

Work-related Deaths Protocol:

Practical Guide

(England and Wales)

Signatories to the Work-related Death Protocol

	National Police Chiefs' Council (NPCC) NPCC brings together the expertise and experience of chief police officers from the UK, providing a professional forum to help deliver effective policing. Work-related deaths - the police will assume primacy for the investigation until any suspicion of a homicide related offence is discounted. In all cases the police will work in partnership with other investigating & enforcement agencies.
	British Transport Police (BTP) BTP has responsibility for investigating all deaths on the Railway infrastructure and where appropriate will submit files to the CPS to consider criminal charges for offences of Murder, Manslaughter and Corporate Manslaughter. BTP work closely with partners such as Office of Rail and Road (ORR) and Rail Accident Investigation Branch (RAIB) to establish primacy for incidents and ensure relevant matters are investigated.
	National Fire Chiefs' Council (NFCC) In England and Wales, Fire and Rescue Authorities are responsible for enforcing the Regulatory Reform (Fire Safety) Order 2005 in all premises with the exception of premises that are comprised in a house which is occupied as a single private dwelling. Some Authorities also enforce explosives and petroleum licensing requirements.
	Crown Prosecution Service (CPS) CPS is the principal prosecuting authority for England and Wales and has responsibility for prosecuting all criminal charges resulting from work-related deaths, except cases where the only charges to be pursued are under the Health and Safety at Work etc. Act. The CPS will only prosecute those cases in exceptional circumstances.
	Care Quality Commission (CQC) CQC is the independent health and social care regulator in England. We regulate the provision of health and social care services by those registered with CQC and prosecute unregistered providers.
	Care Inspectorate Wales (CIW) CIW is the independent inspectorate and regulator for social care in Wales. We regulate child care and social care providers who are registered with CSSIW and take enforcement action against unregistered providers.
	Health and Safety Executive (HSE) HSE enforces the Health and Safety at Work etc. Act 1974 in a range of sectors, including general manufacturing, construction, domestic gas safety, agriculture, public services & quarries, onshore major hazards (including mines, explosives, biological agents, chemical & petrochemical manufacturing) and offshore major hazards (including oil & gas installations).

	Local Government Association (LGA) Local Authorities in England enforce the Health and Safety at Work etc. Act 1974 which covers a diverse range of work activities and workplaces that have different levels of health and safety risk in a range of sectors, including retail, offices, wholesale / retail warehouses, hospitality & leisure (including hotels, camp sites, restaurants, night clubs, cinemas, social clubs, sports facilities, racecourses, pleasure boat hire, museums, theatres, art galleries), places of worship, undertakers, animal care, therapeutic & beauty services, care homes and private pre-school child care.
	Maritime and Coastguard Agency (MCA) The Maritime and Coastguard Agency (MCA) is responsible for the regulation and enforcement of safety standards in all shipping sectors. The Agency covers UK vessels anywhere in the world and foreign registered vessels when within UK waters. MCA prosecute on behalf of the secretary of state for Transport.
	MHRA Medical Devices Division (MHRA) The MHRA is the UK regulatory authority for medicines and medical devices. The Devices Division investigates all reported incidents involving medical devices used in hospitals, primary care and social care settings. We work closely with the HSE, the Police and Coroners in cases involving patient deaths, as appropriate.
	Office for Nuclear Regulation (ONR) ONR is responsible for regulating health and safety on GB Nuclear sites, Authorised Defence sites, Nuclear Warship sites, and Nuclear New Build. ONR is responsible for the investigation of Work Related Deaths which may occur at those sites.
	Office of Rail and Road (ORR) ORR is the independent safety and economic regulator for Britain's railways. We regulate health and safety for the entire mainline rail network in Britain, as well as London Underground, light rail, trams and the heritage sector.
	Welsh Local Government Association Local Authorities in Wales enforce the Health and Safety at Work etc. Act 1974 in the same range of sectors as in England (see Local Government Association for detail).

Foreword

The Work-related Deaths Protocol expects joint investigation of deaths in the workplace. The purpose of this *Practical guide* is to assist the police, enforcing authorities and prosecutors in the joint investigation and where applicable, the prosecution of cases in relation to deaths in the workplace. It is intended to be read in conjunction with the *Work-related deaths: A protocol for liaison* document from which the core of the *Practical guide* has been drawn. This *Practical guide* is not mandatory but gives practical guidance on the principles of liaison and joint investigation advocated by the Protocol.

This guide is not a training document. It has been prepared on the assumption that those tasked with investigating such serious and tragic matters, from whichever organisation, are qualified to do so. It provides a straightforward approach to the joint investigation of deaths within the workplace. The guide, and the protocol, promote liaison with colleagues from other enforcing authorities, and advocates that such liaison is not left to chance or to the discretion of the individuals involved.

This guide also provides an event-driven timetable with liaison issues pertinent to each event. The Appendices contain checklists of actions to be taken by the first officer at the scene, the supervisory officer and the senior investigating officer (SIO).

In preparing the Practical guide, attention has been paid to the legislation that impacts upon all criminal investigations. It also takes account of the specific guidance provided to Police from National Police Chiefs' Council manuals, including those dealing with homicide, road deaths and the Human Rights Act 1998. Equal account has also been taken of the Health and Safety Executive's operating policies, which are mirrored in guidance issued to other local authority agencies. The 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 a serious criminal offence (other than a health and safety offence), the relevant enforcing authority¹ has a responsibility to ensure dutyholders (who may also be suspects) take immediate action to deal with serious risks, and to promote and achieve sustained compliance with the law.

¹ A relevant enforcing authority means the health and safety regulator with responsibility for the activity or workplace involved and includes HSE, ORR, local authorities, MCA and the Fire and Rescue Services.

Introduction

This *Practical guide* commences with a contents page, which seeks to encapsulate the Protocol on one page. This allows investigators to consider their actions within the context of the Protocol, and to navigate to the applicable section of the guidance. The appendices to this guide list actions to be taken by the first officer at the scene, the supervisory officer and the senior investigating officer (SIO).

