Memorandum of Understanding between the Coroner and the HSE-6 Months on…

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In June 2019 the Chief Coroner for England and Wales issued a new Memorandum of Understanding ("MoU") with the Health and Safety Executive ("HSE"). We take a look at what changed and how the changes are being adopted.

What is it:

Coroners and the HSE have different, yet overlapping, functions following a work-related death. The HSE's function is to investigate the actions of the duty-holders, gather evidence, interview witness and take enforcement action against those they deem not to have discharged their duties under health and safety legislation. The statutory responsibility for ascertaining the Deceased's identity together with when, where and how they came to their death, remains with the Coroner.

The MoU aims to define the relationship between the Coroner and HSE by promoting consistency, setting out the level of cooperation the Coroner expects from the HSE and promoting the wider public interest of holding effective Inquests, without prejudicing ongoing investigations or criminal proceedings.

What did the new MoU introduce and what has it changed:

We set out below our comments on some of the key changes.

Communication

In circumstances where the HSE have commenced an investigation (and retain primacy), the HSE will now provide the Coroner with an initial report within four months of investigation commencement (and quarterly thereafter). The initial report must contain a summary of the HSE's investigation to date and the final report must be full and factual, summarising and providing the evidence in support.

- The intention behind the quarterly reporting was not to provide lawyers with an early insight into the HSE's investigation. Instead, the MoU made clear that these reports would be provided to assist the Coroner understand the issues, identify witnesses / interested persons and project a timetable for proceedings. They were not to be disclosed to interested persons.
- It was hoped that these reports would serve as a prompt to the HSE to keep cases progressing, resulting in speedier enforcement decisions. The reality is that at this stage it is too early to see any real changes. If the HSE continue to have limited resources, cases are likely to progress at the same rate as before and little change will be seen.

Chronology

The Coroner should usually consider suspending the coronial investigation pending completion of the criminal investigation.

Where the HSE has completed its investigation, it will consider whether it is appropriate to commence criminal proceedings for breach of health and safety legislation at that stage, or await the result of the Coroner's inquest.

- It remains to be seen whether in practice Coroners will suspend an Inquest pending the HSE investigation. This is established procedure when the Police investigate manslaughter offences, but with the new MoU advocating such, lawyers are now arguing (with varied success) that all Inquests should wait until the conclusion of any HSE enforcement proceedings.
- The obvious benefit is that witnesses should be less concerned about incriminating themselves giving evidence and therefore, in some cases, witness evidence should be given more freely.
- Furthermore, lawyers are arguing that by awaiting conclusion of the HSE investigation and enforcement decision, the number of full Inquests that need to be heard can be reduced, if the HSE investigation has aired all the facts of the case.
- Six-months on, our experience is that it remains commonplace for the HSE to argue that the Inquest should be heard first, giving them the ability to test the evidence prior to making an enforcement decision.

- Coroners are clearly retaining discretion here, and what constitutes a *"completed investigation"* remains open to interpretation, with parties taking very different views.

Specialist Inspectors

Coroners are to give proper consideration to reading out the report of a Specialist Inspector, as opposed to calling them.

- It is a welcome addition to the MoU to see that Coroners may now give consideration to the reading of the Specialist Inspector's report – this has the potential to speed up Inquests.
- However such reports are a common area of contention in health and safety cases and if the view in the report is disputed (as it often is), it remains that the parties are unlikely to agree to the report being read.
- The recommendation in the MoU should, however, ensure that Specialist Inspectors are not having to attend Inquests unnecessarily.
- Of course, should a Specialist Inspector need to be called to answer questions, the MoU is very clear that they may only answer questions on matters covered in their report and only where necessary to assist the Coroner answer the statutory questions about the Deceased (who, when, where and how they came by their death).
- Finally, to achieve a balance in situations where the Specialist Inspector cannot be asked questions, will the Coroner allow expert evidence (such as from the representatives of interested persons, who may be potential suspects in the criminal investigation) to be read as well? It is too early to comment, but in the interests of justice, the default position of lawyers must be that the Coroner should hear expert evidence from all interested parties.

Conclusion – 6 months on:

The effectiveness of the 2019 MoU was always going to be largely dependent on its application by individual Coroners. From a regulatory viewpoint, the possibility of more efficient HSE investigations and speedier enforcement decisions was attractive. But there was no guarantee of such and six-months on, little has changed in reality.

The coming year will be the real test for the MoU. Concerns about the increased pressure on the HSE to report to the Coroner regularly, resulting in more aggressive investigations, may prove to be unfounded. Instead, it is hoped that the MoU will result in greater consistency around the structure, content and timings of preliminary hearings, reducing the number of full Inquests taking place and ultimately providing for more efficient and effective Inquests. This benefits all parties, none more so than the families of the Deceased. No doubt this was the Chief Coroner's intention.

Ultimately, all of those involved in inquests can shape how the MoU is applied given they can make representations about their application, subject to the Coroner's discretion. But with the MoU set to be reviewed again after five years (or more frequently as required) these areas are likely to be debated for many years to come.

For more information or advice on this Memorandum of Understanding, please contact one of our experts in our regulatory team.

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