

CERTIFYING AND INVESTIGATING DEATHS IN ENGLAND, WALES AND NORTHERN IRELAND

THOMPSONS RESPONSE TO THE REVIEW OF CORONERS



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S O L I C I T O R S

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1. INTRODUCTION

Thompsons is the UK's largest trade union and personal injury law firm. It has a network of 18 offices across the UK, including the separate legal jurisdiction of Scotland and Northern Ireland. Thompsons' only acts for the victims of injury.

Thompsons has been an active participant in government consultation on legislation.

Thompsons is the UK's largest personal injury law firm. At any one time Thompsons will be running 70,000 personal injury claims on behalf of Claimants only. Thompsons does not act on behalf insurers or employers. The vast majority of personal injury cases pursued by Thompsons relate to employment liability claims.

This response is directed primarily to the issue of inquests in work related deaths ie when a person dies in the course of the operation of an organisation's business, whether or not employed by that organisation.

The Consultation Document of the Review of Coroners contends that there should no longer be an automatic right to an inquest in a work related death case and if an inquest should take place no automatic right to a jury. Thompsons opposes this for the reasons that are set out in this response.

2. EUROPEAN CONVENTION ON HUMAN RIGHTS

Article 2(1) of the European Convention on Human Rights (ECHR) imposes a positive obligation on states to protect the right to life by law. Procedurally, the obligation on states to protect the right to life by law requires effective enforcement of the law. This means taking appropriate measures to protect life, investigating all suspicious deaths efficiently and prosecuting alleged offenders where appropriate to do so.

The European Court has found that whenever a person dies in suspicious circumstances, Article 13 ECHR, the right to an effective remedy, requires, without prejudice to the availability of any other remedy, a thorough and effective investigation capable of leading to the identification and punishment of those responsible (see **Aksoy -v- Turkey (1997) 23 EHRR 553**; **Aydin -v- Turkey (1998) 25 EHRR 251**; **Kaya -v- Turkey Court (19th February 1998)**; and **Kurt -v- Turkey (21999) 27 EHRR 373**).

3. PURPOSE OF AN INQUEST

An inquest is to determine how, where and when the deceased came to his/her death.

The meaning of “how” is defined widely. It was said in **R -v- HM Coroner for Western District of East Sussex ex parte Humberg [1994] 158 JP 357**:

“Although the word “how” is to be widely interpreted, it means “by what means” rather than “in what broad circumstances”. In short the inquiry must focus on matters directly causative of the death and must indeed be confined to these matters alone”.

It was also said:

“..the question of how the deceased came by his death is of course wider than merely finding the medical cause of death and it is therefore right and proper that the coroner should inquire into acts and omissions which are directly responsible for the death.....

Once an inquest is held, the duty to inquire into “how the deceased came by his death” requires one then to take a broader view and investigate not merely the dominant cause but also ...any acts of omission which are directly responsible for the death.”

It should be noted that unlike a criminal prosecution or a civil claim, an inquest is *inquisitorial* not *adversarial*. Rule 42 of the Coroners Rules states that no verdict shall be framed in such a way as to determine criminal or civil liability. This relates to the verdict not to the inquiry.

4. UNDERLYING CAUSES

The understanding of the causes of work related incidents, that on occasions lead to death, has developed greatly in the last two or so decades.

HSG65, *Successful health and safety management*, (first published by the Health and Safety Executive (HSE) in 1991 with the second edition in 1997) states at page 9:

“Accidents, ill health and incidents are seldom random events. They generally arise from failures of control and involve multiple contributory elements. The immediate cause may be a human or technical failure, but they usually arise from organisational failings which are the responsibility of management. Successful policies aim to exploit the strengths of employees. They aim to minimise the contribution of human limitations and fallibilities by examining how the organisation is structured and how jobs and systems are designed.

Organisations need to understand how human factors affect health and safety performance. These are explained in more detail in the HSE publication HSG48 [Reducing error and influencing behaviour] which also contains guidance on how to develop suitable control strategies in a systematic way...”

The HSE estimates that some 80% of work place accidents involve some form of human factors. HSG 48, *Reducing error and influencing behaviour*, (first published by the HSE in 1989, with a second edition in 1999) states at page 4:

“Many accidents are blamed on the actions or omissions of an individual who was directly involved in operational or maintenance work. This typical but short-sighted response ignores the fundamental failures which led to the accident. These are typically rooted deeper in the organisation’s design, management and decision-making functions.”

5. OTHER PROCEEDINGS

The Consultation Document states that work related death inquests were thought by coroners to be less useful than others. It is not stated exactly why coroners believe this nor upon what criteria this contention is made.