This guide was first published on the HSE website as the 'Investigators Guide' in March 2004 and updated in September 2011 and May 2012. It was reviewed by the National Liaison Committee on the Work-Related Deaths Protocol (NLC) in 2014, re-named 'Practical Guide' and published in February 2015. An amended version was published in June 2022. The guide is intended to be a living document, that is, it can be updated and revised by the NLC as necessary.

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1. Determining whether the incident is a Work-related death

A work-related death is a fatality resulting from an incident arising out of, or in connection with, work. The protocol and associated guidance also apply to cases where the victim suffers injuries that are so serious that there is a clear indication, according to medical opinion, of a strong likelihood of death.

Establishing whether a death is work-related can be difficult. On notification, relevant enforcement authorities should liaise and agree on whether an incident is work-related. Each incident must be considered on its own merits, which may not be immediately apparent, and will therefore require initial enquiries to establish.

Enforcing authorities will also be guided by their own internal policies, procedures & guidance in determining whether a death is considered to be work-related. A decision should be made without delay. The incident scene remaining secure until a decision has been made.

Determining whether a death is work-related

The following questions may assist in determining whether a death is work-related:

Is there, or was there a work activity or undertaking on-going at the time and place of the incident?

Was the deceased / injured party an employee or self-employed person who was at work at the time of the incident?

Was the deceased / injured party a member of the public who was injured as a result of a work activity?

In the case of domestic or similar premises, has there been any recent maintenance or refurbishment work undertaken e.g. work associated with gas or electrical installations or appliances?

Examples of work-related incidents which are not immediately apparent could include: gas or electrical incidents at rented accommodation; food related anaphylaxis; road traffic incidents; incidents in prisons or health care institutions; derelict buildings held for investment or development purposes; and the collapse of buildings and other structures.

Definitions

Work means: work carried out by an employee or self-employed person.

Undertaking means: enterprise or business, whether carried out for profit or not.

An employee is: an individual who works under a contract of employment or an apprenticeship, the terms of which can be formalised orally or in writing, or the relationship can be informal or implied; Police Officers/Cadets; and persons in service of the Crown holders.

Self-employed persons are: individuals who work for gain or reward, but not under a contract of employment. They may employ others.

2. Initial Action

In most instances, the first person at the scene will be a police officer, but this may not always be the case. Consequently, other relevant Enforcing Authorities who arrive in advance of the Police will be expected to take appropriate action where they have the powers to do so.

To assist the first officer at the scene, the following checklists are contained within Appendix 1:-

Duties of first officer – All Incidents.

Additional duties of first officer – Domestic Gas Incidents.

Additional duties of first officer – Road Death Incidents.

Additional duties of first officer – Railway Incidents.

Additional duties of first officer – Maritime Incidents.

In all suspected work-related death cases, a police officer of supervisory rank should attend the incident scene to assess the situation, review actions taken to date and assume responsibility for the investigation. To assist the attending supervisory officer attending, the following checklists are provided in appendices 2 & 3.

Appendix 2: Duties of supervisory police officer.

Additional duties of supervisory police officer – Railway Incidents.

Additional duties of supervisory police officer – Fire Incidents.

Additional duties of supervisory policy officer – Incidents involving a Medical Device.

Appendix 3: Duties of senior investigating officer (SIO)

The checklists in Appendix 1 should assist the first officer at the scene to take the appropriate action. However key actions to note on arrival at the scene are to:

- secure the scene of the incident,
- perform an initial risk assessment to ensure those investigating the incident are not exposed to significant health and safety risks; and,
- contact the relevant enforcing authority.

On arrival at the scene, early questioning of potential witnesses, and even suspects, by the relevant enforcing authority may be necessary to establish whether there is a need to take immediate action to address any residual risks which may exist post-incident. Such questioning may continue into the early stages of a joint investigation to identify systemic underlying causes.

3. Management of the investigation

Wherever more than one enforcing authority has an interest in a death, the investigation of health and safety and/or other offences should commence immediately and be carried out in parallel to the investigation of manslaughter. Investigations should be jointly conducted, with one of the parties taking the lead, i.e. assuming primacy. An investigation may also require liaison with other enforcing authorities who have an interest, as well as the Crown Prosecution Service (CPS).

Whilst one party will assume primacy, other parties to a joint investigation should by working jointly and in parallel, progress their own investigation as quickly as practicable. Agreeing primacy should not delay the investigations of individual parties to a joint investigation. At an early stage of the investigation, the police and other relevant authorities should agree:

- (a) who will assume/retain primacy;
- (b) a strategy for the on-going management of the joint investigation. This should include regular joint reviews of the progress of the investigation;
- (c) lines of enquiry, either joint where applicable, or those to be investigated separately by the parties to the joint investigation;
- (d) what resources are required and how they are to be used/shared. This should include the use of specific powers by an enforcement authority (e.g. section 20 Health and Safety at Work etc. Act 1974 or sections 62 to 65 of the Health and Social Care Act 2008) to ensure their use is necessary, justified and legitimate i.e. powers are only used for the purposes for which they were provided;
- (e) how relevant material gathered or generated during the investigation is to be recorded, stored, revealed and shared between the parties. Normally it would be appropriate for the parties to the investigation to share evidential material with each other, or permit access to it, as the investigation progresses;
- (f) what specialist and expert advice is required; for what lines of enquiry i.e. gross negligence manslaughter, corporate manslaughter or health and safety breaches; and how they are to be commissioned and funded. The aim is to ensure, where possible, that an expert addresses the issues in relation to all potential offences at the same time;
- (g) how the forensic examination of relevant material is to be co-ordinated eg. physical items, DNA evidence, digital material;
- (h) an interview strategy which establishes the identification of witnesses and potential suspects, including how, when and where they are to be interviewed. Interviews of witnesses and suspects should be jointly planned and conducted, covering all alleged offences whenever possible;
- (i) how, and to what extent, corporate or organisational failures should be investigated, and how and when advice will be sought from CPS. Normally it will be appropriate for the investigation to consider individual and organisational failures in parallel;
- (j) a strategy for keeping the bereaved family/next of kin and witnesses informed of developments in the investigation. Initially it is the police who will provide the necessary liaison. In the event of primacy passing to another enforcing authority, there should be discussion and agreement as to the best way of maintaining communication with the bereaved family/next of kin and witnesses;

(k) liaison with HM Coroner, including the submission of factual reports to the coroner, disclosure of relevant material, and how any request for the coroner to suspend their investigation is to be pursued. Normally for an investigation of any length, it will be appropriate to make an application for the suspension of the coronial investigation;

(l) a media strategy to take into account the sensitivities of the bereaved family/ next of kin and others involved in the incident, the messages which all parties investigating the incident wish to convey, and to encourage consistent reporting. Normally it will be appropriate to consult with all parties in the investigation in relation to the timing and content of any media activity.

