CHIEF CORONER

HSE
Health & Safety Executive

MEMORANDUM OF UNDERSTANDING

between

THE CHIEF CORONER OF ENGLAND AND WALES

and the

THE HEALTH AND SAFETY EXECUTIVE

Introduction

1. This Memorandum of Understanding (MoU) has been agreed between the Chief Coroner of England and Wales and the Health and Safety Executive (HSE).

2. The parties agree to review this MoU (which replaces that between HSE and the Coroners Society of England and Wales) every five years or more frequently if the need arises.

Aims

3. The aims of this MoU are:

   - To promote and continue effective working relationships between coroners and HM Inspectors of Health and Safety, and foster constructive co-operation;
   - To enable coroners and HSE to discharge their different and independent statutory functions, and to use their limited resources to best effect;
   - To describe the assistance that HSE can legitimately provide to the coroner following a work-related death;
   - To promote the wider public interest of holding effective and timely inquests into deaths at, or arising from, work[1] without prejudicing ongoing investigations or criminal proceedings.

[1] For a comprehensive guide to work-related deaths please see http://www.hse.gov.uk/pubns/wrdp1.pdf at paras 3.1 and 3.2, and http://www.hse.gov.uk/pubns/wrdp2.pdf at p6.

Basis for co-operation

4. It is HSE's policy to assist a coroner wherever possible. The parties recognise that such assistance is incidental to, and not a part of, HSE's function.

5. The parties recognise that coroners and HSE have limited resources. For example, HSE is not resourced to prepare jury bundles prior to an inquest or serve documents on other interested persons. The statutory responsibility for ascertaining the identity of the deceased, and when, where and how they came by their death, remains with the coroner.

6. The parties recognise that coroners and HSE have different roles and responsibilities in relation to work-related deaths and that each has its own statutory powers and duties and that neither can direct, interfere or hinder the others' investigations.

7. The powers and duties of HSE's inspectors are as provided in the Health and Safety at Work etc Act 1974 ("HSWA"). Inspectors are not empowered to act otherwise than in accordance with HSWA and cannot undertake enquiries (including those which might otherwise assist the coroner) outside those undertaken for HSE's own purposes.

8. Nothing in this MoU is intended to replace the principles contained in the Work-related Deaths Protocol (and associated guidance) which HSE will apply when undertaking a joint investigation with another agency. For example, in joint investigations led by the police, the police will take the lead in communicating with the coroner.

9. Once an HSE investigation is complete the investigator's statutory functions cease. The coroner cannot require the HSE to resume the investigation or require a further witness to be interviewed.

Communication

10. The parties recognise that clear and timely communication between coroners and HSE is important to ensure coronial investigations proceed efficiently and without prejudicing HSE's ongoing investigations or criminal proceedings.

11. If HSE has commenced an investigation arising from a work-related death for which it has primacy (which is also the subject of a coronial investigation) HSE will provide an initial report to the coroner normally within four months of the commencement of its investigation.

12. The initial report will contain a summary of HSE's investigation to date and provide an estimate for the time required to provide a final report.

13. HSE will provide a quarterly written progress report to the coroner following submission of its initial report.

14. Following completion of its investigation (or completion of a joint investigation if the police retain primacy) HSE will provide the coroner with a final factual report, and the evidence that supports that final report.

15. Coroners and their staff will ensure that HSE inspectors are kept fully informed of developments in the coronial investigation including ensuring that any hearing date is properly communicated and that copies of any documents provided to the coroner by interested persons are shared with the inspector.

Chronology

16. The parties acknowledge that it is rarely necessary to proceed with an inquest whilst a related criminal investigation is ongoing. Subject to being kept informed of the criminal investigation (see above) a coroner should usually consider suspending the coronial investigation pending completion of the criminal investigation (whether being conducted by the police and HSE or by HSE alone).

17. Where HSE has completed its investigation, it will consider (being a decision for HSE alone), whether it is appropriate to commence criminal proceedings for breach of health and safety legislation at that stage, or to await the result of the coroner's inquest before doing so. In making the decision to prosecute before an inquest HSE will consult as appropriate including with the coroner.

Disclosure

18. The parties acknowledge the two-stage process described in the Worcestershire case[2] that disclosure of information (including that supplied by HSE) means disclosure to the coroner and any onward disclosure to interested persons is a matter for the coroner applying the relevant legislation.

19. HSE recognises that coroners will be provided with reports which may not be disclosed further. They may assist the coroner in understanding the issues and in deciding which witnesses to call. The coroner acknowledges that such reports may not amount to primary evidence and therefore should not be adduced in evidence at the inquest.

20. If an inspector wishes to raise objections to onward disclosure he/she will raise such objections in accordance with the relevant legislation.

21. The coroner having taken into account any HSE objections as to onward disclosure will decide what is to be disclosed and will provide copies to interested persons.

22. If a coroner is in possession of material which the HSE inspector has not seen then, normally, the coroner will share this with the inspector.

Specialist Inspectors

23. When assisting coroners, HSE may provide the coroner with a copy of a report from a specialist inspector prepared during HSE's investigation.

24. The parties recognise that a coroner may also wish to hear evidence from a specialist inspector and that, ultimately, the decision as to who to call as a witness is one for the coroner.

