



# Memorandum of Understanding between the Coroners' Society of England and Wales and the Health and Safety Executive

## Introduction

This Memorandum records an agreement between the Coroners' Society of England and Wales and the Health and Safety Executive (HSE). It is intended to promote and continue effective working relationships between Coroners and HM Inspectors of Health and Safety, with the object of fostering constructive co-operation.

## Nature of the agreement

The Memorandum describes a voluntary agreement. The parties to it recognise that Coroners are independent judicial officers. The agreement is not binding and is not intended to create any legally enforceable rights, obligations or restrictions.

## Aims

- To promote consistency, with the intention that this will allow Coroners and HSE to discharge their different and independent statutory functions and to use their limited resources to best effect.
- To set out clearly the level of assistance that HSE can legitimately provide to the Coroner following a work-related death.
- To promote the wider public interest of holding effective inquests into deaths at, or arising from, work without prejudicing ongoing investigations or criminal proceedings.

## Basis for co-operation

This Memorandum recognises that Coroners and HSE have limited resources. HSE is resourced with the aim of protecting people's health and safety, by ensuring that risks in the workplace are properly controlled in accordance with its statutory functions, as set out in the Health and Safety at Work etc. Act 1974 (HSWA).

The parties recognise that Coroners and HSE have different roles and responsibilities in relation to work-related deaths.

HSE (or another relevant enforcing authority) will investigate and, where appropriate, prosecute breaches of health and safety law under the HSWA. HSE does not investigate or prosecute unlawful killing, or any other criminal offences outside its health and safety remit.

The Coroner alone is responsible for deciding on the scope or ambit of the inquest. The Coroner must ensure that the relevant facts are fully and fairly investigated and are the subject of public scrutiny during the inquest hearing. The wider public interest also includes the need to ensure that the risk of prejudice to any ongoing investigation and potential criminal proceedings is minimised.

The Coroner may request assistance from HSE. It is HSE's policy to assist a Coroner wherever possible. This agreement recognises that such assistance is incidental to, and not a part of, HSE's function. The statutory responsibility for ascertaining the identity of the deceased, and when, where and how they came by their death, remains with the Coroner. HSE can only investigate within the authority granted by the HSWA.

Coroners and HSE have agreed to work cooperatively in the interests of justice, recognising their different statutory roles, to resolve any differences or conflicts. This Memorandum provides a best practice framework to achieve this; but it recognises that there may be certain occasions when a more formal approach to resolving issues is needed.

## **Basis of the agreement**

This Memorandum of Understanding (MoU) was drafted following discussions between the parties regarding identified best practice.

The parties accept that HSE assistance to Coroners avoids unnecessary duplication of effort. Whilst the statutory regime allows for evidence to be called at a hearing, the arrangements set out in this MoU benefit the inquest by providing for information to be shared with the Coroner in advance. The parties also agree that HSE has limited resources with which to meet its core responsibilities and strategic priorities. Any assistance to the Coroner is incidental to, and not a part of, its function.

The parties recognise that, for the purposes of ensuring an effective and consistent approach to its investigations, HSE provides guidance to its Inspectors. This is set out in the HSE Enforcement Guide at: [www.hse.gov.uk/enforce/enforcementguide/wrdeaths/index.htm](http://www.hse.gov.uk/enforce/enforcementguide/wrdeaths/index.htm).

HSE's Enforcement Guide is a publicly available document which sets out guidance for Inspectors on investigating and prosecuting breaches of health and safety law. The Guide contains advice on working with Coroners, setting out best practice in the investigation of workplace fatalities and co-operation with other investigatory bodies. The parties understand that this guidance will be updated from time to time and that the best source is therefore to be found at the above website address.

## **Investigation**

The Enforcement Guide sets out the different roles of the Coroner, HSE, police and Crown Prosecution Service (CPS) and their responsibilities in relation to work-related deaths. The guidance it gives is consistent with the Work-Related Deaths Protocol (WRDP).

The Coroners' Society has undertaken to adopt an approach to HSE investigations similar to the way they treat police investigations: ie Inspectors can be confident that Coroners will only use those parts of witness statements, reports and other investigation material which are necessary for the purposes of the inquest. Coroners will have regard to the fact that HSE may need to undertake further enquiries (including the taking of additional witness statements) and, given that criminal proceedings might arise from the same subject matter, they will avoid wholesale disclosure of investigatory material. The Coroners' Society recognises the possible complications that can be presented by the implications of the employer-employee relationship that commonly exists in health and safety investigations.

