation). He said that the post mortem report supported a finding to this effect. As regards (b) the PFD submitted that there were a number of failings in Fife Council's child protection actions and procedures, that the Crown wished the inquiry to explore them, and it did not matter whether a CPO would have been granted had it been applied for. As discussed, I had some difficulty with these submissions. As regards issue (a), in the first place, cause of death is a matter of fact to be established on a balance of probabilities, not a 'reasonable degree' of likelihood. Secondly, I am not sure that the post mortem report carries the interpretation which the PFD sought to put on it. On one view it says that David Howsego either died from SUDI or from co-sleeping, that both are equally likely causes, and therefore that neither can be established as being the actual

cause on a balance of probabilities. Nor am I sure that the report is saying that the death might have been caused by both SUDI and co-sleeping, let alone that that this combination is more likely than not. Oral evidence will hopefully clarify the position. As regards issue (b), unless it can be established that a CPO would likely have been granted if it had been applied for, it is difficult to see how there could a sufficient causal connection between any failures involved in not making the application and David Howsego's death. On the other hand, it might be argued that if there were grounds for a CPO, then obtaining it could still have been a reasonable precaution by which the death might have been avoided, ie even if these grounds did not focus on or include - an anticipated risk of death by co-sleeping. The cause of death is the first issue for the inquiry, however. If it cannot be established, then it is hard to see how any non formal findings or recommendations could be made in terms of section 26 of the Act. The same would be the case if it were to be established that SUDI were the most likely cause of death. Only if co-sleeping were established to be either the sole or a materially contributing cause of death might there be scope for non formal findings, although even this is not without difficulty. These are matters which all participants should consider further. As discussed today, in the circumstances it may be more expeditious and efficient (per rule 2.1 of the FAI Rules) to hold - in effect - a preliminary evidential hearing to determine (if possible) the cause of death, as this determination may dictate whether and if so to what extent any further inquiry into the actions and procedures of Fife Council social work department is necessary or appropriate.

f. The PFD submitted that the Crown was ready to fix a hearing of the inquiry. However the PFD also submitted that it had only just received around 280 pages of health visitor records and documents relating to David Howsego, that these had not yet been fully analysed or disclosed, and that it was possible that this might lead to further witnesses or productions. Deon Howsego and Fife Council submitted that a further preliminary hearing should be fixed, as they had only received the existing disclosure bundle less than two weeks previously, and their preparations were therefore still at an early stage. Fife Health Board also sought a further preliminary hearing. As matters stood, it was not anticipated that the health board would be the subject of any non formal findings or recommendations. Accordingly it was submitted on their behalf that they were appearing simply in order to assist the inquiry. But final confirmation of that position would have to wait the now anticipated disclosure of the health visitor records and the Crown's position in the light of them.

g. As regards evidential issues, the PFD said that the Crown was seeking a statement from Caroline Moir, Chief Social Worker at Fife Council, who provided annotations (Crown Production 17) to an expert social work report by Maggie Melon (Crown Production 16). Ms Moir did not have direct involvement with David Howsego and was not to be a participant, but might be required to give evidence. The Crown was concerned that Deon Howsego might be a vulnerable witness, but accepted that this was for her to progress by way of a vulnerable witness application if so advised. The PFD submitted that a draft joint minute had been produced and lodged. This had not as yet been discussed with the other participants, let alone agreed. No notices to admit were

required. The Crown had indicated in its witness list those whose evidence appeared to it to be capable of agreement, for example, by treating their statement as their whole evidence. There were currently three expert witnesses, and it was anticipated that they would give their oral evidence in the usual way. No video or other technology would be required. Given the early state of their preparation, no other participant was yet able to confirm whether they would wish to call witnesses not on the Crown list or lodge further productions. Counsel for Deon Howsego confirmed that he would consider whether a vulnerable witness application was required for her, although he expressed some doubt that it would be necessary.

h. Counsel for Deon Howsego indicated that she had sought an undertaking from the Crown that she would not now face prosecution arising from David Howsego's death. It had now been made clear that no such undertaking would be given. He pointed out that this meant that if called she would have to be given a warning against self-incrimination, and that this might mean that she would be entitled, and perhaps well advised, to decline to answer any questions at the inquiry.

i. Counsel for Deon Howsego confirmed that legal aid had been granted and was in place for her.

