27 November 2002

HSE RESPONSE TO THE REVIEW OF CORONERS SERVICES

Thank you for the opportunity to comment on your Consultation Paper concerning the fundamental review of death certification and the coroner services in England, Wales and Northern Ireland.

Your paper highlighted many areas of key interest to HSE and I hope that you find the following comments, set out in the annex to this letter, of value. All of these comments should be taken in the context of the broad support of the HSE for the principles underpinning the Paper, in particular the need for fairness, openness and support for the bereaved.

Your Paper makes reference to other aspects of the Review such as the results of Peter Jordan's research, the proposed national protocol for post-mortems and the drafting of a consistent set of procedures laid down by a Rules Committee. We also note the Review's interest in the Home Office Review of Forensic Pathology Services, and the ongoing consideration of the application of the European Convention on Human Rights to Coroner Services. The HSE has an interest in these matters and would appreciate the opportunity to comment on any relevant papers published, particularly those relating to procedures and Rules.

I can confirm that if the Review decides to establish any subgroups to explore these, or any other issues upon which HSE has commented, then HSE would welcome the opportunity to field a representative to contribute from our experience.

As anticipated, you will note that our concerns relate primarily to the way the Coroners Service is resourced, organised and supported rather than to the performance of Coroners themselves, with whom HSE generally enjoys a good working relationship.

HSE has also been asked to comment upon a Discussion Paper that has been circulated by the Shipman Inquiry and will be doing so in due course. Please contact my office should you require a copy of these comments.

Please do not hesitate to make contact should you require clarification on any of the points raised. Correspondence of this nature should be sent in the first instance to Mr Jonathan Russell at this address.

Yours, etc

Timothy Walker
DIRECTOR GENERAL

ANNEX

1. The resourcing of Coroner Services

1.1 The HSE is committed to fairness during inquests and therefore notes the critical system defects in the current death certification and coronial services as identified at paragraph 20 of the Consultation Paper. The Executive is in agreement with the Review as to these defects, subject to certain points that will be developed later in this response. However, the Executive believes that several of the defects identified result from the inadequacy of the resources made available to Coroners.

1.2 The HSE believes that Coroners, and therefore the coronial system, are hindered in many ways by a shortage of investigative staff. This can lead to long delays before inquests, which in turn delays HSE's decision as to whether or not to bring legal proceedings. Delays can also arise from a lack of administrative resources when coroners attempt to convene a jury and/or an appropriate venue. To overcome this latter point, HSE would consider it wholly appropriate for Coroners to have both their own courtrooms and access to Crown Court jury pools.

1.3 The delays that result from the above only add to the distress of the bereaved, the amelioration of which is a consistent theme throughout the Paper. We also note that although HSE policy requires Inspectors to take an active role in keeping the bereaved informed, these efforts could be undermined by delays that are beyond their control.

1.4 In addition, delays in the holding of an inquest can prove detrimental to HSE's role as prosecutor. The need to wait, sometimes for a very considerable period, for an inquest to precede any legal proceedings can result in evidence becoming stale, witnesses moving on and momentum being lost. Such delay also risks an abuse of process argument during any subsequent criminal proceedings. Nevertheless, the HSE believes that the current case law on the order in which health and safety prosecutions and inquests should take place is entirely correct and that it is in the public interest.

1.5 Moreover, the proper resourcing of Coroner Services acquires yet further importance given the acknowledgement by the Review that deaths from industrial disease are expected to increase.

1.6 Any failure to sufficiently resource Coroners has implications for both HSE and for Coroners in the disclosure of evidence, which has the potential to impact upon the relationship between HSE and Coroners due to the limits on HSE's ability to disclose information through the statutory and non-statutory

restraints upon HSE in this regard. Further matters relating to disclosure of evidence will be addressed later in this response.

