WORK - RELATED DEATHS

INVESTIGATORS GUIDE

Foreword

This "Investigators Guide" has been produced to assist those tasked with investigating deaths in the workplace. It is intended to be read in conjunction with the revised "Work-Related Deaths: A Protocol for Liaison" document from which the core of the "Investigators Guide" has been drawn. This "Investigators Guide" is by no means mandatory but takes into account best practice and is intended as helpful practical guidance on following the principles of liaison from the Protocol.

The "Investigators Guide" is not intended to be a training document. It has been prepared on the assumption that those so tasked with investigating such serious and tragic matters, from whatever organisation, are qualified to do so.

The "Investigators Guide" sets out to provide a straightforward step-by-step approach to investigating deaths within the workplace and includes guidance in respect of domestic gas incidents and road deaths.

In preparing the "Investigators Guide", attention has been paid to the legislation that impact upon all criminal investigations. This includes the Police and Criminal Evidence Act 1984, Criminal Procedures and Investigations Act 1996 and the Youth Justice and Criminal Evidence Act 1999. In addition, it also takes account of the specific guidance provided to Police from ACPO manuals including those dealing with homicide, road death and the Human Rights Act 1998. Equal account has also been taken of the Health and Safety Executive's own operating policies, which are mirrored in guidance, issued to other Local Authority Agencies. The "Investigators Guide" applies to all work related deaths including deaths within the signatory organisations.

Police Officers should be aware that in addition to conducting a criminal investigation for the purpose of ascertaining whether a person (or company/organisation) should be charged with an offence, the Health and Safety Executive and Local Authorities have a responsibility to ensure duty holders (who maybe also suspects) take action to deal immediately with serious risks, and to promote and achieve sustained compliance with the law.

The construction of the "Investigators Guide" very much takes into account the underlying principles of the Protocol. It places an emphasis on a sound investigation and, in particular, the philosophy of Joint Investigation. The theme throughout the "Investigators Guide" is the need to liaise with colleagues from partner agencies. This is not left to chance or to the discretion of the individuals involved. A specific requirement is placed on the first person at the scene, the Police Supervisor and Investigating Officer to have appropriate liaison. The "Investigators Guide" provides not only the requirement to liaise; it provides an event driven timetable and presents the issues pertinent to the liaison when it takes place.

Introduction

The "Investigators Guide" commences with a flow chart, which seeks to encapsulate the Protocol on one page. This allows the Investigator to consider their action within the context of the Protocol. Following the flow chart is the "Investigators Guide".

The "Investigators Guide" has been laid out in a sequential and numbered 'tick-box' order. It commences with the initial actions at the scene through to the management stage of the investigation. Each numbered action has up to three 'tick-boxes'. Each of these 'tick boxes' sits within a column. The first column's title is **Done**. The second column's title is **Review** and the third column's title is **Police Only**.

The system is designed to be simple but effective. At each stage the user is expected to consider each action in turn. When that action has been done the appropriate **Done** 'tick-box' will be endorsed with a tick. The user will then move onto the next action.

The **Review** 'tick-box' allows the user to note when an action has been considered but not done, leaving the action subject to later review. The **Done** and **Review** 'tick-boxes' are always present and each user – irrespective of their parent organisation, is expected to endorse one of these two 'tick-boxes'.

The third 'tick-box' reflects the fact that some actions can only be undertaken by the Police. In the **Police Only** cases all three 'tick-boxes' will be present. The same process applies in terms of whether the action has been **Done** or **Reviewed.** The third **Police Only** 'tick-box' is intended to make it clear to the user that that particular action is for the Police to address, albeit in most instances, after consultation with the other parties. The **Police Only** boxes have been shaded and do not need to be ticked.

The only variation from the above is within the mandatory fields of the Joint Review and the Critical Review. In these areas only the **Done** 'tick-box' will be found. This allows for the decision making process to be conducted and for a clear indication to be made within the **Done** 'tick-box' as to which option has been adopted.

