

Chapter 21: Investigations involving the AIBs

KEY MATERIALS

Cases

[R \(Secretary of State for Transport\) v. HM Senior Coroner for Norfolk \[2016\] EWHC 2279 \(Admin\)](#)

[HM Senior Coroner for West Sussex v. Chief Constable of Sussex and Secretary of State for Transport \[2022\] EWHC 215 \(QB\)](#)

[R \(Mid and West Wales Fire and Rescue Service\) v HM Acting Senior Coroner for Pembrokeshire and Carmarthenshire \[2023\] EWHC 1669 \(Admin\)](#)

Introduction

1. The three Accident Investigation Branches (AIBs) are independent state authorities, that have a statutory duty to conduct safety investigations into accidents and certain incidents in their respective transport sectors.
2. Where the Air, Marine or Rail Accident Investigation Branch has undertaken, or is undertaking an investigation into an accident which has led to a death, there are specific features in the way that coroner's investigations should be conducted.

AIB investigations

3. The AIBs are effectively part of a worldwide community of accident investigation bodies, each with the aim of improving the safety of transport. The AIBs routinely lead or participate in complex multi-national investigations in accordance with international treaty obligations, and frequently provide advice and expertise to other States on accident investigation matters.
4. Following notification of a fatal accident, the relevant AIB will obtain sufficient information from the organisations and individuals involved to decide 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. They may be assisted by accredited representatives, technical advisers and experts from other States.
5. AIB Inspectors are accorded a wide range of statutory powers, including having immediate and unrestricted access to the accident site, wreckage and its contents, recordings and early access to witnesses. They have powers to control the removal of evidence from the site for examination. They can request medical information, results

of post-mortem examinations and tests on the people involved. They can obtain other sources of evidence such as any documentary record relevant to the safety investigation.

6. Once sufficient information has been gathered to identify the general circumstances of an accident, the relevant AIB's Chief Inspector will decide whether the potential safety benefits to be gained warrant a full investigation and publication of an investigation report. This may involve conducting detailed examinations, testing and analysis to gain the fullest possible understanding of events.
7. At any stage of the investigation, the AIB may issue safety recommendations to the authorities concerned, on any preventative action that it considers necessary to be taken promptly to enhance safety. A safety recommendation shall in no case create a presumption of blame or liability for the accident.
8. On completion of the investigation, the AIB will publish a final report, after consulting with relevant parties in accordance with its legislation.
9. Following publication of the final report, the Chief Inspector of each AIB has powers to re-open an investigation, if they consider that new and significant evidence has become available.

Interaction with AIBs in the preliminary stages

10. Following a fatal air, marine or rail accident, the relevant AIB and coroner both have statutory responsibilities to conduct independent investigations to establish relevant facts and causes without attributing blame or liability. Their objectives may overlap to some extent but are not identical. The relevant AIB and coroner will determine the scope of their respective investigations.
11. It is likely to be desirable for the coroner to use their discretion to suspend their investigation until the relevant AIB has completed its investigation and published its final report¹. This will enable the AIB to support the inquest fully with the confirmed findings of its investigation underpinned by a publicly available final AIB report. Where the coroner feels it is essential to hold the inquest before the AIB's report has been published, the coroner may wish to limit the scope of the inquest by excluding detailed consideration of the causes of the accident².
12. Following a fatal air, marine or rail accident, the coroner will have control of any deceased persons and the relevant AIB will generally control the recovery and assessment of the wreckage. There should be an early discussion between the coroner and the AIB as to the evidence held by each of them, and how access to it can be

¹ See R (Secretary of State for Transport) v. HM Senior Coroner for Norfolk [2016] EWHC 2279 (Admin)

² See paragraph [18] below.

facilitated. The AIB may also identify any specific tests or examination of the deceased that will assist its investigation and should discuss this with the coroner.