1.7 HSE would welcome proposals that called for the resourcing of sufficient Coroners' Officers with the ability and training to obtain evidence for the purpose of the inquest and to deal with the bereaved sensitively. This would mean that the Coroner would be free to disclose the results of inquiries carried out on his/her behalf to properly interested persons as the Coroner sees fit.

2. The use of the public inquest

2.1 The Review is considering whether it is necessary to hold public inquests into all the categories of death that are normally the subject of a public inquest. The categories identified by the Review as relevant to this include deaths from occupational disease and accidents at work.

2.2 HSE are opposed to any changes in the coronial system that would remove the statutory requirement for a public inquest to follow a death in circumstances that require it to be notified to an HSE Inspector.

2.3 We believe that this risks sending the message to society that work-related deaths are not to be given the fullest consideration. We have no doubt whatsoever that this does not accord with the intention of the Review.

2.4 The resulting message that this proposal would send out also has the potential to jeopardise the Government's and HSC's Revitalising Health and Safety Strategy (RHS), announced in June 2000. This strategy sets national targets for the health and safety system in the reduction of fatal accidents, major injury accidents and cases of work-related ill health. These targets have been set to give new impetus to health and safety improvements by all stakeholders. The 15% fall in the number of employed and self-employed workers killed in Great Britain in 2001-2, as compared to the previous year, is encouraging in respect of this and would indicate that now is the time to maintain the tide of improvements by stakeholders. The suggested removal of inquests in this field risks sending a message that could be interpreted as downgrading its importance in the eyes of the public and bereaved.

2.5 Removal of the statutory requirement for a public inquest in such circumstances also begs the question as to who will investigate the death. The Review envisages that there should be openness and independence in such situations where another investigative process exists and that this, presumably, should be sufficient to meet the needs of all properly interested persons.

2.6 It should be noted that although HSE, with the automatic right to be treated as a properly interested person, will attempt to assist the Coroner this must be in a manner which is consistent with our own statutory duties and our own responsibilities under the Code for Crown Prosecutors. HSE investigations can in no way be seen as an alternative to the inquest, for the following reasons:

a) While the HSC's Enforcement Policy Statement refers to death or serious injury as an aggravating factor in any breaches of health and safety legislation (and, where death occurs, HSE will normally prosecute given sufficient evidence in respect of these breaches) this does not mean that HSE investigates the cause of death. The HSE investigation is concerned with the risk arising from alleged breaches of health and safety duties and while these may well be illustrated by the fact that someone was killed or injured, HSE is not required to prove death or the cause of death in order to secure a conviction. (The Review may be assisted to note the exact requirements of the general duties imposed by the Health and Safety at Work etc Act 1974, which form the bases of many HSE prosecutions).

b) To do otherwise is likely to result in HSE acting outside its powers. HM Inspectors are equipped with specific powers to obtain evidence. These powers are limited to the purposes of the relevant statutory provisions.

c) As a result, evidence gathered by HSE will not necessarily answer the important questions that Coroners need to pursue. Nor do the duties under the Code for Crown Prosecutors allow involvement of others in the investigatory process that may result in improper influence of the prosecution decision.

d) The countersigning by juries of the factual findings of an inquest can be said to represent the independence of the proceedings from the state. This can be important to families where there is an inquiry regarding a possible breach of Article 2 of the ECHR.

e) HSE has statutory responsibilities regarding the disclosure of information under Section 28 of the Health and Safety at Work etc Act 1974 (HSWA), in addition to common law duties of confidentiality. This means that HSE may not disclose certain information; in an investigation in which legal proceedings, for whatever reason, were not pursued this places great restrictions on what the bereaved family may be told and runs counter to the Review's aim of giving bereaved families' better rights.

3. Disclosure

3.1 We note that the Review favours clear, consistent and predictable rules of procedure, including those on disclosure, with a presumption in favour of disclosure of all witness material and a right on the coroner's part to receive relevant material from all parties for the duration of the inquest.