In large-scale investigations it may be beneficial to form a strategic liaison group to ensure effective inter-organisational communications, and to share relevant information, good practice and experiences.

Sharing Information

Normally there should be no legal barriers to sharing relevant information. However, in some cases it may be appropriate to set out in a written agreement what information will be shared, when and how it will be shared and the legal basis for doing so.

Monitoring / Reviewing Investigation Progress

Throughout the joint investigation, the police and other relevant enforcing authority should keep the progress of the investigation under review. Milestones should be agreed and monitored, and policy and key decisions recorded in Key Decision Logs (when used) by each authority. Whilst all investigations will be managed differently, it is suggested that in cases where primacy remains with the police at 3 months post incident, a comprehensive review of the investigation is carried out by the police and the relevant enforcing authority.

The review should be jointly conducted and involve the police, CPS and relevant enforcing authority and should:

- assess progress;
- review the evidence obtained to date and seek advice from the CPS, if not already obtained, on whether the investigation into potential negligent homicide² should continue;
- where the police are to retain primacy for the investigation, agree (unless there is a good reason) that the CPS seek suspension of the coronial investigation³, and the adjournment of any associated inquest; and

² Negligent Homicide means 'Serious criminal offence other than a health and safety offence

³ **Coroners powers to suspend an investigation under Schedule 1 (Section 11) of the Coroners and Justice Act 2009**

1 (1) A senior coroner must suspend an investigation under this Part of this Act into a person's death in the following cases.

(2) The first case is where a prosecuting authority requests the coroner to suspend the investigation on the ground that a person may be charged with—

(a) a homicide offence involving the death of the deceased, or

(b) an offence (other than a service offence) that is alleged to be a related offence

- where there is no evidence of a negligent homicide offence, agree how and when primacy should be passed to the relevant enforcing authority.

Reviews between parties to a joint investigation should be conducted at regular intervals to ensure the investigation and any resulting prosecution can be completed as quickly as practicable. It is recommended that, where necessary, key reviews are undertaken at the 1st and 2nd anniversaries of the date of death. The overall aim is to ensure that investigations are completed, and any decision to prosecute made, as quickly as possible. All parties should aim to ensure that any prosecution is brought as soon as possible and except in exceptional circumstances no later than 3 years after the death.

In cases where CQC are investigating criminal offences, shorter timescales may apply due to statutory time-limits on certain offences. This should be discussed and agreed between parties to a joint investigation.

Escalation

It is important when investigations have stalled that there are clear processes in place to ensure issues delaying investigations can be escalated to a senior level in an efficient and effective manner. The names and contact details of individuals of immediate seniority, and one level beyond, i.e. two levels of seniority above, lead investigator / senior investigating officer should be provided and shared by the police, CPS and relevant enforcing authority.

Delay

Investigators should at all times be conscious of and avoid any unnecessary delay in the progress of the investigation. Following the principles of the protocol and this guide should assist in avoiding undue delay.

4. Decision Making

Gross Negligent Manslaughter (GNM) and Corporate Manslaughter (CM)

Whenever there is a suspicion that a negligent homicide may have caused the death, the police will assume primacy for an investigation and work in partnership with other relevant enforcing authorities.

For gross negligence manslaughter (GNM) and corporate manslaughter (CM) to be considered by the CPS, the conduct of those suspected of breaching the law must fall far below that expected of a reasonable person in the Defendant's position. A single mistake, even if serious, is unlikely (although it is not impossible) to meet this criteria. There must be an element of real reprehensibility rather than someone doing their inadequate best in difficult circumstances.

GNM by a number of people cannot be aggregated to mean that altogether their conduct fell far below the required standard. All those suspected of breaching the law must be considered individually. The police are advised to make contact with the CPS at the earliest opportunity to ensure that consideration of possible corporate manslaughter or gross negligence manslaughter charges can be made promptly. The CPS has specialist lawyers to assist police colleagues who may not have much experience of the crime involved in these cases.

Success in the prosecution of these cases will depend upon a careful, incremental case-building strategy, drawing upon reports from one or more technical experts, and are often undertaken in liaison with other investigative agencies. Working with the CPS to identify other key agencies at the earliest stages will be essential to ensuring the effective management of case progression.

Police investigation of potential GNM / CM cases does not preclude an Accident Investigation Branch conducting a safety investigation in parallel.

In the case of *R v Rose* [2017] EWCA Crim 11681, the Court of Appeal set out the principles that apply to gross negligence manslaughter. These were summarised as follows:

- (1) The offence of gross negligence manslaughter requires breach of an existing duty of care which it is reasonably foreseeable gives rise to a serious and obvious risk of death and does, in fact, cause death in circumstances where, having regard to the risk of death, the conduct of the defendant was so bad in all the circumstances as to go beyond the requirement of compensation and to amount to a criminal act or omission;
- (2) There are, therefore, five elements which the prosecution must prove in order for a person to be guilty of an offence of manslaughter by gross negligence:
 - (a) The defendant owed an existing duty of care to the victim;
 - (b) The defendant negligently breached that duty of care;
 - (c) It was reasonably foreseeable that the breach of that duty gave rise to a serious and obvious risk of death;
 - (d) The breach of that duty caused the death of the victim;
 - (e) The circumstances of the breach were truly exceptionally bad and so reprehensible as to justify the conclusion that it amounted to gross negligence and required criminal sanction;

- (3) The question of whether there is a serious and obvious risk of death must exist at, and is to be assessed with respect to, knowledge at the time of the breach of duty;
- (4) A recognisable risk of something serious is not the same as a recognisable risk of death, and
- (5) A mere possibility that an assessment might reveal something life-threatening is not the same as an obvious risk of death: an obvious risk is a present risk which is clear and unambiguous, not one which might become apparent on further investigation.