13. It is often 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 determine whether or not they were impaired in any way at the time of the accident. The AIB is likely to request that a forensic post-mortem examination be conducted³. In certain circumstances, it may be beneficial for the AIB's Inspectors to liaise with the pathologist, as this can shed light on injury mechanisms and the forces involved. Coroners should therefore discuss with the AIB whether the AIB wishes to speak to the pathologist directly, and seek confirmation as to the matters upon which the AIB wishes to seek the pathologist's opinion. The AIB is likely to seek the earliest possible release of post-mortem examination results and toxicology reports as these can have a direct bearing on the focus of the AIB investigation.
14. The AIBs will normally deploy to the accident site to secure, preserve and assess the physical evidence. Wreckage, debris and components may be removed to a secure location for further examination or analysis. Some items may be subjected to tests that will modify the condition of, dismantle or possibly destroy all or part of the physical evidence. At the coroner's request, the AIBs will usually agree to keep secure the physical evidence that they hold until the conclusion of the inquest and provide access for the coroner and interested persons (IPs) if permitted by the regulations, or alternatively will transfer the evidence into the custody of the coroner.
15. An AIB that has investigated a fatal accident is likely to request to be given IP status in any inquest that is opened into that death.

The nature of a coroner's investigation where an AIB has investigated

16. In *R (Secretary of State for Transport) v. HM Senior Coroner for Norfolk [2016] EWHC 2279 (Admin)*, the Court gave a direction as to how inquests into deaths should be conducted, where the death resulted from an accident that has been investigated by an AIB.
17. At paragraph 49, Mr Justice Singh (as he then was) stated as follows:

“49. Finally, in my view, it is important to emphasise that there is no public interest in having unnecessary duplication of investigations or inquiries. The AAIB fulfils an important function in that it is an independent body investigating matters which are within its expertise. I can see no good reason why Parliament should have intended to enact a legislative scheme which would

³ Specific guidance on autopsy practice for aviation-related fatalities has been issued by the Royal College of Pathologists <https://www.rcpath.org/uploads/assets/c692998e-bc2e-42bf-8d70e195323cb8cb/G172-Guidelines-on-autopsy-practice-Aviation-related-fatalities.pdf>

have the effect of requiring or permitting the Coroner to go over the same ground again when she is not an expert in the field. ...”

18. The then Lord Chief Justice, Lord Thomas, developed this analysis at paragraphs 56 and 57:

“56. ...There can be little doubt but that the AAIB, as an independent state entity, has the greatest expertise in determining the cause of an aircraft crash. In the absence of credible evidence that the investigation into an accident is incomplete, flawed or deficient, a Coroner conducting an inquest into a death which occurred in an aircraft accident, should not consider it necessary to investigate again the matters covered or to be covered by the independent investigation of the AAIB. The Inquest can either be adjourned pending the publication of the AAIB report or proceed on the assumption that the reasons for the crash will be determined by that report and the issue treated as outside the scope of the Inquest.

57. It should not, in such circumstances, be necessary for a coroner to investigate the matter *de novo*. The coroner would comply sufficiently with the duties of the coroner by treating the findings and conclusions of the report of the independent body as the evidence as to the cause of the accident. There may be occasions where the AAIB inspector will be asked to give some short supplementary evidence: see, for example, *Rogers v Hoyle* [2015] QB 265 at paragraph 94. However, where there is no credible evidence that the investigation is incomplete, flawed or deficient, the findings and conclusions should not be reopened. ...”

19. In *HM Senior Coroner for West Sussex v. Chief Constable of Sussex and Secretary of State for Transport* [2022] EWHC 215 (QB), a differently constituted Divisional Court of the High Court (the President of the Queen’s Bench Division and Mr Justice Saini) endorsed this approach.
20. As a result of those decisions, coroners should usually not reinvestigate matters that the relevant AIB has already investigated (see below).
21. If following the AIB’s report there are no wider matters to deal with at an inquest and the coroner’s investigation has been suspended, the coroner may decide not to resume it⁴.
22. If the case proceeds to inquest, the scope should be set by the coroner in the usual way, but in respect of each planned issue:

⁴ See Guidance No 33: Suspension, Adjournment and Resumption of Investigations and Inquest for the considerations relating to resumption of investigations.