3.2 HSE supports the aim of the review to seek a process where there is greater consistency. However, we have significant concerns as to how a change in procedures may impact upon matters of disclosure. As stated in 2.6e), there are restrictions on the way in which information obtained using Inspector's powers may be used and disclosed, some of which flow from the 1974 Act and others from the need to avoid potential prejudice to possible criminal proceedings. At present, HSE will assist the Coroner in the provision of evidence while seeking

assurances that the Coroner will abide by those restrictions that are imposed on HSE and not disclose material obtained under Inspector powers.

3.3 This situation has the potential to reflect negatively on HSE and can cause frustration on the part of the Coroner. However, we have statutory obligations to enforce and we need to meet these obligations, including bringing legal proceedings in accordance with our Enforcement Policy Statement and our duties under the Code for Crown Prosecutors. Parties might seek disclosure of information during the inquest process as a way of obtaining pre-action discovery; in addition, any corresponding press coverage could lead defendants to claim that their right to a fair trial has been prejudiced.

3.4 If the inquest process is used as a means of obtaining material which may be relevant to a civil claim of criminal defence, this could impact negatively on the Coroner's ability to ensure that an inquest remains within the bounds of the Coroner's inquiry and risks prejudice to health and safety cases. It would also be a way in which the clear intention of Parliament as set out in Section 28 of the HSWA could be circumvented. The rights of parties to civil claims are adequately protected by the pre-action disclosure procedures and Defendants are provided with disclosure as per the Advance Information Rules and the Criminal Procedure and Investigations Act 1996. HSE prosecutions are not conducted solely with the aim of a sentence as retribution and punishment but also have a wider role in revealing serious wrongdoing to wider scrutiny and about deterring others so that risks to employees and the public are reduced. HSE is concerned to avoid prejudicing the aim of the HSWA.

3.5 Such is the concern of HSE regarding this matter that guidelines for Inspectors are being prepared that set out the limits of disclosure at inquests and the possible effect that breaches of these limits could have on future legal proceedings. HSE will make these guidelines available to Coroners via the Coroner's Society.

3.6 In summary HSE could not support any proposals with regard to disclosure that may, in any way, put future criminal proceedings brought by HSE in jeopardy. To overcome this difficulty, we suggest that Coroners are properly resourced to undertake their own enquiries. That statutory requirement should remain with the Coroner but there should be appropriate resourcing in order to discharge the duties on the state. In this way Coroners will be able to direct their Officers to gather evidence sufficient for the inquest, which the Coroner will then be free to disclose as appropriate, within the proposed Rules of Procedure.

4. The approach to the bereaved

4.1 The approach to the bereaved outlined by the Review and the aim of ensuring respect for individual, community and family wishes concords with HSE's own approach to the bereaved and in the wider context, to our position on diversity. Within this, it would seem appropriate that certain of the information given to the family be bounded by appropriate rules safeguarding the confidentiality of that information.

4.2 The HSE particularly welcomes those proposals by the Review to improve the support offered for bereaved people, such as clear and timely notification of all inquest arrangements, full explanation of what an inquest is and what happens at it, decent premises with disability access and private rooms and proactive support in finding sources of bereavement counselling. The HSE also believes there should be appropriate training for Coroners and their Officers for dealing with the bereaved and recognises the great pressures that can be placed on them as a result of their duties.

4.3 The stated aim of the Review to ensure the involvement of families and the bereaved in the investigation of the cause of death helps underscore the view of HSE that the Coroners investigation fulfils a separate function to investigations carried out by HSE.