The judgment in *R v Broughton* [2020] EWCA Crim 1093 is particularly apt when considering the issue of causation, as it confirms that to prove causation in gross negligence manslaughter, the prosecution must show that, had the defendant not been grossly negligent, the deceased would have lived and exclude the realistic possibility that even with the relevant treatment / medical intervention, the deceased might still have died.

For corporate manslaughter, there are a number of elements to the offence which need to be proved:

- (a) the defendant is a qualifying organisation;
- (b) the organisation caused a person's death;
- (c) there was a relevant duty of care owed by the organisation to the deceased; and
- (d) there was a gross breach of that duty which fell far below what was reasonably expected of the organisation in the circumstances.

Additionally, for corporate manslaughter, the conduct (the way in which the company's activities were managed or organised) of senior management must be a substantial part of the corporate failing. Senior management are those who make decisions about how all or a large part of the company's conduct is managed or organised.

In deciding whether there has been a gross breach of duty, the jury must consider whether any health and safety legislation was breached, and if so must consider:

- (i) the seriousness of the breach; and
- (ii) how much of a risk of death it posed.

The bar to prove GNM and/or CM is therefore set very high and, if at any stage of the investigation, it becomes apparent that it is unlikely that there will be sufficient evidence to prove such an offence, primacy should be assumed by the relevant enforcing authority as expediently as possible.

The police/CPS will work closely with the enforcing authority assuming primacy, to ensure that in cases where the decision is reached not to pursue a prosecution in relation to a negligent homicide, that this is properly communicated to the suspect and victim's family as well as the enforcing authority assuming primacy.

Change of Primacy and Investigation Handover

Both parties should record in writing the change of primacy in writing by completion of a handover document. The formal handover process should include the transfer of relevant investigation material (statements, photographs, pocket notebooks, physical items, documents etc.) not already passed to the authority assuming primacy. Relevant material retained by the police, either for Public

Interest Immunity (PII) purposes or some other reason, must also be revealed to the authority assuming primacy to ensure they can comply with the Criminal Procedure Investigation Act 1996 (CPIA).

Handover can occur very early in the investigation process and, in the case of some incidents, may occur after the police have carried out initial enquiries only. A handover document has been produced by the NLC for use in such circumstances.

Where an evidential review in relation to a negligent homicide offence is informed by legal advice from the CPS, the process should be carried out as expediently as possible. Where the evidential test is not met, primacy for the investigation should be transferred as soon as possible.

Where an enforcing authority other than the police has primacy and new information is discovered which gives cause to reconsider whether a negligent homicide offence has been committed, the information should be shared with the police as soon as possible. The police should decide whether to re-assume primacy, consulting the CPS if necessary. Where the police re-assume primacy, a further handover document must be prepared by the enforcing authority passing primacy. Handover should include the transfer of relevant material not already in the possession of the police.

There will also be rare occasions where, as a result of the coroner's inquest, judicial review or other legal proceedings, further consideration of the evidence and surrounding facts may need to be made. Where this takes place the police, the relevant enforcing authority with primacy for the investigation and the CPS will work in partnership to ensure an early decision. There may also be a need for further investigation.

5. Disclosure of material

To comply with the requirements of the Criminal Procedure Investigations Act 1996 (CPIA), Home Office Code of Practice (CoP) under Part II of the Criminal Procedure and Investigations Act 1996, and the Attorney General's Guidelines on Disclosure, enforcing authorities should retain and record all relevant material gathered or generated during the investigation.

Effective management and liaison should ensure that enforcing authorities jointly investigating an incident have access to all relevant material as it is gathered during the investigation. However, even with effective material management and liaison systems, there may well be additional material, both used and unused, which has not been revealed and shared between authorities, either during the investigation or on handover where primacy for an investigation changes.

Enforcing authorities who have investigated an incident, regardless of the level of involvement, should therefore ensure that all material is revealed and disclosed to another authority when such a request is received. On revelation and/or receipt, the material should be recorded and categorised accordingly by the receiving authority.

Effective liaison between enforcing authorities should ensure that the required procedures are followed where there is an application to the court to withhold sensitive material which would otherwise fall to be disclosed on the grounds of a risk of serious prejudice to an important public interest.

The approach to disclosure should be outlined in a Disclosure Management Document (DMD) by the prosecuting authority. The document should include the steps taken to obtain material in the possession of other enforcing authorities i.e. third-party material.

6: Special Inquiries

Health and Safety Executive

In the case of some incidents, particularly those involving multiple fatalities, HSE may, with the consent of the Secretary of State direct that a public inquiry be held. Alternatively, the HSE Board may authorise HSE, or any other person, to investigate and produce a special report.

In such circumstances, the police will provide any necessary support and evidence to the person appointed to conduct the public inquiry, or to the special investigation, subject to the relevant regulations.

Complex legal issues may arise when there are parallel public inquiries and criminal investigations or prosecutions. The signatories will aim to keep inquiry chairs informed of the progress of the investigation.

Sometimes the report of a public inquiry may be delayed to await the conclusion of criminal proceedings, and on other occasions, there may be no such delay because of strong public interest in publishing the report and the recommendations of a public inquiry quickly. In either event, the signatories to the protocol will work together to ensure that the decision to prosecute is made as expeditiously as possible and any criminal proceedings commenced without delay.

Care Quality Commission

In exceptional circumstances and only at the request of or with the approval of the Secretary of State, CQC may conduct a special review or investigation pursuant to Section 48 of the Health and Social Care Act 2008.

Investigation involving Accident Investigation Branches ('Safety Investigations')

The UK has legal obligations to conduct safety investigations into air, marine and rail transport accidents to identify the causes and make recommendations to prevent a recurrence. UK safety investigations are conducted by three Accident Investigation Branches (AIB), which are functionally independent units within the Department for Transport; these are the:

- Air Accidents Investigation Branch (AAIB)
- Marine Accident Investigation Branch (MAIB)
- Rail Accident Investigation Branch (RAIB)

The AIBs are not signatories to the WRDP and their safety investigations are conducted independently of, and in parallel with, other investigations. AIB safety investigations do not seek to apportion blame or liability and the AIBs have specific powers to protect evidence including the identity of witnesses and the information they provide. AIB inspectors also have powers to gain access to accident sites.

