EVERSHEDS SUTHERLAND

A new Memorandum of Understanding between the Chief Coroner and the HSE

A new Memorandum of Understanding ("MoU") has been agreed between the Health and Safety Executive ("HSE") and the Chief Coroner of England and Wales. It is a welcome review and provides clarity on the co-operation and communication between the HSE and the Coroner.

In early July 2019, the HSE released its annual workplace fatality figures. Between April 2018 and March 2019, 147 workers were fatally injured (an increase of six workplace fatalities from 2017/18) and a further 92 members of the public were fatally injured in incidents connected to work. It follows that an inquest would have been held or is due to be held for the majority of these fatalities.

It is hoped that the new MoU will speed up the inquest process in cases where the HSE has primacy of an investigation. According to government statistics published in May, in 2018 the average time taken to process an inquest (the date the death was reported until the conclusion of the inquest) rose by five weeks to 26 weeks (although this rise is attributed to the removal of the requirement to report Deprivation of Liberty Safeguard deaths to Coroners, as uncontroversial cases could be decided on papers and took less time to process). This is higher in some areas, such as West London where the average time was 50 weeks.

We have taken a look at the new MoU and what this means for how inquests will be conducted in cases where the HSE is carrying out a criminal investigation. The Work-related Deaths Protocol still applies and will continue to govern a police led investigation.

Key paragraphs in the MoU

- **if the HSE has commenced an investigation arising from a work-related death, it will provide an initial report to the Coroner normally within four months of the commencement of its investigation.** This is likely to focus the HSE on the investigation, prioritising the collation of documents and witness statements immediately after the incident using its section 20 powers under Health and Safety at Work etc. Act 1974. This is advantageous in that, if interviewed closer to the time of the incident, evidence will be fresher in a witness' mind

- **the HSE will provide a quarterly written progress report to the Coroner.** While under the previous MoU communication between the HSE and the Coroner was anticipated on the progress of its enquiries, the new MoU details the timing of this ongoing obligation to keep the Coroner informed of the status of the HSE investigation

- **the Coroner will usually consider suspending an inquest pending ongoing criminal investigations.** This is normally the case when the police are investigating an incident, but is now also clearly set out in relation to investigations conducted by the HSE

- **where the HSE has completed its investigations, it may consider awaiting the result of the Coroner's inquest before deciding whether to commence criminal proceedings.** In practice, we often see the HSE awaiting a Coroner's inquest before making a decision on whether or not to prosecute. This chronology of events was explicitly provided for in the previous MoU, and continues to be an option, but less detailed considerations to be taken into account when making this decision are explicitly stated. It is unlikely that this change will have a great impact on the HSE's current preference, but it can be assumed that, either due to the preceding paragraph or the reporting requirements, the HSE's investigation will be at a relatively advanced stage when an inquest is held

- **the reports provided by the HSE to the Coroner may not necessarily be disclosed to interested persons.** Disclosure is described as a two-stage process: disclosure to the Coroner and any onward disclosure to interested persons. The MoU seeks to clarify the position in relation to regulatory investigation reports. It is recognised that the purpose of providing these reports to the Coroner is to assist in the understanding of key issues and setting a witness timetable for the inquest. The MoU outlines that these reports do not amount to primary evidence and therefore should not be adduced in evidence at the Inquest. For these reasons and the likelihood of objections for onward disclosure being raised by the HSE it is unlikely these reports will be included within the disclosure to interested persons. Nevertheless, interested persons may be able to request an overview from the Coroner or gain an insight as to what such a report contains, given the line of questioning at an inquest

- **coroners will give proper consideration to reading out specialist inspectors' reports rather than calling them to testify in person. The HSE will not usually provide additional specialist or expert evidence to a Coroner beyond that prepared for its own investigation and will not usually be legally represented at an inquest.** The final paragraphs of the MoU detail the demand placed on specialist inspectors (of the HSL) within the HSE. Going forward, rather than specialist inspectors giving evidence at inquests, we are likely to see an increasing number of their reports read under 'Rule 23'. Not only will this quicken the evidential process, it will lower the costs associated with an inquest. The MoU also makes it clear that it is not necessary for the HSE to provide evidence beyond that prepared for its own investigation or for it to be legally represented, again controlling the associated costs incurred by the HSE

What's next?

The MoU is set to be reviewed every five years or more frequently if the need arises. It provides welcome clarity on how the HSE and the Coroner should interact following a fatality connected to the workplace. While the reporting requirements may lead to a quicker progression of investigations, it remains to be seen whether these detailed requirements will lead to a quicker conclusion of the investigation and decision on prosecution, or whether the HSE will seek to provide the initial report to the Coroner and await the outcome of the inquest before making its final decision.

The Chief Coroner is set to review all MoUs signed by the Coroner's Society. In the coming months, we are likely to see a change in MoUs across the board with other authorities such as local authorities and the Care Quality Commission.

For further information on this topic please contact specialist health and safety lawyer Sarah Valentine or visit our website.

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