Within the "Investigators Guide" explanation has been provided as to certain issues. This can be identified by that part of the text being shown in ***bold italics***.

This guide was produced by a working group of the National Liaison Committee on the Work-Related Deaths Protocol (NLC). It was first published on the HSE website in March 2004. The Guide is intended to be a living document, that is, it can be updated and revised by the NLC as necessary.

Send feedback to the NLC at http://www.hse.gov.uk/enforce/wrdifeedback.htm

FLOW CHART – THE WORK RELATED DEATHS PROTOCOL 2003 Summary by Supt. D Kilbride, DC Yates Hampshire Constabulary

The Decision to prosecute Para 8 Page 8, WRDP

8.1 The decision to prosecute any serious criminal offence arising out of the death will be taken by the CPS according to the Code of Crown Prosecutors.
8.2 There should be no undue delay in reaching the prosecution decision
8.3 The CPS should take into account the consequences for the bereaved of the decision whether or not to prosecute and any views expressed by them
8.4 When the CPS has made its decision it will be communicated to all parties as soon as practicable
8.5 The HSE or other authority will decide whether to prosecute H&S offences without delay
8.6 No prosecution decision will be made public until the bereaved, the coroner, and potential defendants have been notified.
8.7 Any announcement must comply with the agreed media strategy
8.8 Where there is no CPS prosecution , CPS policy is to explain why to the bereaved. The Enforcing Authority's decision will be made after the Inquest.

Advice prior to charge para 7 , page 8, WRDP

7.1 Early liaison with CPS is to be encouraged
7.2 7.2 Police should seek advice of the CPS before charging an individual with any serious criminal offence arising out of a work related death
7.3 The police must consult the CPS Casework Directorate for advice when there is any consideration of charging a company or corporation.

Decision Making Para 4 page 7 WRDP

4.1 Where the investigation gives rise to suspicion that a serious criminal offence may have caused death police will assume primacy and will work in partnership
4.2 Where it becomes apparent that there is insufficient evidence that a serious criminal offence caused the death the investigation should be taken over by agreement by the HSE, local authority or other enforcing authority. Both parties should record the decision and the reasons
4.3 Where the HSE or other authority is investigating the death and raise new information which may assist the police to consider a serious criminal offence then this information will be passed to the police (it may be passed via enforcing authority solicitors to the CPS. The police should then reconsider whether to resume primacy (the decisions and reasons will be recorded
4.4 On rare occasions a Coroner's inquest, judicial review, or other legal proceedings, further consideration of the evidence and the facts may need to be made. This will be done jointly and may require further investigation.

Management of the Investigation Para 3.0 to 3.4 page 6 WRDP

3.1 Investigations should always be managed professionally, with communications between the signatory organisations continually maintained. Investigations should generally be jointly conducted, with one of the parties taking the lead, or primacy and may require liaison with an enforcing authority eg CPS.
3.2 Milestones should be agreed and monitored and policy and key decisions recorded. (This will include operating base and management structure)
3.3 The police HSE and local authority should agree upon
a) How resources are to be specifically used (Roles should be specified and OIC appointed)
b) How evidence is to be disclosed between parties (Where a joint Police /HSE manslaughter investigation is possible, care should be taken to secure evidence compliant with Pace and section 9 witness statements or Pace S8 searches. The HSWA s 20 gives powers to HSE Inspectors to enter premises, seize equipment, to require people to answer questions and sign as to the truth. Police use of evidence so gained must be lawful and reconciled. Police and HSE exhibit and disclosure officers should be appointed) (see 5.2 page 7 WRDP)
c) How the interviewing of witnesses, the instruction of experts (Home Office Pathologist) and the forensic examination of exhibits is to be coordinated
d) How and to what extent, corporate or organisational failures should be investigated.
e) A strategy for keeping the bereaved, witnesses, and other interested parties such as the coroner informed of developments (Family Liaison officers)
f) A media strategy to take account of the sensitivities of the bereaved and those involved in the incident, and to encourage consistency of approach of reporting.
3.4 In certain large-scale investigations it may be beneficial to form a strategic liaison group to ensure effective inter organisational communication, and to share relevant experiences.