While effective co-operation and communication should ensure that all parties are able to progress their investigations accordingly, there will be incidents when public safety interests must take precedence over criminal investigations. However, the police/CPS and any relevant enforcing authority will be fully consulted in all cases.

In the event of an air, rail or maritime transport accident, WRDP signatory organisations must make contact with the relevant AIB as soon as practicable. Good working relationships between

enforcement agencies and the AIBs will be key to ensuring effective parallel investigations. Working relationships in such cases are facilitated by a series of Memorandums of Understanding (MoU) such as those that the AIBs have with the CPS, NPCC, Chief Coroner of England and Wales and the relevant transport regulators. These MoUs refer to the regulations relevant to each AIB and explain in more detail the processes for co-operation, co-ordination, sharing of evidence where permissible and, where necessary, the need for precedence of the safety investigation.

The following MoUs between AIBs and WRDP signatories exists and should be followed in all relevant investigations:-

Memorandum of Understanding between the UK Accidents Investigation Branches and the National Police Chiefs' Council.

Memorandum of Understanding between the Crown Prosecution Service and the Air, Marine and Rail Accident Investigation Branches.

Memorandum of Understanding between the Health and Safety Executive, the Maritime and Coastguard Agency and the Marine Accident Investigation Branch for health and safety enforcement activities and accident investigation at the water margin and offshore.

Principles of co-operation between the Marine Accident Investigation Branch and the Maritime and Coastguard Agency

Memorandum of Understanding Between the National Fire Chiefs Council and Air, Marine and Rail Accident Investigation Branches.

Memorandum of Understanding between the Rail Accident Investigation Branch, the British Transport Police and the Office of Rail and Road relating to the investigation of rail accidents and incidents in England and Wales.

Memorandum of Understanding between the UK Accident Investigation Branches and the National Police Chiefs' Council.

Memorandum of Understanding between Care Quality Commission (CQC) and Health and Safety Executive (HSE)

Memorandum of Understanding between Care Quality Commission (CQC) and National Police Chiefs Council (NPCC)

7. Advice prior to charge

Where there is a suspicion that a negligent homicide may have caused the death, the CPS should be involved at the earliest opportunity and, if not, consulted within 3 months from the start of the investigation. Discussions with the CPS should not be restricted to the police, but include all other enforcing authorities involved in the investigation.

The CPS Special Crime Division (part of the CPS Special Crime and Counter Terrorism Division) deal specifically with all cases of corporate manslaughter, medical manslaughter and all other cases of gross negligence manslaughter, save for those arising from road traffic collisions or cases involving neglect (including those concerning children, patients or Care Home residents). The latter cases are dealt with by the Complex Crime Units in each CPS Area.

These cases require particular expertise often at the earliest stage.

Early engagement of CPS lawyers will assist in the planning of a case strategy to ensure that the investigation is timely, targeted and effective. This is likely to include:

- Advice and guidance on pursuing relevant lines of enquiry.
- The nature of any manslaughter charge (individual or corporate).
The selection of experts, including the preparation of detailed terms of reference for those experts.

Discussions between the police, other enforcing authorities and the CPS should not be restricted to manslaughter issues. They should also cover lines of enquiry, the use of expert evidence and potential offences e.g. health and safety or environmental offences.

As detailed in section 4 of this guidance, if at any stage of the investigation, it becomes apparent that there is insufficient evidence that a negligent homicide offence caused the death, primacy for the investigation should be passed to the relevant enforcing authority as soon as possible.

8. The decision to prosecute

The decision to prosecute any negligent homicide offence arising out of a death should be made by the CPS without undue delay after the provision of a full file by the investigating authority. Any undue delay in making prosecution decisions and the associated reasons should be promptly communicated to the police and relevant enforcing authority. Effective liaison between the CPS, police, and other enforcement authorities should ensure all parties are kept up-to-date on case progress. Additionally, enforcing authorities can assist the CPS in its decision by providing advice on other relevant legislation, approved codes of practice, guidance and other standards.

In addition to a negligent homicide offence⁴, the CPS should normally also consider whether to prosecute for any related health and safety offences against that or any other defendant. When considering other offences, the CPS will consult with, and give full consideration to, the opinion of relevant enforcing authorities⁵. To assist the CPS, if requested, the relevant enforcing authority should provide advice on potential health and safety related offences.

Upon reaching its decision, the CPS should communicate it to the police, the coroner, relevant enforcing authorities and, where appropriate, the relevant accident investigation branch as soon as practicable. Where no prosecution is proposed by the CPS in respect of a negligent homicide and/or other offences, the CPS will work closely with the relevant enforcing authority, if requested, to indicate how and why the CPS has concluded the decision taken. Prior to communicating the prosecution decision to the suspect and bereaved family/next of kin⁶, the CPS should consult with the relevant enforcing authority to agree the content of any communication to ensure that no prejudice is caused to any future prosecution in relation to other offences eg. health and safety offences. Any views expressed by the CPS or other enforcing authority during the consultation should not be disclosed by any party.

When communicating the prosecution decision to the bereaved, the CPS should explain that primacy for the investigation will be passed to the relevant enforcing authority, who on completion of their investigation, may pursue a prosecution. On assuming primacy for the investigation, the relevant enforcing authority should ensure the provision of adequate liaison arrangements with the bereaved.

No prosecution decision should be made public until the bereaved, the Coroner's Office and any potential defendants have been notified as appropriate and according to any media strategy agreed between the CPS, police and relevant enforcing authorities. Where there is to be no CPS

⁴ The roles and responsibilities of the CPS, the police and coroners in investigations which give rise to suspicion that a negligent homicide offence has been committed are set out in the Memorandum of Understanding between The Crown Prosecution Service, The Association of Chief Police Officers, The Chief Coroner and The Coroners' Society of England and Wales.

⁵ An offence of failing to comply with the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 including a failure to provide safe care and treatment resulting in avoidable harm or a significant risk of exposure to avoidable harm can only be prosecuted by CQC unless the Attorney General provides written consent to another person (Section 90 Health and Social Care Act 2008). The same restrictions apply to unregistered provider prosecutions (Section 10 Health and Social Care Act 2008).