Paragraph 86 of the Consultation Document points out that investigations at work are investigated by the HSE and in some cases the police. It also says there may be civil proceedings. The implication is that the necessity for an inquest is being questioned in cases where there are criminal or civil proceedings because no doubt it is believed that these processes will determine “how” the deceased died. If this is the case, then this is a misunderstanding as to the nature of those processes.

CRIMINAL PROCEEDINGS

An HSE investigation is not about “how” a person died, but whether there has been a breach of the Health and Safety at Work Act 1974 (HSWA) ie a criminal offence has been committed. A prosecution by the HSE will be normally for a breach of Sections 2 and/or 3 of the HSWA.

Section 2 of the HSWA states:

“It shall be the duty of every employer to ensure, so far as is reasonably practicable, the health and safety and welfare at work of all his employees.”

Section 3 of the HSWA states:

“It shall be the duty of every employer to conduct his undertaking in such a way as to ensure, so far as is reasonably practicable, that persons not in his employment who may be affected thereby are not thereby exposed to risks to their health and safety.”

It is important to note, that for a company to be guilty of either a breach of Section 2 or 3, it does not have to be proved by the HSE that the breach *caused* the death of the deceased, only that a risk of injury was *created* by the breach. Thus the causation element of the inquest is not required by this type of investigation.

A police investigation into a work related death, will be concerned individual manslaughter and corporate manslaughter, more than likely based on *gross negligence*.

The leading case on this area of law is **R -v- Adamako [1994] 3 All ER 79**. **Adamako** establishes that to convict someone of gross negligence manslaughter the jury must be satisfied:

1. The defendant owed a duty of care to the deceased; and
2. He/she was in breach of that duty; and
3. The breach of duty was a *substantial* cause of death (ie it has to be more than trivial, it has to be a significant); and
4. The breach was so grossly negligent that the defendant can be deemed to have had such disregard for life of the deceased that it should be seen as criminal and deserving of punishment by the State.

In **R -v- Litchfield [1998] Crim. L.R. 507** the Court of Appeal approved the following direction as to what is meant by gross negligence:

“Before you could convict this defendant of manslaughter, the negligence established must go way beyond the mere matter of compensation between parties. It must be more than just some degree of fault, or mistake, or error of judgement, or careless even though that led to death. It must be such as to demonstrate a reckless disregard for the lives of others of such a nature, and to such an extent, that in your judgement the negligence is so bad that it can properly amount to a criminal act”.

Like an HSE prosecution it is concerned with whether a criminal offence has been committed. In terms of looking at causes it is only concerned with the acts or omissions of the individual who has been charged with the offence of manslaughter. However there may be other causes which are not part of the investigation of the police.

To prove corporate manslaughter the police must satisfy the doctrine of the ‘directing mind’. This means the police have to prove that a senior person (normally a director) in the company has been grossly negligent and that this negligence can be deemed to be that of the company (see the Attorney General’s appeal to the Court of Appeal on 15th February 2000 – **Attorney General’s Reference No 2/1999**).

Proving corporate manslaughter has been notoriously difficult. Thus a police investigation is unlikely to consider ‘management failures’ that were involved in the deceased’s death.

There are of course the Government's proposals for 'corporate killing' but at the moment they only remain proposals. Even if these become law, this will be a criminal investigation and so may not adequately deal with the "how" question.

An inquest may also result in the prosecuting authorities considering criminal proceedings where they have not done so before eg **R -v- P & O European Ferries (Dover) Ltd [1991] 93 Cr App R72**.

CIVIL PROCEEDINGS

A civil claim is a legal action by one party, the claimant, against another party or parties, the defendant(s), to settle a 'dispute'. In a work related death incident there is a possibility of a personal injury claim being brought by the estate of the deceased. This will be about whether there has been a breach of common law or statutory duty by a party and if this 'materially' contributed to the death of the deceased. The purpose of the proceeding is to obtain compensation, not to find out "how" the deceased died.

Well over 90% of personal injury cases are settled without the case going to a trial. They may be settled without the defendant accepting liability.

A civil claim will normally only be brought if there is a 'dependency'. Thus if the deceased is an adult, not married and without children, the claim will only be worth the funeral expenses. In such cases it would be hard to justify a civil claim.

However there may be other parties who have a right to appear at an inquest but would not be entitled to bring a civil claim eg a trade union who represent members in the industry in which the deceased died.

The consultation fails to mention the position where there is a public inquiry. Since Section 17 of the Access to Justice Act 1999 came into effect, any inquests will normally be adjourned until after the public inquiry as effectively the inquiry will determine the cause of the incident and thus how the deceased came to die.

Paragraph 88 sets out the criteria that would be applied to determine if there were to be an inquest. It is Thompsons position that there should be an automatic right to an inquest. However if there were to be criteria, the issues would be how they were applied and by whom.