The Prosecution Para 9 , Page 9 WRDP

9.1 The prosecution shall be jointly managed.

START HERE

Work related Death

Any person who dies as a result of an accident arising out of or in connection with work. S3 (1) RIDDOR

The Principles of the Work Related Death Protocol 2003 (WRDP). Page 4 WRDP

1. An appropriate decision on prosecution will be made on a sound investigation of the circumstances
2. The Police will investigate where there is an indication of a serious criminal offence (other than Health and safety offence). The HSE , the local authority, or other enforcing authority will investigate health and safety offences. There will usually be a joint investigation, but on the rare occasion this would not be appropriate, there will still be liaison and cooperation.
3. The decision to prosecute will be coordinated and made without undue delay
4. Bereaved families and witnesses will be kept informed
5. The parties to the protocol will maintain effective mechanisms for liaison

In what circumstances will this protocol apply? Page 5 WRDP

1. For the purposes of the protocol a work related death is a fatality resulting from an incident arising out of, or in connection with work. (It also applies to incidents where injury occurs but there is a strong likelihood of death)

2. In some cases it is difficult to determine whether a death is work related within the protocol(eg some road traffic incidents , in prisons, nursing homes, or following a gas leak) In such difficult cases each fatality will be considered individually and the enforcing authorities will hold discussions and agree a conclusion without delay.

Statement of intent Para 1.1 Page 5 WRDP

In the early stages of the investigation it is not always apparent if a serious criminal offence has been committed. Parties to the protocol should work together ensuring the investigation is thorough and appropriate. Parties should work together to reach a conclusion as to who leads the investigation and the direction it should take. The decision should be informed by best evidence and technical expertise.

Initial Actions at Scene

Duties of First Officer

See Work Related Death Investigators Guide numbers 1-28.

Duties of Supervisory Officer

See Work Related Death Investigators Guide numbers 29-37.

And to perform **Joint Review** number 38.

Duties of Investigative Officer

See Work Related Death Guide numbers 39-54 paying particular reference to the **Critical Review**. In respect of key issue of primacy (43) and scene release/retention (44).

In considering Gross Negligence Manslaughter

The principles of law of negligence apply

a) Does a duty of care exist towards the victim
b) Is the defendant in breach of that duty of care towards the victim
c) Did the breach of duty cause the death of the victim
d) Should it be characterised as gross negligence and therefore a crime
e) Was the conduct of the defendant so bad in all the circumstances as to amount to a criminal act or omission or reckless (was there an obvious serious risk which the defendant deliberately chose to run by doing nothing about it)

In considering Unlawful Act Manslaughter.

The following should be considered:
In DPP V Newbury 1977 the House of Lords approved the following dictum "where the act which a person is engaged in performing is unlawful, then if at the same time it is a dangerous act, that is, an act which is likely to injure another person, and quite inadvertently the doer of the act causes the death of that other person by that act then he is guilty of manslaughter.
The following propositions appear to need to be established
a) The killing must be the result of the accused's unlawful act
The unlawful act must be one, such as assault, which all sober and reasonable people would inevitably realise, must subject the victim at least, to the risk of some harm resulting, albeit not serious.
b) It is immaterial whether or not the accused knew that the act was unlawful and dangerous and whether or not he intended harm
c) Harm means physical harm

