MEMORANDUM OF UNDERSTANDING

between

THE CHIEF CORONER OF ENGLAND AND WALES

and the

THE AIR ACCIDENTS INVESTIGATION BRANCH

THE MARINE ACCIDENT INVESTIGATION BRANCH

THE RAIL ACCIDENT INVESTIGATION BRANCH

Introduction

1. This Memorandum of Understanding (MoU) has been agreed between the Air Accidents Investigation Branch (AAIB), the Marine Accident Investigation Branch (MAIB), the Rail Accident Investigation Branch (RAIB), (the AIBs) and the Chief Coroner of England and Wales [the parties]. It sets out the principles for co-operation between these parties so that deaths resulting from air, railway and marine accidents can be investigated thoroughly and independently by each party. This MoU takes into account relevant legislation, and the parties' respective roles and responsibilities. The parties realise that each has different roles and responsibilities in relation to an accident that has resulted in the death of a person or persons. The parties agree to review the MoU every five years, or more frequently if the need arises.
2. The MoU recognises that coroners are independent judicial officers, that the AAIB, MAIB and RAIB are independent safety investigation authorities; all parties have duties in relation to investigating how a person lost their life in an air, rail or marine accident; and that each party in fulfilling these duties should take into account the respective roles and responsibilities of the other party.
3. The MoU provides a framework within which the AIBs and coroners can carry out their roles and discharge their responsibilities in co-operation with one another, to minimise

duplication and promote the wider public interest of holding effective inquests into deaths arising from accidents without prejudicing ongoing parallel investigations.

Accident Investigation Branch (AIB) safety Investigations

4. Following notification of a fatal accident the AIB will obtain sufficient information from the organisations and individuals involved to take a decision on what level of response is required. Where appropriate, the AIB will deploy to the accident site inspectors who are trained and experienced in both the industry and in the investigation of industry specific accidents, to gather evidence and conduct witness interviews.
5. An investigation may involve interviewing witnesses, gathering and analysing both documentary and physical evidence, and conducting detailed examination, testing and analysis. Where relevant, computer modelling or reconstructions will be undertaken to gain the fullest possible understanding of events.
6. Once sufficient information has been gathered to identify the circumstances of an accident, and the key facts of an accident have been established, the AIB's Chief Inspector will decide whether the potential safety benefits warrant a full investigation and publication of an investigation report.
7. Frequently it is necessary, as part of an AIB investigation, to determine: the state of health of any deceased persons immediately prior to the accident; any injuries caused during the accident; and the cause of death. It may also be necessary to identify and, in particular, determine whether or not they were impaired in any way at the time of the accident. In such cases, the AIB will seek the earliest possible release of post mortem examination results and toxicology reports. In certain circumstances, it is also beneficial for the AIB's inspectors to liaise directly with the pathologist, as this can often shed light on injury mechanisms and the forces involved.

Basis for co-operation

8. The parties recognise that each has its own statutory powers and that neither is entitled to direct, interfere with or hinder the others' investigations.
9. There should be an early discussion between the AIBs and the coroner after the respective AIB commences an investigation as to:

- the likely progress of the investigation;
- the evidence held by each party and how access to it can be facilitated within the limits of the applicable regulations;
- the need/desirability of the AIB having 'interested person' status under the Coroners and Justice Act 2009;
- the arrangements for briefing the bereaved;
- the timing of any pre-inquest hearing and the inquest itself;
- the chronology of any legal proceedings; and
- how and when future updates will be provided.

This should enable the coroner to pursue any separate lines of enquiry.

10. The AIBs will co-operate with the coroner to share factual evidence, where this is permitted by the applicable regulations.

11. Coroners may request assistance from the respective AIB. This agreement recognises that such assistance is incidental to, and not a part of, the AIBs' function.

12. In the event of a mass fatalities incident requiring a meeting of the Mass Fatalities Coordination Group, the coroner will invite a representative from the AIB and a representative will attend that meeting.

13. In almost every case it will be desirable for the coroner's inquest to take place after the relevant AIB has published its investigation report. This will enable the AIB to support the inquest fully with the confirmed findings of its investigation and avoid a situation where the investigation and the inquest separately cover the same ground. Where the coroner feels it to be essential to hold the inquest before the AIB's report has been published, the AIB will be constrained in the extent to which they will be able to provide the inquest with any analysis of the evidence. In these circumstances, the coroner may wish to consider limiting the scope of the inquest by excluding detailed consideration of the causes of the accident.

AIB witnesses

14. Obtaining the trust and confidence of witnesses is fundamental to the AIBs' ability to function effectively, and the AIBs are obliged under their enabling regulations to keep confidential the details of any AIB witnesses interviewed and any statements or declarations taken from them in the course of the AIB investigation.