⁶ Bereaved families are entitled to receive services from the CPS as set out in the document: Crown Prosecution Service: Service to Bereaved Families.

prosecution, the media announcement should include, where applicable and appropriate, a statement that primacy for the investigation will be passed to the relevant enforcing authority.

Following a CPS decision not to prosecute in respect of a negligent homicide offence and/or other relevant offences, the relevant enforcing authority should:

- assume primacy for the investigation (see guidance on assuming primacy in section 4);
- complete its investigation;
- liaise with the coroner;
- consider appointment of a single point of contact (SPOC) for family liaison; and,
- decide whether to prosecute for a relevant offence as soon as possible.

A decision not to prosecute made by the CPS or any other enforcing authority may be the subject of a victims rights to review (VRR). Such a request could result in a decision not to prosecute being changed. Therefore, where such a request has been received from a victim, the CPS or receiving enforcing authority should immediately contact:

- the relevant party who has assumed primacy for the investigation; and
- any other parties who are jointly investigating;

and inform them accordingly.

9. The Prosecution

In addition to negligent homicide charges, the CPS may decide to pursue a prosecution for health and safety or other offences, although only on rare occasions will the CPS prosecute health and safety offences without other charges⁷. When this occurs, the relevant enforcing authority does not have any formal role in the prosecution. However, the CPS should continue to liaise with the relevant enforcing authority to ensure the continuing involvement and assistance in:

- the wording and nature of any health and safety or other charges;
- relation to issues which arise during the trial;
- any issues in relation to the disclosure of material (both used and unused);
- any case conferences with counsel;
- the preparation of key documents such as the case summaries, skeleton arguments etc.;
- keeping the bereaved and witnesses informed;
- the announcement of the decision;
- key decisions in relation to the conduct of the prosecution, in particular, any decision to withdraw any health and safety offence, accept a guilty plea, or any basis of plea;
- providing information as to any costs application to be made on behalf of any enforcing authority in the event of a conviction.

Where the CPS prosecutes for negligent homicide, and no health and safety related offences are pursued, the CPS should keep the relevant enforcing authority informed on the progress of the case and any final result.

⁷ An offence of failing to comply with the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 including a failure to provide safe care and treatment resulting in avoidable harm or a significant risk of exposure to avoidable harm can only be prosecuted by CQC unless the Attorney General provides written consent to another person (Section 90 Health and Social Care Act 2008). The same restrictions apply to unregistered provider offences (Section 10 Health and Social Care Act 2008).

10. HM Coroner

Ongoing Investigations

In the event of an investigation into a death, the coroner will be notified by the police and/or other enforcing authority with primacy. Where the police retain primacy, the police or the CPS will inform, and update the coroner as to whether someone **may** be charged with a homicide offence⁸.

Where involved, the CPS should normally request that HM Coroner suspend the coronial investigation and adjourn any inquest. If requested, the coroner must suspend the coronial investigation for at least 28 days or for whatever longer period the coroner specifies. Any suspension may be extended, or further extended, by the coroner on receipt of a request from the CPS.

Where the CPS have not yet been involved, or primacy has been passed to another enforcing authority, the police or other enforcing authority should consider requesting HM Coroner suspend the coronial investigation and adjourn any inquest. The coroner may suspend the coronial investigation if they deem it appropriate. In considering a request for suspension, the coroner should have regard to any Memorandum of Understanding made between the relevant enforcing authority and the Coroners' Society of England and Wales.

To assist HM Coroner in determining a suitable suspension period, the police, the CPS (where involved) and other enforcing authority should provide the coroner with:

- (i) an update on the progress of the investigation; and
- (ii) where applicable, the projected timescales for the various stages of the criminal proceedings.

Prosecutions

Where a prosecution for a homicide offence, or a related offence has commenced, the CPS or other prosecuting authority⁹ should consider making a request to the coroner to suspend. On receipt of such a request, the coroner must suspend a coronial investigation and adjourn any inquest, where:

⁸ Homicide offence means –

murder, manslaughter, corporate manslaughter or infanticide;

an offence under any of the following provisions of the Road Traffic Act 1988 (c. 52)—

- (i) section 1 (causing death by dangerous driving);
- (ii) section 2B (causing death by careless, or inconsiderate, driving);
- (iii) section 3ZB (causing death by driving: unlicensed, disqualified or uninsured drivers);
- (iv) section 3A (causing death by careless driving when under the influence of drink or drugs);

an offence under section 2(1) of the Suicide Act 1961 (c. 60) (encouraging or assisting suicide);

an offence under section 5 of the Domestic Violence, Crime and Victims Act 2004 (c. 28) (causing or allowing the death of a child or vulnerable adult);

⁹ Prosecuting authority” means—

- (a) the Director of Public Prosecutions, or
- (b) a person of a description prescribed by an order made by the Lord Chancellor.

- (i) a person has appeared or has been brought before a Magistrate; or has been charged on indictment with a homicide offence involving the death of the deceased.
- (ii) a prosecuting authority informs the coroner that a person has appeared or has been brought before a Magistrate; or has been charged on indictment with a related offence.

Where a prosecution for a non-Homicide-related offence is proposed by an enforcing authority (which is not a prosecuting authority as defined by s48 of the Coroners and Justice Act 2009), the coroner, if requested, has a general discretion to suspend the investigation and adjourn any inquest until after completion of the prosecution.

Where an enforcing authority is proposing to pursue a prosecution in relation to health and safety offences before the inquest, the coroner, along with the police, CPS, and the deceased's family and any other person with a legitimate interest should be consulted in accordance with the Guidance on the timing of criminal proceedings in a work-related death case. When requesting suspension of a coronial investigation, the relevant enforcing authority should make reference to any relevant Memorandum of Understanding with the Coroners Society of England and Wales.

DISCLOSURE

Sharing of Documents and/or Reports submitted to the coroner by the police/CPS and other enforcing authorities

As detailed in parts 3 and 5 of this guide, relevant material should be shared between enforcing authorities involved in the joint investigation. Where the police maintain primacy for an investigation, other enforcing authorities should pass copies of any documents and/or reports submitted to the coroner to the police and CPS, if involved.