WORK RELATED DEATH
INVESTIGATORS GUIDE

DUTIES OF FIRST OFFICER

	DONE	REVIEW	POLICE ONLY	
				In most instances this will be a Police Officer. However, this may not always be the case. Consequently, HSE, Local Authority or other Investigating or Enforcing Authority who arrive in advance of the Police will also be expected to take appropriate action, unless the act in question is indicated as being within the Police Only category.
1.	☐	☐		Identify scene(s).
2.	☐	☐		Perform initial risk assessment. (Ensure area is safe).
3.	☐	☐		Ascertain location of fatality, Police will need to treat body as separate scene if removed.
4.	☐	☐		Set and secure parameters of scene(s).
5.	☐	☐		Commence written record.
6.	☐	☐	■	Request attendance of Scenes of Crime.
7.	☐	☐	■	Request attendance of Photographic.
8.	☐	☐		Establish who pronounced death.
9.	☐	☐		Identify witnesses.
10.	☐	☐		Enquire whether employer (or other responsible person) has contacted Police, HSE, Local Authority or other Local Enforcing Inspector.
11.	☐	☐	■	Inform Supervisory Police Officer.
12.	☐	☐	■	Inform Coroner.

	DONE	REVIEW	POLICE ONLY	
13.	☐	☐		Which gas appliances were on when the victim(s) were found?
14.	☐	☐		If seen, were the gas flames yellow (a correctly adjusted gas burner produces a blue flame, sometimes with a yellow core)?
15.	☐	☐		Was there any ventilation (open windows, doors etc) to the room where the victim(s) were found?
16.	☐	☐		Are there any substantial sooty stains above or around any gas appliance in the property?
17.	☐	☐		Did any of the emergency service personnel suffer illness (typically headaches, nausea) while attending the property?
18.	☐	☐		Are there other people still in the property (who might be at risk if the gas appliances are used again)?
19.	☐	☐		Is the property rented?
20.	☐	☐		When and by whom were appliances certified?
21.	☐	☐		Inform TRANSCO – (0800 111 999).

DUTIES OF FIRST OFFICER – IN CASE OF ROAD DEATH INCIDENTS

	DONE	REVIEW	POLICE ONLY	
				Road traffic law is enforced by the Police and others including Highways Authorities and Traffic Commissioners. The Police will in most cases take the lead in the investigation of Road Traffic Incidents (RTI) on public highways. The immediate "on-road" investigation will remain the responsibility of the Police and HSE Inspectors should not normally have an "on-road" presence at RTI's.
22.	☐	☐	■	Attend and deal with the incident in accordance with Force Policy and procedures.
23.	☐	☐	■	In accordance with the Road Death Investigation Manual a Supervisory Traffic Officer **MUST** be informed and attend.
				HSE will need to be contacted and may wish to attend the scene if the Road Death involves: -
24.	☐	☐	■	Exposure to a dangerous substance being conveyed by road.
25.	☐	☐	■	Loading and unloading of an article or substance (not passengers) onto or off a vehicle.
26.	☐	☐	■	Where works vehicles and where workers (not in vehicles) are engaged in specific work activity (other than travelling) e.g. hedge cutting, construction, demolition, alteration, repair or maintenance activities on or alongside public roads and vehicles connected with work premises manoeuvring out but in proximity of those work premises.
27.	☐	☐	■	An accident involving a train. (Also request attendance of BTP).

	DONE	REVIEW	POLICE ONLY	
28.	☐	☐	■	Ensure safety of responding Agencies by close liaison with Infrastructure Controller (normally Network Rail) in accordance with Rail Incidents Code of Practice (Network Rail/ACPO)
29.	☐	☐	■	Liaise with Rail Incident Officer (RIO) from Infrastructure Controller (normally Network Rail)
30.	☐	☐	■	Advise and request attendance of British Transport Police (BTP)
31.	☐	☐	■	Preserve all equipment involved in the incident including rolling stock
32.	☐	☐	■	Consider screening breath test of relevant workers – (Consult with BTP by telephone as necessary)
33.	☐	☐	■	Consult with BTP/HSE regarding preservation of off site evidence (Signal boxes etc.)
34.	☐	☐	■	Consider securing all paperwork on site including safety briefings etc.