15. If requested to do so, the AIB will contact specified witnesses to advise them that the coroner wishes to speak to them. Witnesses may then decide if they wish to contact the coroner as a result of this approach. The coroner may at any stage contact and arrange to interview any witness whose identity is already known to the coroner.

Disclosure

16. The regulations applicable to the AIBs require that they shall not disclose statements taken from persons by AIB inspectors in the course of the safety investigation, or records revealing the identity of persons who have given this and other evidence to the AIB. They shall not provide notes, and opinions written or expressed in the analysis of information. In addition, the Air Accidents Investigation Branch shall not make available cockpit voice and image recordings and their transcripts.

17. The AAIB and RAIB are prohibited by the applicable regulations from disclosing the draft report to the coroner. It may be possible for the MAIB to share a copy of the draft report with the coroner 'in confidence', if requested to do so.

18. If the coroner and the AIB cannot identify a means by which information can be disclosed without causing prejudice to an ongoing or future safety investigation, it is open to the coroner to make the relevant application to the High Court. To avoid protracted legal proceedings that might hamper the progress of an inquest, coroners should make requests at the earliest opportunity for any material collected by AIBs during the course of an accident investigation. This will enable the AIBs to tell the coroner whether or not they can release any such material.

19. Prior to finalising and publishing their reports, the AIBs are required, by the respective regulations, to circulate draft copies for consultation to any person or organisation that could be adversely affected by the report. The purpose is to give those involved, and those whose reputations may be adversely affected, the opportunity to submit representations on the relevant parts of the report to correct any factual discrepancies or to point out any relevant considerations that they believe have not been taken into

account in the draft report. Where a person whose reputation could be affected is deceased, the AIB will circulate the draft report to the person it considers best to represent the interests and reputation of the deceased.

AIB attendance at an inquest

20. The normal function of an AIB inspector at a coroner's inquest is to substantiate only the factual findings of the AIB's safety investigation. To facilitate understanding, they may also provide technical explanation of the material included in the AIB report. They will also answer questions on factual matters contained in the AIB's report. Noting that an AIB report may be the cumulative product of several inspectors' inputs, coroners should specify any areas they intend to explore so that the AIB can ensure the appropriate inspector is available to the inquest.

21. AIB inspectors are prohibited by regulation from attributing blame or liability and so do not act as expert witnesses as this may draw them into speculation. Coroners, therefore, should not invite AIB inspectors to provide any opinions, as this could give the impression that they were apportioning blame or liability.

Agreement

22. The parties have agreed to co-operate according to the principles outlined in this Memorandum.

Dated 23/10/17

Signed by ..... CELSMW OBE

Chief Inspector of Air Accidents On behalf of the Air Accidents Investigation Branch

Dated 23/10/17

Signed by ..... SIMON FRENCH

Chief Inspector of Rail Accidents On behalf of the Rail Accident Investigation Branch

Dated 23/10/17

Signed by .....

Chief Inspector of Marine Accidents On behalf of the Marine Accident Investigation Branch

Dated 23/10/17

Signed by .....

Chief Coroner of England and Wales

Annex 1

ROLES AND RESPONSIBILITIES

Accident Investigation Branches - General

22. The sole purpose of an AIB safety investigation is to determine the causes and circumstances of transport accidents and make recommendations to prevent a recurrence. It is not the purpose of an AIB investigation to apportion blame or liability.

23. The AIBs are functionally independent bodies within the Department for Transport, separate from the transport regulators[1] and report directly to the Secretary of State on all investigation matters.

24. The AIBs have a collective Memorandum of Understanding (MoU) with the Crown Prosecution Service. Individual AIBs have separate MoUs with the National Police Chiefs' Council that set out the grounds for co-operation and, where appropriate, primacy, such that safety investigations can proceed in parallel with criminal investigations. The AIBs are not signatories to the Work Related Death Protocol.

The Air Accidents Investigation Branch

25. The AAIB investigates aircraft accidents and serious incidents that occur in the UK. It also participates in accident investigations worldwide where there is a specific UK interest.

26. The AAIB conducts investigations into civil aviation accidents in accordance with the Civil Aviation (Investigation of Air Accidents and Incidents) Regulations 1996, and Regulation (EU) 996/2010 of the European Parliament and of the Council of 20 October 2010 on the investigation and prevention of accidents and incidents in civil aviation. These regulations take account of international standards and recommended practices for this activity described in Annex 13 to the Convention on International Civil Aviation.

The Marine Accident Investigation Branch

27. The MAIB was established in 1989 with responsibility for investigating marine accidents to determine their circumstances and causes. Its legislative powers are primarily contained in Part XI of the Merchant Shipping Act 1995 and associated secondary legislation. The Merchant Shipping (Accident Reporting and Investigation) Regulations 2012 (SI 2012/1743) put this framework into effect.