As indicated by HSG 65 work related deaths are seldom random events. Therefore there are nearly always “causes” to be investigated. Families and others will want to know not only about the immediate causes (which are often obvious), but also the underlying causes, which an inquest has a better chance of ascertaining (because it is inquisitorial and is about “how” the deceased died). It is suggested that it would be very rare to find a family that did not want an inquest.

In an inquest the family can be involved in the hearing, unlike in a criminal prosecution. For the reasons set out above, in a civil claim, they are unlikely to get to a hearing.

It is difficult to see exactly how these criteria can be applied practically in an equitable way to a work related death, particularly when there is a need to find immediate and underlying causes.

The Consultation Paper appears to make a distinction between deaths at the hand of, or premises controlled by, State Bodies as opposed to other organisations. This is of concern since corporate bodies are arguably less accountable than state bodies and it is more difficult to find out information about them.

It should be remembered that inquests also have an important reporting provision. Rule 43 of the Coroners Rules allows a coroner to announce at an inquest that he/she is reporting the incident to the relevant authorities in order to prevent similar fatalities. This is an important function which should not be overlooked. Given the nature of work related deaths this can best be performed after a hearing of the evidence. Thus the need for work related deaths to be automatically investigated.

6. JURIES

A possible outcome of an inquest into a work related death is for the matter to be referred to the prosecuting authorities to consider whether a criminal offence has been committed. Thompsons submits that given this there should be a presumption of a jury inquest, unless all the parties involved agree otherwise.



7. VERDICTS

Thompsons is of the view that without short form verdicts, the inquest process would be deprived of an important meaning which is now has, particularly in relation to verdicts such as “unlawful killing”. However it is accepted, that since the causes of work related deaths are often multi-faceted that there is room for, and indeed an requirement for, there to be the possibility for a more narrative addition to the verdict.



8. CIVIL LIABILITY ISSUES

The Consultation Paper suggests that the inquest could be extended to deal with civil liability issues. Thompsons is opposed to this.

The proposal mixes the two different purposes of these types of proceedings: a civil claim is adversarial and is to determine if there has been a breach of duty which was a material cause of death where as an inquest is inquisitorial and is to determine “how” the deceased died. Further if this were to be adopted it may result in jurisdictional problems.

There is no reason why the decision of an inquest could not be used in civil proceedings in the same way a criminal conviction can now be pleaded and relied upon.

9. FUNDING

Thompsons agree that funding is an issue that needs urgent attention. In a work related death case the legal representation of the company will be met by its insurers. Legal aid is not available to the family of the deceased. Unless the family of the deceased can afford legal representation, or it is provided for it, the family is reliant upon lawyers acting on a pro bono basis. There is therefore a clear inequality of arms.

Perhaps when considering this issue, parallels can be drawn from the arrangements made at public inquiries.

The representation of individuals involved in the work related death incident should not be overlooked. The evidence from the inquest might lead to a criminal investigation against them. Their rights need to be protected. Thus there is a need for provision to be made for their representation.

A front line worker involved in the incident will not be covered by a “Directors and Officers” insurance policy. If the individual is represented by his/her employer’s lawyers, there is almost likely to be the possibility of a ‘conflict of interest’.

10. IMPROVEMENTS TO INQUESTS

There can be few who would argue that the inquest procedure is in need of updating and improving so that it can meet the needs of the 21st Century. The following are areas that need consideration in work related death inquests. This is by no means an exhaustive list.

1. That the procedures meet the requirements of Article 2 of the ECHR.
2. The nature of the verdicts available (see 7 above)
3. Funding (see 9 above)
4. There is a need for full time coroners who have been fully trained and properly understand work related incidents (and the law that surrounds them).
5. The scope of an inquest to ensure it can adequately deal with immediate causes and underlying causes
6. That all parties involved have access to the evidence. Often witness statements and documents are not provided to the representatives of the bereaved until the inquest has started giving little or no time to prepare. This puts the representatives at a disadvantage to the lawyers for the company. There is an inequality of arms.
7. All parties should have involvement in the decision as to the documents that should be part of the inquest and the witnesses that are to be called.
8. The evidence given at the inquest should be taped so that there is a proper record.
9. The important role of reporting the findings to prevent future incidents should not be overlooked. Perhaps something along the lines of the Fatal Accident Inquiry in Scotland should be considered.
10. There should be a process of appeal

11. CONCLUSIONS

Thompsons submits for the reasons set out above that there should be an automatic right to an inquest where there has been a work related death. Further there should be a presumption of a jury inquest.

The role of the inquest should not be overlooked or underestimated. It is there to consider “how” a person died. It is the only inquisitorial investigation that is ensured into the death. Criminal and civil proceedings are not there to fulfil this function.

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