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[2] Worcestershire County Council & Anor v HM Coroner for the County of Worcestershire [2013] EWHC 1711 (QB)

25. However, specialist inspectors are a small cadre of professionals in HSE. They are, through qualifications and experience, experts in their discipline and their services are in high demand to assist HSE and police-led investigations across the United Kingdom, including by acting as witnesses in criminal proceedings. Consequently, coroners will apply the following principles when dealing with their evidence:

    - proper consideration will be given to reading out their report rather than calling specialist inspectors to testify in person;

    - if a specialist inspector is required to attend an inquest, proper consideration will be given to agreeing a time for the specialist inspector to testify. It will rarely be necessary for the specialist inspector to attend the entire inquest;

    - if a specialist inspector is required to attend an inquest, then it is recognised that he/she can only assist the coroner as described in their report and cannot answer questions about matters outside their discipline or to conduct further investigation or consider additional issues outside those considered for the HSE investigation;

    - recognising that an inquest is not a proxy for a criminal or civil trial but rather is a court of record, if a specialist inspector is required to attend an inquest, interested persons should be restricted in their questioning to those matters contained in the specialist inspector's report and only as is necessary to assist the coroner answer the statutory questions.

26. HSE will not provide additional specialist or expert evidence to a coroner beyond that prepared for its own investigation unless specifically agreed by HSE and subject to an agreed fee.

Representation

27. HSE will usually be an interested person in an inquest concerning a work-related death. HSE will not usually be legally represented at an inquest (but may choose to be) and, if not legally represented, the inspector is nevertheless entitled to ask questions of witnesses and make any submissions they deem appropriate to assist the coroner.

Agreement

28. The parties have agreed to co-operate according to the principles outlined in the Memorandum

Dated 6.6.19

Signed by David Snowball

David Snowball
Acting Chief Executive
Health and Safety Executive

Dated 20th May 2019

Signed by M. Lucraft

HHJ Mark Lucraft QC
Chief Coroner of England and Wales

Annex 1

ROLES AND RESPONSIBILITIES

Health and Safety Executive

29. The Health and Safety Executive (HSE) is Britain's national regulator for workplace health and safety responsible for the encouragement, regulation and enforcement of workplace health, safety and welfare, and for research into occupational risks in Great Britain.

30. It aims to prevent work-related death, injury and ill health in a range of sectors, including general manufacturing, construction, domestic gas safety, agriculture, public services & quarries, onshore major hazards (including mines, explosives, biological agents, chemical & petrochemical manufacturing) and offshore major hazards (including oil & gas installations).

31. HSE's work covers a varied range of activities; from shaping and reviewing regulations, producing research and statistics and enforcing the law. HSE's emphasis is on prevention but, where appropriate, will enforce the law especially when it is being deliberately flouted.

32. HSE enforces the Health and Safety at Work etc. Act 1974 ("HSWA") including by bringing criminal prosecutions in England and Wales for serious breaches of the Act and associated regulations.

33. HSE takes enforcement action to ensure duty holders deal immediately with serious risks (so they prevent harm); comply with the law and are held to account if they fail in their responsibilities. As part of its work, HSE investigates industrial accidents, small and large, including major incidents.

34. HSE's powers and duties primarily arise from HSWA. Enforcement is carried out by health and safety inspectors having regard to HSE's Enforcement Policy Statement. Their powers are mainly contained in section 20 of HSWA.

The coroner

35. Coroners are independent judicial officer holders with statutory responsibility for investigating the cause and circumstances of any death which may be violent, unnatural or of unknown cause. The coroner has lawful physical control of the body in such circumstances and for all practical purposes is the only person who can authorise a post mortem examination.

36. The coroners' service is a local service. England and Wales is divided into a number of coroner areas. Areas vary according to the size and nature of the area and population. Each coroner area has a senior coroner who is primarily responsible for the provision of coroner services in that area. Coroners are available at all times for certain functions but may work part time. In some areas the senior coroner is assisted by an area coroner and in all areas he or she will have one or more assistant coroners as well as coroner's officers and administrative staff often supplied by the local authority and/or local police

force. Staffing levels vary from area to area. In some areas the level of support is very limited, as are the resources for administrative and judicial work.

37. The coroner's jurisdiction is territorial in that it is generally the location of the dead body that determines which coroner may have jurisdiction in any particular case. However, when a person dies out at sea the 'location of the dead body' for the purpose of determining which coroner has jurisdiction may be either a) the port where the body is landed upon arrival ashore b) the location where the body is to be buried or cremated or c) the jurisdiction where the deceased lived before they went to sea. The distance the body is from the shore when found may also have an impact on the jurisdiction of the coroner.

38. The role of the inquest into a death is to determine the identity of the deceased, and to establish when, where and how the deceased came by his or her death. The conclusion will be recorded as a record of the inquest, which may take a narrative form.

39. The inquest is not a trial of rights and obligations, but a fact-finding exercise, with no parties or pleadings. The inquest finding cannot determine or appear to determine civil liability. Findings appearing to determine criminal liability are permitted, but not on the part of a named person.

40. 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 coroner alone is responsible for deciding on the scope of the inquest and the evidence to be called. The relevant issues will vary from case to case, and may or may not be the subject of disputed evidence. This means that the conduct of the inquest will vary from case to case.

41. At the conclusion of the inquest the coroner (but not the jury) may make a 'Report on Action to Prevent Future Deaths under paragraph 7, Schedule 5, of the Coroners and Justice Act 2009 and Regulations 28 and 29 of the Coroners (investigations) Regulations 2013 (normally called PFD reports or Regulation 28 reports). Such a report is to a person in authority if the coroner believes that action should be taken to prevent the recurrence of similar fatalities.