28. The UK is obligated to investigate marine accidents by the International Maritime Organisation's Maritime Safety Committee Resolution MSC.255(84)[2], and European Council (EC) Directive 2009/18/EC[3]. The EC Directive requires member states to carry

[1] The transport regulators are: the Civil Aviation Authority (CAA), the Maritime and Coastguard Agency (MCA), and the Office of Rail Regulation (ORR) or, in the case of the Channel Tunnel, the Intergovernmental Commission.

[2] MSC.255(84) - Code of the International Standards and Recommended Practices for a Safety Investigation into a Marine Casualty or Marine Incident (the Casualty Investigation Code).

[3] Directive 2009/18/EC - Establishing the fundamental principles governing the investigation of accidents in the maritime transport sector and amending Council Directive 1999/35/EC and Directive 2002/59/EC of the European Parliament and of the Council.

out safety investigations into Very Serious Marine Casualties[4] involving most types of vessels. The obligation does not apply to leisure craft carrying less than 12 passengers, fishing vessels under 15 metres in length, and certain other types of craft including warships.

29. The Accident Reporting and Investigation Regulations are the foundation for the MAIB's work. They apply to merchant ships, fishing vessels and (with some exceptions) pleasure craft. They define accidents, set out the purpose of investigations, and lay down the requirements for reporting accidents. They make provision for the ordering, notification, and conduct of investigations; but allow the Chief Inspector the necessary discretion, given the wide variety of cases, as regards when he chooses to commence an investigation into an accident or incident.

The Rail Accident Investigation Branch

30. The RAIB was established by the Railways and Transport Safety Act 2003 (RTSA). It is the independent railway accident investigation body for the United Kingdom, as required by the European Railway Safety Directive, 2004/49/EC.
31. The Railways (Accident Investigation and Reporting) Regulations 2005 (SI 2005/1992) implement that part of the Directive dealing with rail accident investigation which was not implemented already by the Railways and Transport Safety Act 2003. It sets out the procedures for dealing with specified accidents and incidents, including notification requirements, dealing with evidence and publishing reports and recommendations.
32. The RAIB is required by the Directive to investigate serious accidents, as defined by the Directive, and has discretion to investigate other accidents and incidents. Its remit covers all railways, except for those in: most industrial curtilages; museums; and funfairs. The remit also includes tramways in England and Wales, and the UK side of the Channel Tunnel Fixed Link up to the mid-point.

The coroner

33. Coroners are independent judicial officer holders with statutory responsibility for investigating the cause and circumstances of any death which may be violent, unnatural or of unknown cause. The coroner has lawful physical control of the body in such circumstances and for all practical purposes is the only person who can authorise a post mortem examination.
34. The coroners' service is a local service. England and Wales is divided into a number of coroner areas. Areas vary according to the size and nature of the area and population. Each coroner area has a senior coroner who is primarily responsible for the provision of coroner services in that area. Coroners are available at all times for certain functions, but may work part time. In some areas the senior coroner is assisted by an area coroner and in all areas he or she will be have one or more by assistant coroners, as well as coroner's officers and administrative staff often supplied by the local authority and/or local police force. Staffing levels vary from area to area. In some areas the level of support is very limited, as are the resources for administrative and judicial work.

[4] A very serious marine casualty is one that involves loss of a vessel, death, or serious pollution (as determined by the member state).

35. The coroner's jurisdiction is territorial in that it is generally the location of the dead body that determines which coroner may have jurisdiction in any particular case. However, when a person dies out at sea the 'location of the dead body' for the purpose of determining which coroner has jurisdiction may be either a) the port where the body is landed upon arrival ashore b) the location where the body is to be buried or cremated or c) the jurisdiction where the deceased lived before they went to sea. The distance the body is from the shore when found may also have an impact on the jurisdiction of the coroner.

36. The role of the inquest into a death is to determine the identity of the deceased, and to establish when, where and how the deceased came by his or her death. The conclusion will be recorded as a record of the inquest, which may take a narrative form.

37. The inquest is not a trial of rights and obligations, but a fact-finding exercise, with no parties or pleadings. The inquest finding cannot determine or appear to determine civil liability. Findings appearing to determine criminal liability are permitted, but not on the part of a named person.

38. 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 coroner alone is responsible for deciding on the scope of the inquest and the evidence to be called. The relevant issues will vary from case to case, and may or may not be the subject of disputed evidence. This means that the conduct of the inquest will vary from case to case.

39. At the conclusion of the inquest the coroner (but not the jury) may make a ‘Report on Action to Prevent Future Deaths under paragraph 7, Schedule 5, of the Coroners and Justice Act 2009 and Regulations 28 and 29 of the Coroners (investigations) Regulations 2013 (normally called PFD reports or Regulation 28 reports). Such a report is to a person in authority if the coroner believes that action should be taken to prevent the recurrence of similar fatalities.