DUTIES OF SUPERVISORY POLICE OFFICER

	DONE	REVIEW	POLICE ONLY	
				In respect of Road Traffic Incidents involving death (other than those contained within boxes 23-28), the Supervisory Traffic Officers will attend the scene and deal with the incident in accordance with Force Policies and Procedures and in accordance with the Road Death Investigation Manual. In such cases there is not a need for Supervisory Traffic Officers to continue with this guide beyond this point, but ensure continued liaison and co-operation between all concerned parties.
				In cases where boxes 23-28 apply the Supervisory Traffic Officer is expected to fulfil the Joint Review process. (Box 47 below).
35.	☐	☐	■	Review Risk Assessment. (Ensure area is safe).
36.	☐	☐	■	Review Scene Parameters.
37.	☐	☐	■	Ensure all duties of First Officer are completed.
38.	☐	☐	■	Identify and inform Investigating Officer if not already in attendance.
39.	☐	☐	■	Brief scene Officers/Guards.
40.	☐	☐	■	Force Control Vehicle to scene if necessary.
41.	☐	☐	■	Identify all Closed Circuit TV/Video cameras in premises or vicinity of scene and secure any relevant recordings.
42.	☐	☐	■	Ensure host Basic Command Unit (BCU) are aware of incident.

AND IN THE CASE OF RAILWAY INCIDENTS

	DONE	REVIEW	POLICE ONLY	
43.	☐	☐	■	Liaise with Rail Incident Officer and review safety arrangements.
44.	☐	☐	■	Liaise with BTP and agree Police handover as necessary.
45.	☐	☐	■	Ensure HSE (Her Majesty's Railway Inspectorate) have been advised.

JOINT REVIEW (Mandatory)

46.	☐			Contact HSE, Local Authority or other Investigating or Enforcing Authority and ensure that they are fully informed of the incident and what action has been taken to date, then agree what actions should now be taken and by whom. Acknowledging the HSE, Local Authority or other Investigating or Enforcing Authority are not emergency services. In some instances it will not be possible for them to attend the scene to discuss the case. In the event of non-attendance a Joint Review should be conducted by telephone.
47.	☐	☐	■	Consider impact of railway closures on National Infrastructure.

DUTIES OF INVESTIGATING OFFICER (SIO).

The principal decision maker in a major investigation is referred to as the Senior Investigating Officer (SIO). This will normally be a Detective Inspector or above. In cases of RTI involving death it will be an appropriately trained Traffic Officer.

48.	☐	☐	■	Attend the scene.
49.	☐	☐	■	Review Risk Assessment.
50.	☐	☐	■	Commence Policy Record.
51.	☐	☐	■	Review Scene(s).

DONE | REVIEW | POLICE ONLY

CRITICAL REVIEW (Mandatory)

The purpose of the Critical Review is to establish the issue of primacy. HSE, Local Authority or other Investigating or Enforcing Authority should be present. There may well need to be more than one Critical Review as the investigation progresses.

ESTABLISH ISSUE OF PRIMACY

52. In accordance with the underlying principles of the Work Related Death Protocol there will usually be a Joint Investigation.

Options:-

Ongoing joint investigation with:-

☐ Police primacy.

☐ HSE/local Authority or other Investigating or Enforcing Authority primacy.

OR

☐ Police withdraw – HSE/Local Authority or other Investigating or Enforcing Authority take primacy.

53. *SCENE RELEASE/RETENTION*

It is acknowledged that the HSE, Local Authority or other Investigating or Enforcing Authority are not Emergency Services. In some instances it will not be possible for them to attend the scene to discuss the case. However, the Investigating Officer will need to address the issue of scene retention. If not present the discussion could take place by telephone.

Options:-

☐ Retain the scene with appropriate Police Guard.