The parties to this Memorandum recognise that HSE investigations are restricted by virtue of the HSWA. HSE Inspectors have their own statutory powers. Coroners will not attempt to direct HSE's investigations. Coroners and/or their officials need to be kept informed of the progress of those enquiries. HSE will, therefore, regularly keep the Coroner informed as to progress of their investigation and discuss issues arising from the investigation (that are relevant to the inquest). There should be an early discussion between HSE and the Coroner after HSE takes primacy for the investigation as to: the likely timescales for the investigation; timing of any inquest; chronology of any legal proceedings; and how and when future updates will be provided. This will enable the Coroner to pursue any separate lines of enquiry, or to take additional statements, that they consider necessary for their inquest.

### **Chronology of proceedings**

The Enforcement Guide also advises that, once an investigation is complete, HSE will consider whether to bring any criminal proceedings against any organisation or person. If HSE decides that it does not intend to bring such proceedings it will notify the interested parties and the Coroner accordingly. However, HSE will also notify interested parties that it will reconsider that decision in the event of any new information arising at any subsequent inquest. If HSE decides that it does intend to bring criminal proceedings against any organisation or person, it will consider in each case whether to commence those proceedings before or after any inquest. In making this decision, HSE will take into account a number of factors including:

- When any inquest could be held.
- The views of the Coroner, police, CPS and the bereaved family members.
- Whether the investigation has been carried out in accordance with the WRDP.
- Whether any further information may come to light as a result of the inquest.

In making such decisions, the HSE will be primarily concerned in ensuring that the situation in *R v Beedie* (in which a health and safety prosecution taken before an inquest prevented a subsequent prosecution for manslaughter) will not arise.

In a case where the HSE believes it is in the interests of justice to commence proceedings before an inquest, HSE will request that the inquest be adjourned. In those circumstances, the Society has agreed to treat that request in line with the provisions of section 16(1)(b) of the Coroners Act 1988.

### **The Coroner and HSE**

The Enforcement Guide acknowledges that the practices of individual Coroners vary widely.

This Memorandum recognises that both Coroners and HSE are responsible for meeting their own responsibilities. The statutory responsibility for ascertaining the identity of the deceased, and when, where and how they came by their death, remains with the Coroner. The Enforcement Guide seeks to set out the minimum standard that Coroners can expect from HSE by way of assistance. The parties have agreed that requests for assistance will be dealt with in line with the principles outlined in this Memorandum.

## Disclosure by Coroners

In cases where HSE decides not to bring any criminal proceedings, or where proceedings have been commenced and completed before any inquest, there should be no objections from HSE in relation to the Coroner disclosing to properly interested persons any of the material provided by the HSE.

In cases where HSE decides to await the outcome of the inquest, there shall be discussions between the Coroner (or the Coroner's Officer) and the HSE Inspector to ascertain whether there is any concern regarding the disclosure of any documents. Some of HSE's investigatory material will be relevant to HSE enforcement matters but will have no part or use within inquest proceedings. Discussions should focus on whether the disclosure of any material may prejudice HSE's investigation or future criminal proceedings. In most cases, the risk of prejudice will reduce once the investigation is complete, and in particular, once any suspect has been interviewed.

It is recognised that the Coroner must act fairly in considering what information to disclose or not disclose to properly interested persons and will have to balance this against any claim of prejudice made by HSE. This will depend on the nature of the material, the timing of disclosure, the issues being investigated at the inquest and the nature of any prejudice claimed. Blanket disclosure of all material provided by HSE during an ongoing investigation would not be appropriate. Where HSE identifies an issue over disclosure, HSE will communicate to the Coroner the specific nature of the issue and why non-disclosure is, in HSE's opinion, appropriate.

*Example:* HSE may obtain evidence to rebut potential 'defences' that may be raised by an employer. This evidence may not have any bearing on the death but, if disclosed, would raise a significant risk of prejudice to the criminal investigative process, which will continue after the inquest. Coroners may be informed of such evidence but they should treat the information appropriately.

If the Coroner and HSE cannot identify a means by which information can be disclosed without causing prejudice to an ongoing investigation or future criminal proceedings, the Coroner shall not give disclosure without HSE being formally heard on the matter.

However, if adhered to, this Memorandum should provide sufficient reassurance to Inspectors to allow ready disclosure of investigatory material to Coroners. It is intended to ensure a sensible approach to disclosure, avoiding the need for any formal applications by HSE to the Coroner over disclosure.

This Memorandum will be reviewed annually.

Signed 26 September 2011

Last reviewed September 2011