- a) The coroner should consider whether the issue was investigated by an AIB. If it was then it should not be necessary for the inquest to investigate again the issue covered by the AIB, and in most cases the coroner can simply direct that the relevant sections of the AIB’s report be adopted;
 - b) There should usually be no need to adduce any further evidence on any issue investigated by an AIB, save as is necessary for the purposes of explanation or clarification by the AIB. However, which witnesses to call remains a matter for the coroner’s discretion.
 - c) At the conclusion of the inquest the jury should be directed to treat the “*findings and conclusions of the report of the [AIB] as the evidence as to the cause of the accident*”⁵.
 - d) The coroner must examine any issues in respect of the death which are within the scope of the coroner’s investigation, but were outside the scope of the AIB investigation. For example, the coroner may need to investigate the quality of care that a person who initially survived the accident received before they then died. The medical cause of death itself may also not have been investigated by the AIB.
23. The exception to the principle that the AIB’s investigation cannot be reopened is where there is credible evidence that the AIB’s investigation is incomplete, flawed or deficient. In *West Sussex*, the Court described this as “*An important and narrowly prescribed exception*”⁶. The Court emphasised that this exception is “*a strict requirement*”, as “*anything less would open the door to wasteful and duplicative reinvestigation by coroners*”.⁷ The fact that an expert might have been identified who takes a different view from the AIB “*would not mean that there was arguably credible evidence that the [AIB’s] investigation...was incomplete, flawed or deficient.*”⁸
24. Whether there is credible evidence should also usually be considered in relation to the investigation as a whole.⁹ It is a “high hurdle”, and minor criticisms of the investigation or some of the conclusions cannot amount to credible evidence for these purposes¹⁰.
25. If a coroner is going to hear submissions which suggest an AIB report is incomplete, flawed or deficient, this should ideally be done at an early stage of the investigation, given the potential impact on proceedings. If a coroner is presented with what they consider may be credible evidence, it would be sensible in the first instance to raise

⁵ *Norfolk*, paragraph 57.

⁶ Paragraph 125

⁷ Paragraph 126

⁸ *West Sussex*, paragraph 133(2)

⁹ *R (Mid and West Wales Fire and Rescue Service) v HM Acting Senior Coroner for Pembrokeshire and Carmarthenshire* [2023] EWHC 1669 (Admin), para 70-72

¹⁰ *Mid and West Wales*, para 73

this with the AIB Chief Inspector to consider whether the evidence requires the AIB to re-open their investigation.

26. Ultimately, it will be for the coroner to decide whether it is necessary for an application to be made to the High Court for protected material forming part of an AIB investigation to be made available to the inquest, taking into account the relevant case law (see the sections entitled ‘Disclosure and ‘Witnesses’ below).

Disclosure

27. The need for disclosure, and the extent of the investigation required by a coroner, is to be determined in accordance with the *Norfolk* and *West Sussex* principles. Bearing in mind the more limited nature of the investigation that is usually required in a *Norfolk* inquest, a Coroner may decide that significantly less disclosure is required for the purposes of their investigation than would otherwise have been the case. Disclosure should not normally be sought in order to ascertain whether there is credible evidence that the AIB investigation was incomplete, flawed or deficient.
28. If disclosure of evidence is required, the coroner should usually try in the first instance to obtain that evidence directly from the original source, or other investigative authorities such as the police, rather than from the AIB.
29. Certain categories of information held by the AIBs are protected from disclosure and can only be provided to the coroner by order of the High Court (or the Crown Court for the RAIB). The categories of protected material are specific to each AIB and depend on their governing legislation. If seized of a disclosure request, the Court is required to carry out a public interest balancing test between the benefits of disclosure in the interests of justice against the potential adverse impact it might have on the AIBs in conducting their current or future investigations.
30. To avoid protracted legal proceedings that might hamper the progress of an inquest, requests for disclosure from an AIB should be narrow and specific and made at the earliest opportunity.