DONE	REVIEW	POLICE ONLY	
☐			Retain the scene under seal without Police Guard.
☐			Release the scene
			And
☐			In the event of HSE/Local Authority or other Investigating or Enforcing Authority being in attendance - hand the scene to them.
			In the event of the investigation and scene being passed to the HSE/Local Authority or other Investigating or Enforcing Authority and the Police withdrawing from the matter, arrangements should be put in place to ensure continued liaison and co-operation between the parties.
			Should this be the case the HSE/Local Authority or other Investigating or Enforcing Authority will conduct their investigation in accordance with the relevant authorities existing policies and procedures. There would not be a need to continue with this guide beyond this point, but continued liaison and co-operation between all concerned parties should be ensured.
			In the event of a Joint Investigation in which the Police have primacy, the SIO will be expected to conduct the investigation within the guidance provided by the Murder Investigation Manual (MIM), in accordance with the Best Practice set out in the Major Incident Room Standard Administrative Procedures (MIRSAP) and where appropriate the Road Death Investigation Manual (RDIM).

SPECIAL CONSIDERATIONS

In order to achieve an effective Joint Investigation the following should be considered with due consultation between the parties and be the subject of the SIO's policy record.

54.	☐	☐	☐	**Investigation Management Structure** – To include Police, HSE/Local Authority or other Investigating or Enforcing Authority to ensure all interests are represented.

	DONE	REVIEW	POLICE ONLY	
55.	☐	☐	☐	**Joint Media Policy** – To ensure effective media management via an agreed strategy in accordance with the policy record.
56.	☐	☐	☐	**Forensic Strategy** – To take account of the wider range of scientific services and technical expertise available to Police, HSE, Local Authority or other Investigating or Enforcing Authority acting in co-operation.
57.	☐	☐	☐	**Evidence Management –** To agree arrangements for sharing evidence between investigating parties and for the retention and disclosure of all material.
58.	☐	☐	☐	**Determine Lines of Enquiry** – To ensure investigation takes account of the evidential needs of all agencies subject to the Joint Investigation.
59.	☐	☐	☐	**Financial Management** – To ensure that adequate budgetary provision is made by the parties to the investigation.
60.	☐	☐	☐	**Powers** – Various investigative powers are available to party agencies. A decision needs to be made as to the use of such powers and recorded within the policy record.
61.	☐	☐	☐	**Interview Strategy** – The interview strategy will need to address two specific areas, namely that of witnesses and that of suspects. Only appropriately trained interviewers should conduct interviews with those individuals defined as being Significant and Vulnerable witnesses and suspects. The appointment of a Tactical Interview Manager is recommended. In arriving at an interview strategy it is expected to include all the relevant parties in its preparation and, where appropriate, execution, in a way that meets the needs of all the investigating organisations.
62	☐	☐	☐	**Family Liaison –** It is important for the parties to liaise and agree arrangements for keeping the bereaved informed regarding the progress of the investigation and other health and safety matters that may be relevant, e.g. action taken to prevent recurrence of a similar incident.

DONE	REVIEW	POLICE ONLY	

Where Police have primacy.

63. ☐ ☐ ■ **Crown Prosecution Service (CPS)** – At an early stage and thereafter at regular intervals the CPS should be consulted. The key issue for Police will relate to sufficiency of evidence in respect of offences of the investigation of serious offences. The HSE, Local Authority or other Investigating or Enforcing Authority should be involved within that process to ensure full consideration is given to all the relevant related legislation.

64. ☐ ☐ ■ **CPS Advice** – On the basis of CPS advice the investigation may advance toward a prosecution for Manslaughter and or Corporate Manslaughter. In this case Joint Co-operation should continue to the extent it is considered necessary.

In deciding whether a prosecution is appropriate the CPS will consider the case in the context of 'The Code for Crown Prosecutors'. Should the decision be to not take proceedings for Serious Criminal Offences (other than Health and Safety offences) then normally the Police would relinquish primacy and withdraw from the investigation or remain as part of the ongoing joint investigation for which the HSE, Local Authority or other Investigating or Enforcing Authority has primacy.

Arrangements would need to be put in hand to ensure the case transferral to HSE, Local Authority or other Investigating or Enforcing Authority is conducted expeditiously whilst maintaining continuity and integrity of the exhibits, evidence and unused material.

Irrespective of which agency has primacy of the Investigation or Prosecution continued liaison is advocated up to the point of any resulting trial and or inquest.