OFFICE OF **RAIL REGULATION**

The Coroners' Society of England and Wales

Memorandum of Understanding between the Coroners' Society of England and Wales and the Office of Rail Regulation

Introduction

This Memorandum records an agreement between the Coroners' Society of England and Wales and the Office of Rail Regulation (ORR). It is intended to promote and continue effective working relationships between Coroners and HM Inspectors of Railways, 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 ORR 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 ORR can legitimately provide to the Coroner following a work-related death.

- To promote the wider public interest.

Basis for cooperation

This Memorandum recognises that Coroners and ORR have limited resources. ORR is resourced with the aim of protecting people's health and safety, by ensuring that risks in the workplace are properly controlled. Its role is to discharge its statutory function, as set out in the Health and Safety at Work etc. Act 1974 (HSWA) as amended by the Railway Act 2005.

The parties recognise that Coroners and ORR have different roles and responsibilities in relation to work-related deaths. ORR will investigate and, where appropriate, prosecute breaches of health and safety law under the HSWA insofar as they relate to railway activities. ORR 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 ORR. It is ORR policy to assist a Coroner wherever possible. This agreement recognises that such assistance is incidental to, and not a part of, ORR'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. ORR can only investigate within the authority granted by the HSWA.

Basis of the agreement

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

The parties accept that ORR 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 ORR 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, ORR provides guidance to its inspectors. In line with others health and safety enforcing authorities ORR follows the guidance set out in the HSE Enforcement Guide at:
www.hse.gov.uk/enforce/enforcementguide/wrdeaths/index.htm

The HSE 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 cooperation 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 HSE Enforcement Guide sets out the different roles of the Coroner, relevant enforcing authority (ORR for railways), 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.

The Coroners' Society has undertaken to adopt an approach to ORR investigations similar to the way they treat police investigations: i.e. 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 ORR 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 ORR investigations are restricted by virtue of the HSWA. ORR inspectors have their own statutory powers. Coroners will not attempt to direct ORR's investigations, but Coroners and/or their officials need to be kept informed of the progress of those enquiries. 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 HSE Enforcement Guide also advises that prosecutions by the enforcing authority will generally take place after the conclusion of the inquest, and identifies the relevant legal authority. It is ORR policy that a final decision on enforcement action will not normally be made until after the inquest is held. This policy recognises that additional information may come to light as a result of the inquest and/or that the Coroner may decide to refer the case back to the police/CPS for further consideration of a manslaughter charge.

The HSE Enforcement Guide clearly states that this policy is not designed so as to allow the enforcing authority (ORR for railways) to use the inquest as an opportunity to test the available evidence in advance of enforcement proceedings. However, ORR is mindful that a jury could still return a verdict of unlawful killing, in which case the CPS may reconsider the evidence with a view to prosecuting for gross negligence manslaughter. In exceptional cases, where that risk is insignificant, ORR might request that the inquest be adjourned until after its prosecution. 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 ORR

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

This Memorandum recognises that both Coroners and ORR 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 HSE Enforcement Guide seeks to set out the minimum standard that Coroners can expect from the

enforcing authority (ORR for railways) 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

It is envisaged that there will be discussions between the Coroner (or the Coroner's Officer) and the ORR inspector to ascertain whether there is any concern regarding the disclosure of any documents. Some of ORR's investigatory material will be relevant to ORR enforcement matters but will have no part or use within inquest proceedings. If documentary evidence from the ORR investigation is being considered for disclosure pursuant to rule 37 or otherwise, there should be a discussion to identify any evidence which is likely to be controversial e.g. by way of prejudice to ongoing enquiries or potential proceedings. Any advance disclosure should be specific and targeted, rather than blanket disclosure of all information supplied by ORR.

Example: Where an inquest follows a road traffic collision (e.g. at a level crossing) , the circumstances of which involve potential offences under section 3 of the Road Traffic Act, the inquest will normally be held before any criminal proceedings. If the car, at the time of the collision, was being used to traffic drugs, the police might know this and will probably share that information with the Coroner. However, that fact is unlikely to be relevant to the inquest (unless it was relevant to how the death occurred) and will not be disclosed.
Similarly, ORR may obtain evidence to rebut potential 'defences' that may be raised by a dutyholder involved in an incident. 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 adhered to, this Memorandum should provide sufficient reassurance to inspectors to allow ready disclosure of investigatory material to Coroners. If the Coroner and inspector cannot identify a means by which information can be disclosed without causing prejudice to an ongoing investigation or future criminal proceedings, it is open to the ORR to make the relevant application. This Memorandum is intended to ensure a sensible approach to disclosure in order to avoid of the need for such applications wherever possible.

This Memorandum will be reviewed each year.

Dated the 26th day of August 2008

Signed by..... Bill Emery .....
On behalf of the Office of Rail Regulation

Signed by..... .....
President Hon. Secretary
On behalf of the Coroners Society of England and Wales