Witnesses

31. Coroners should be aware that the AIBs have extensive powers to call and examine witnesses and to require them to furnish or produce information or evidence relevant to the safety investigation. Central to an AIB investigation is that witnesses feel free to speak openly without fear of recrimination or reprisal. Consequently, witnesses providing evidence to AIB investigations are afforded specific protections. The legislation for each of the AIBs differs in its detail, but all the AIBs are prohibited from disclosing witness details, statements or declarations unless ordered to do so by

the High Court. The High Court has previously ruled¹¹ that it is almost inconceivable that it would order an AIB to disclose a witness statement.

32. When a coroner is considering which witnesses are required to provide statements or be called as witnesses in the inquest, the decision should be informed by the *Norfolk* principles above. Because at the end of the inquest, the jury should be directed to treat the “*findings and conclusions of the report of the [AIB] as the evidence as to the cause of the accident*”¹², witnesses of fact should not usually be required on these matters. Of course, witnesses may be required in respect of any issues that were outside the AIB’s investigation, such as the medical cause of death or medical treatment provided to the deceased.
33. It will often be helpful for an AIB Inspector to give evidence at the inquest to explain the AIB’s conclusions and provide any necessary clarification or explanation to assist the Court in understanding the scope, factual basis, analysis and findings of the AIB investigation. Inspectors can describe their actions and provide an explanation of the material included in the report. The Inspector can be asked to elucidate as appropriate, including upon the analysis and findings and upon technical matters and factual evidence.
34. Given the technical nature of the evidence, and the fact that it will usually be a jury that has to reach the necessary findings, the coroner should liaise with the AIB in order to agree the most effective way for the Inspector(s) to present their evidence and the findings of the AIB investigation. This may include the jury hearing the evidence in part by way of a short presentation from the Inspector with relevant visual aids.

The need for a jury

35. Any inquest into a death arising from an accident or incident that has been investigated by an AIB is likely to require a jury (subject to the rules relating to resumed hearings¹³). This is because the AIB will in almost every case have investigated because the accident was required to be notified to the Chief Inspector of the AIB¹⁴, making them notifiable accidents for the purposes of s.7(2)(c) of the Coroners and Justice Act 2009, whether or not they are also notifiable accidents for any other reason.

¹¹ *Chief Constable of Sussex Police v Secretary of State for Transport and British Airline Pilots Association* [2016] EWHC 2280 (QB), paragraphs 42-43.

¹² *Norfolk*, paragraph 57.

¹³ See [Guidance No. 33 Suspension, Adjournment and Resumption of Investigations and Inquests](#)

¹⁴ The notification will have been under Regulation 20 of the Civil Aviation (Investigation of Air Accidents and Incidents) Regulations 2018/321 for the AAIB, Regulation 6 of the Merchant Shipping (Accident Reporting and Investigation) Regulations 2012 for the MAIB, or Regulation 4 of the Railways (Accident Investigation and Reporting) Regulations 2005 for the RAIB.

Communication

36. To enable coroners and AIBs to discharge their statutory duties efficiently, coroners should seek an early discussion in any AIB-related case as to:

- The scope of the AIB investigation and the likely scope of the inquest;
- The evidence held by the coroner and the AIB, and how access to evidence can be facilitated within the constraints of the applicable regulations;
- The need/desirability of the AIB having IP status;
- The arrangements for briefing the bereaved;
- The likely timescales of the AIB investigation, any other legal proceedings and the inquest.
- How and when future updates will be provided.

37. Coroners are advised to maintain regular communication with the AIB, as the AIB investigation and the preparations for the inquest progress.