In the light of the above:

1. A further preliminary hearing will be held on Monday 2 March 2026 at 10 am in Falkirk Sherif Court. The intention is that this should give parties sufficient time to carry out any investigations they wish to make and finalise their preparations so as to enable a hearing of the inquiry to be fixed;

2. The Crown must, by close of business on Monday 19 January 2026, disclose to all parties the health visitor records referred to above;

3. The Crown must convene, at a time and place suitable to all participants, a meeting to discuss and agree the terms of a joint minute. All participants must attend at this meeting ready and willing to engage constructively in identifying facts capable of agreement. The revised (and hopefully expanded) joint minute must be lodged no later than close of business on Monday 23 February 2026;

4. By this same date and time, close of business on Monday 23 February 2026, parties must produce, lodge and exchange revised and updated rule 3.7 Notes for the hearing on 2 March 2026. These must (i) address and set out the essence of the participant's position in relation to the two issues for the inquiry identified above; (ii) name any further witnesses (ie beyond those in the Crown's rule 3.7 Note lodged for today's hearing) which the participant wishes to take evidence from; (iii) identify which witnesses the participant wishes to cite to give oral evidence, and which witnesses' statements it considers may be taken to be their whole evidence; (iv) identify any further productions which the participant wishes to lodge; (v) set out the participant's proposals for further procedure in the inquiry, and in particular as regards how best to determine the cause of David Howsego's death in the light of the discussion today and having regard to the Rule 2.1 principles; and (vi) set out any further issues or motions which the participant intends to raise at the hearing on 2 March 2026.

APPENDIX 3: ORDER OF PRELIMINARY HEARING AND NOTE, 2 MARCH 2026

The sheriff, having heard from parties at a continued preliminary hearing, ex proprio motu, assigns an evidential hearing on 25 May 2026 at 10am within Falkirk Sherif Court, for the purpose set out in the attached Note, and subject to the directions contained therein.

Note:

1. All participants lodged and spoke to revised rule 3.7 Notes as directed by the interlocutor of 29 December 2025.
2. The PFD moved for a hearing to be fixed in relation to all issues, to be of one and a half to two weeks duration. He maintained that the Court could and should inquire into social work practice prior to the death even if the cause of death could not be ascertained. He confirmed that the Crown had disclosed the health visitor records. He said that the Crown intended to cite 13 witnesses, which did not include the pathologists, but did now include Chistine Moir. He also intended to cite both Deon Howsego and Aiden Hynd, albeit that he confirmed that neither would be granted immunity from prosecution, and so might decline to answer questions. He said that he had met with Dr Penman, one of the two pathologists, and that she had not changed her position as set out in her joint report, Crown Production He said that a note of that meeting had been made and would be circulated to the other participants. He had no further productions to lodge. A joint minute had been agreed and this could be signed today
3. Mr Black, solicitor for Deon Howsego, said that a vulnerable witness notice would be lodged for Ms Howsego, seeking that she give her evidence with her mother as a supporter. He said that in the light of the Crown's position as regards immunity Ms Howsego would be advised to say nothing which might incriminate her. He had no further witnesses to lead or productions to lodge. In his Note it was suggested that determination of the cause of death was essential, either to resolve the issues, or to focus further inquiry, and that this could be done at a one day hearing.
4. Ms Anderson, solicitor for Fife Council, said in her Note that if cause of death remained as set out in the pathologists' report then only formal findings were appropriate and there was no need to investigate social work practice. She suggested that agreed written questions could be asked of the pathologists to confirm whether their opinion on cause of death remained the same, and thereby avoid the need to hear evidence from them. She said that a decision by the Council as to whether to instruct an expert report had not been made as it was not yet clear that it would be required.
5. Ms Donachie, solicitor for Fife Health Board, repeated that hers remained essentially a watching brief, but that this might change if an expert report were to be obtained by Fife Council which referenced actions by Health Board employees.

6. In the light of the above I direct that:

a. A one day evidential hearing will be held for the sole purpose of considering evidence relevant to the cause of David's death and making findings in fact thereon.

b. The Crown should cite both of the pathologists Drs Penman and Collis to give oral evidence at this hearing. Arrangements should be made with them and the clerk of court to enable their evidence to be given remotely, by live CCTV link.

c. The Crown should lodge copies of the police report and photocopied medical records referred to at page 12 of the pathology report, Crown Production 2.

d. The Crown should also cite Deon Howsego, Aiden Hynd and Aimee Davidson to attend this hearing.

e. The date identified today for this one day hearing was 25 May 2026. However the Crown has not yet established that Dr Collis is available for this hearing. It must make contact with her forthwith, and advise the clerk of court before the end of this week (that is, by close of business on 6 March 2026) whether she is indeed available to give evidence on 25 May 2026. If not, then the Crown must provide the clerk a list of dates to avoid for both pathologists in the period April to July 2026, and a further date for the hearing will have to be identified.

f. In any event, in the light of the evidence led in relation to cause of death the court will wish to hear oral argument as to whether any further procedure in the inquiry is necessary, or appropriate, and if so, what that should be.

g. Should a further evidential hearing be required, the week commencing 29 June 2026 is available and participants should keep themselves free for that week. Further dates may be identified, if required.