Similarly, where primacy has passed to another enforcing authority, copies of all documents and/or reports submitted to the coroner by the police should be passed to that authority. In all cases, documents and reports should not be disclosed to any party without giving written notice to the authority that originally submitted them to the coroner.

Schedule 5 of the Coroners and Justice Act 2009 gives a coroner the power to summon witnesses and to compel the production of evidence for the purposes of an investigation or inquest by way of written notice. It is envisaged that coroners will only use these powers when necessary and where other methods have failed. The matter of disclosure of material should therefore be discussed with the coroner, and material relevant to the coronial investigation should be disclosed. When considering what material is relevant, the police, CPS and enforcing authorities should take into account the matters to be ascertained by the coronial investigation as required by section 5 of the Coroners and Justice Act 2009.

Disclosure of Documents and Reports by the Coroner to Interested Parties

On request for disclosure of a document by an interested person, under Rule 13 of the Coroners (Inquests) Rules 2013, the coroner must provide the document (or copy) as soon as is reasonably practicable.

Documents to which rule 13 applies include:

- (i) any post mortem report;
- (ii) any other report that has been provided to the coroner during the course of the investigation; and
- (iii) any other document which the coroner considers relevant to the inquest.

Under Rule 15 of The Coroners (Inquests) Rules 2013, a coroner may refuse to provide a document or a copy of that document where the document relates to contemplated or commenced criminal

proceedings, or is not relevant to the coronial investigation (i.e. something that the coroner does not intend to rely on at inquest). Rule 15 also allows a coroner to refuse to provide a document, or a copy of that document, where there is a statutory or legal prohibition on disclosure; the consent of any author or copyright owner cannot be reasonably obtained; and where the request is unreasonable.

If documents provided to a Coroner relate to contemplated criminal proceedings and it is believed that onward disclosure to interested persons would prejudice the criminal investigation or future criminal proceedings, the enforcing authority should draw the coroner's attention to his/her powers to withhold/refuse disclosure under Rule 15 above. Any request to the coroner to withhold/refuse disclosure of documents should include reasons as to why onward disclosure to interested parties could prejudice any future prosecution.

Where potentially prejudicial material is not disclosed, the coroner may still use it to inform the coronial investigation. For example, the material may assist the Coroner in identifying the scope of the inquest, the matters each witness may be asked to address, and the potential for witnesses to incriminate themselves.

When considering whether disclosure of material may prejudice an on-going investigation or proposed prosecution, the police and CPS and/or relevant enforcing authority should bear in mind the following:

- (i) Where a witness statement is not disclosed, the coroner can still call that person as a witness and it is likely that the same evidence will be heard publicly at the inquest.
- (ii) On institution of legal proceedings, the core evidence is likely to be disclosed to the defendant at an early stage as part of the provision of initial details.
- (iii) Where a statement has not yet been taken from an important witness, or a suspect interviewed under caution, and the prior release of material may be prejudicial, the coroner may agree not to disclose any prejudicial material to interested parties until the interview has been conducted.
- (iv) Disclosure of a witness statement to interested parties may lead to a risk of intimidation, harassment or assault of the witness.
- (v) Whether the material is subject to legal privilege i.e. confidential communications made for the purpose of seeking, obtaining or giving legal advice. This may include expert reports or draft reports prepared for the purposes of supporting a prosecution, as well as any internal reports or documents produced by the police and CPS or enforcing authority.

11. National Liaison

The Work-related Deaths National Liaison Committee is responsible for monitoring the effectiveness of the Work-related Deaths protocol, including reviewing and making any changes to it, and any associated guidance eg. Practical Guide or Handover Document. The committee comprises representatives from each signatory organisation and meets at least twice yearly.

The role of the NLC is to oversee the protocol and not the progress of individual cases. However, in cases where there are liaison issues that hamper joint investigation, matters can be escalated to the NLC so that the relevant representatives can address any issues at a senior level with their own organisations.

12. Local Liaison

There are nine Regional Liaison Committees (RLC):

- (i) London;
- (ii) South East;
- (iii) South West;
- (iv) East Midlands;
- (v) West Midlands;
- (vi) Yorkshire and North East;
- (vii) North West;
- (viii) East of England; and,
- (ix) Wales

The committees meet on a regular basis to discuss issues of mutual interest and concern and, in particular, the operation of the protocol from a local standpoint, to monitor the protocol's effectiveness, and to communicate any issues to the National Liaison Committee.

Any issues in relation to the operation of the protocol, other than significantly serious issues, should at first be raised at RLC level in an attempt to address any issues at local level via the identified and effective lines of communication between the signatory organisations. If attempts to resolve issues at RLC level prove unsuccessful, the matter should be escalated to NLC level by the relevant signatory organisation representatives.

APPENDICES - Checklists

Appendix 1:

Duties of first officer – All Incidents.

Additional duties of first officer – Domestic Gas Incidents.

Additional duties of first officer – Road Death Incidents.

Additional duties of first officer – Railway Incidents.

Additional duties of first officer – Maritime Incidents.

Appendix 2:

Duties of supervisory police officer.

Additional duties of supervisory police officer – Railway Incidents.

Additional duties of supervisory police officer – Fire Incident.

Additional duties of supervisory police office – Maritime Incident.

Additional duties of supervisory policy officer – Incidents involving a Medical Device.

Joint Review (mandatory).

Appendix 3:

Duties of senior investigating officer (SIO).

Appendix 4:

Special Considerations.

Appendix 5:

Where Police have Primacy.

The checklists have been laid out in a sequential and numbered 'tick-box' order. 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 completed 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 completed, 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 and its use confirms that a particular action is for the police to address, albeit after consultation with 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 selected.

