

Come in number 43

Gerard Forlin QC & Louise Smail assess the impact of Rule 43

Since 1194 when the office of coroner was established, the role and significance of coroners has increased. The coroner's role is an independent judicial officer who investigates sudden, violent, or unnatural death. The verdict must be given in such a way that it doesn't appear to determine any question of criminal or civil liability. An inquest should not take place until the police have confirmed that there are to be no prosecutions. However, if in the course of the inquest evidence arises which suggests there ought to be a prosecution, then the coroner is able to refer the matter back to the police and/or director of public prosecutions to reconsider the matter. If there is an unlawful killing verdict, the matter is automatically referred back to the police. In relation to health and safety prosecutions these normally, but not always, are brought after the inquest has been concluded. See *R v Beedie* [1997] 2 Cr APPR 167.

Changes to Rule 43 have meant that for the last few years coroners may announce at the inquest that they intend to make a report (for example, to the Health and Safety Executive (HSE)) with recommendations for action. The Rules do not specify the information that must be included in a report, however, guidance to coroners (*Guidance for coroners on changes to Rule 43: Coroner reports to prevent future deaths* para 2.9) states that they should take care not to draft reports in a way that might prejudice related legal proceedings or apportion blame. The coroner must send a copy of any Rule 43 report to the lord chancellor and interested persons. In many cases the report is not needed—where organisations have already taken remedial action to prevent a recurrence. The recipient of the report needs to reply within 56 days of receiving to indicate what action they are taking or why they are not taking any action. This is a potentially powerful tool that coroners can use to make recommendations to prevent another death occurring in similar circumstances—especially where the death has involved

issues of health and safety. From the published reports some good and valuable recommendations have been made.

For whom the bell tolls

For instance, a churchwarden climbed a bell tower without a safety harness on a vertical ladder in order to check the weather vane on the top of a church tower. As a result of his fall from the ladder onto a concrete floor he died of his injuries two days later. The HSE regarded the church as a workplace and so the checking of the weather vane, and the use of the ladder, came within the Work at Height Regulations 2005 (SI 2005/735). These Regulations were not being followed and so the church was issued with a prohibition notice. This prohibited the use of the ladder and required improvement work to be carried out within nine months of the incident.

“If recommendations are not heeded by individuals and corporations then future similar events may have a big impact on them”

The coroner wrote to the secretary general of the Archbishops' Council, and asked him to take action to prevent a recurrence of the accident. However, the council advised that it had no powers to provide solutions to local situations as each Parochial Church Council is autonomous, but the council did agree that it would review the guidance issued by the Church Buildings Council on working safely at heights and would stress the importance of using a harness or safety cage. The council also told the coroner that the vertical ladder from which the churchwarden had fallen had been removed and replaced with an angled ladder with a number of safety features, including a harness.

In another case, a householder decorating the side of a house had hired a mobile platform from a company, which provided equipment and instructions. The householder was found at the foot of the platform and he died from his head injuries.

The coroner wrote to the Hire Association Europe (HAE), the representative body of the hire company, as follows:

- Construction of the structure required a minimum of two people with sufficient expertise and up-to-date instructions
- The coroner drew attention to the HSE leaflet *Using Work Equipment Safely*, in particular to page 6 on safety responsibility.
- He said that the HAE should write to its members to ensure that the 2005 Regulations and the HSE leaflet were referred to in any instruction leaflets.
- The HAE should encourage its members to enquire carefully with prospective hirers as to their capability to use the equipment being hired.

HAE replied that they were willing to circulate their membership as requested referring to the particular case.

Scope

The pending changes to the Coroner and Justice Act 2009 are beyond the scope of

this article, but it is crucial to recall that if recommendations are not heeded by individuals, corporations and industries, then future similar events may have a big impact on them.

Given that we have just seen the first successful prosecution of a company under the Corporate Manslaughter Act, this may herald the launch of more prosecutions. This trend needs to be taken more seriously. This general inclusive approach may well also have implications after the introduction of the Bribery Act. One must also consider that when the small defendant company Geotechnical Holdings Ltd was fined 116% of turnover that this may indicate the shape of things to come for other larger organisations and sectors. NLJ

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