5. The proper bounds of inquiry

5.1 The HSE is concerned at the proposal to give the inquest court greater latitude to decide in each case the proper bounds of inquiry, including the use of District, Circuit and High Court Judges to preside over the inquest, if this is taken to extend to incidents arising from work-related activities. This is for the following reasons:

a) HSE is concerned that this may lead to the holding of inquests that might more closely resemble public inquiries. The Health and Safety Commission has a statutory power to order public inquiries into matters of public concern arising from work activities. Granting a similar power to another body may well serve to produce duplication of effort and could create confusion among those we are trying to help. We also suggest that the HSC is vested with the level of expertise that is best qualified to determine when such an inquiry is necessary. In any event the Coroner has the power to make appropriate recommendations to the Secretary of State or the Commission.

b) There appears to be increasing pressure to hold public inquiries and this may result in Coroners' resource being put under increased strain, exacerbating those problems of resource mentioned earlier. Should Coroners not exercise their discretion to extend their inquiry within the bounds of latitude allowed by the proposals there would be a risk of appeal to a specified higher court with resultant delays and the attached implications identified above.

c) The use of an extended Coroners' inquiry would have implications for HSE in matters of disclosure with subsequent risk to future legal proceedings.

d) The ordering of an extended Coroners' inquiry would also be likely to attract significant expenditure of HSE's limited resources in efforts to assist the Coroner. This would in turn divert HSE from the core role of reducing risks and protecting people and impact upon achievement of the targets set in the RHS Strategy (see above).

e) Given the above, HSE considers that a decision in favour of allowing Coroners to decide the proper bounds of inquiry is likely to militate against

the wider aim of the Review to secure a process that offers greater consistency.

6. Inquest outcomes

6.1. The HSE acknowledge that more 'considered outcomes' may in some cases better serve the needs of the bereaved and would offer general support for the spirit of this proposal. However, HSE would also urge that great care in application be taken should this proposal be adopted. Notwithstanding the comments made by the Review in paragraph 100, the boundary between implied incrimination and non-incriminating public comment can be hard to define; again, HSE would be most concerned should legal proceedings be placed in jeopardy because of the nature of an analytical and narrative inquest outcome.

6.2 If it is considered expedient to move towards the kind of verdict referred to above HSE sees strength in the suggestion that verdicts might be a hybrid of the existing system which would still allow the Coroner the ability to refer matters such as an unlawful killing to the Crown Prosecution Service. The Review will appreciate these concerns in light of the case of *R – v – Beedie [1997] 2 Cr App. R. 167 CA.*

6.3 HSE cannot support the suggestion that the inquest settle questions of civil liability. This should follow any prosecution that is taken. The introduction of this proposal risks delaying inquests as full civil disclosure procedures would have to be introduced. We believe this would run contrary to the public interest.

7. Medical Audit Service

7.1 The HSE notes the proposal to establish a Medical Audit Service, which will provide a central authority with expertise in the examination and certification process. We see this as a potentially important resource for Coroners, as well as society as a whole; by way of example, the Service should help to improve upon the monitoring of deaths from occupational illnesses, which will in turn help inform HSE planning and prioritising.

7.2 However, it is important that the resourcing of this Service does not impact negatively upon the need for better resourcing of Coroner Services generally.

8. Post-mortem examinations

8.1 HSE offers general agreement to the proposition that the bereaved should always be informed of the intention to carry out a post-mortem examination, that access to the report should be limited and that families have a formal right to request that a post-mortem be avoided or should take place, subject to a final decision by the medical auditor or coroner on public interest grounds. The opportunity to consider the proposed national protocol on when to hold a post-mortem would be appreciated.

8.2 The Review has noted the work of the State Pathologist's Department in Northern Ireland. Notwithstanding the delays in providing reports referred to by the Review, the HSE notes that it does offer consistency of approach. It also helps avert a potential conflict of interest where a potential properly interested person to an inquest were the same NHS Trust as employed the pathologist in that inquest. The Review will note the prior enforcement action taken by HSE against some NHS Trusts.

8.3 In regard to the question of whether it is necessary to continue the post-mortem after the discovery of a likely cause of death, HSE has significant concerns as to the level of proof that may be required to halt a full post-mortem. In any future prosecution for unlawful killing, this could cause difficulties in proving guilt beyond reasonable doubt. As the Review points out at paragraph 59.4, the absence of full toxicological and histological investigations can undermine the value of a full post-mortem examination.