APPENDIX 1: DUTIES OF FIRST OFFICER

Duties of first officer – All Incidents

	Done	Review	Police Only	In most instances this will be a police officer. However, this may not always be the case. Consequently, the other Investigating or relevant 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. At GB nuclear sites the first officer should liaise with the Civil Nuclear Constabulary present at site for the purposes of initial risk assessment, and coordination of effort.
1.	☐	☐	☐	Identify scene(s).
2.	☐	☐	☐	Perform initial risk assessment. Ensure area is safe.
3.	☐	☐	☐	Ascertain location of fatality, the police will need to treat body as separate scene if removed.
4.	☐	☐	☐	Inform supervisory police officer.
5.	☐	☐	☐	Inform Coroner.
6.	☐	☐	☐	Set and secure parameters of scene(s).
7.	☐	☐	☐	Commence written record.
8.	☐	☐	☒	Request attendance of CSI.
9.	☐	☐	☐	Establish who pronounced death.
10.	☐	☐	☐	Identify witnesses.
11.	☐	☐	☐	Enquire whether employer (or other responsible person) has contacted the police or relevant enforcing authority.
12.	☐	☐	☐	In England and Wales, Fire and Rescue Authorities are responsible for enforcing the Regulatory Reform (Fire Safety) Order 2005 (the Order) in most types of premises, except private dwellings (but includes premises that are in multiple occupancy). However, there could be other regulators who take primacy for enforcing the Order, depending on the premises and nature of the activity . If the premises are not a single private dwelling, or there could be some doubt about responsibility, then contact the local Fire and Rescue Service, who will confirm whether they are the correct enforcing authority in accordance with Article 25 of the Order.

Additional Duties of first officer – Domestic Gas Incidents

	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 National Gas Emergency Service (0800 111 999).



	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 (RTIs) on public highways. The immediate 'on-road' investigation will remain the responsibility of the police and HSE/ONR inspectors should not normally have an 'on-road' presence at RTIs.
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 (or ONR in relation to Class 7 Dangerous Goods) 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 were workers (not in vehicles) are engaged in specific work activity (other than travelling), eg 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. ORR, BTP and RAIB will need to be contacted and may wish to attend the scene if the road death involves:
27.	☐	☐	☒	an accident involving a railway, a tramway or other system of guided transport.

Additional Duties of first officer – Railway Incidents

	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), ORR and RIAB.
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, ORR and RAIB regarding preservation of off site evidence (signal boxes etc).
34.	☐	☐	☒	Consider securing all paperwork on site including safety briefings etc.

Additional Duties of first officer – Maritime Incidents

	Done	Review	Police Only	
35.	☐	☐	☒	Inform/request presence of MCA (Duty Enforcement Officer and Duty Surveyor).
36.	☐	☐	☒	Inform / request the attendance of the MAIB.
37.	☐	☐	☒	Check vessel nationality, and if non-UK, was the incident within 12 miles of the coast?
38.	☐	☐	☒	If vessel still at sea, check port of destination and times of arrival and departure.
39.				Consult with MCA enforcement officer / marine surveyor and the MAIB to seek guidance on the important / perishable evidence that must be immediately secured. This can include:
40.	☐	☐	☒	Documents to be copied/seized.
41.	☐	☐	☒	Breath tests as appropriate.
42.	☐	☐	☒	Securing the vessel's Voyage Data Recorder (VDR).

APPENDIX 2: DUTIES OF SUPERVISORY POLICE OFFICER

Duties of supervisory police officer

	Done	Review	Police Only	
				In respect of road traffic incidents involving death (other than those contained within boxes 25-28), 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 25-28 apply the Supervisory Traffic Officer is expected to fulfil the Joint Review process. (Box 57 & 58 below).
43.	☐	☐	☐	Review risk assessment. (Ensure area is safe)
44.	☐	☐	☐	Review scene parameters.
45.	☐	☐	☐	Ensure all duties of First Officer are completed.
46.	☐	☐	☐	Identify and inform Investigating Officer if not already in attendance.
47.	☐	☐	☐	Brief scene officers/guards.
48.	☐	☐	☐	Force Control Vehicle to scene if necessary.
49.	☐	☐	☐	Identify all Closed-Circuit TV/Video cameras in premises or vicinity of scene and secure any relevant recordings.
50.	☐	☐	☐	Ensure host Basic Command Unit (BCU) are aware of incident.

And in the case of a Railway Incident

	Done	Review	Police Only	
51.	☐	☐	☒	Liaise with Rail Incident Officer and review safety arrangements.
52.	☐	☐	☒	Liaise with BTP and agree police handover as necessary.
53.	☐	☐	☒	Ensure ORR, RAIB have been informed.

And in the case of a Fire Incident

	Done	Review	Police Only	
54.	☐	☐	☒	Ensure the cause of the fire is established; liaison between Fire and Rescue Service investigators, scenes of crime officers and forensic scientists may be required.
55.	☐	☐	☒	Ensure the standard of fire safety provisions to achieve compliance with the Fire Safety Order is established and documented.
56.	☐	☐	☒	Ensure relevant evidence is gathered from attending firefighting crews, statements, video footage etc.

And in the case of a Maritime Incident

	Done	Review	Police Only	
57.	☐	☐	☒	Liaise with the MAIB to review safety arrangements.
58.	☐	☐	☒	Liaise with the MAIB to establish priorities for securing perishable evidence.

And in the case of an incident involving a Medical Device

	Done	Review	Police Only	A medical device is used in the treatment of patients, the diagnosis of disease or to alleviate physical disabilities. All medical devices must be appropriately CE marked before they are placed on the market in the UK in accordance with Europe-wide regulations. Products that have a pharmacological action are normally regarded as medicines and, as such, are licensed through a different regulatory process.
59.	☐	☐	☒	Consider informing the MHRA if a medical device is implicated in a death that is under investigation.

Joint review (mandatory)

	Done	Review	Police Only	
60.	☐			Contact the relevant 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 relevant 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.
61.	☐	☐	☒	Consider impact of railway closures on National Infrastructure.

APPENDIX 3: DUTIES OF SENIOR INVESTIGATING OFFICER (SIO)

Duties of senior investigating officer (SIO)

	Done	Review	Police Only	The principal decision maker in a major investigation is referred 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.
62.	☐	☐	☒	Attend the scene.
63.	☐	☐	☒	Review risk assessment.
64.	☐	☐	☒	Commence policy record.
65.	☐	☐	☒	Review scene(s).

Critical review (mandatory)

The purpose of the Critical Review is to establish the issue of primacy. The relevant Enforcing Authority should be present. There may well need to be more than one Critical Review as the investigation progresses.

Establish issue of primacy

	Done	Review	Police Only	In accordance with the underlying principles of the Work-related death protocol there will usually be a Joint Investigation.
				Options:
				Ongoing joint investigation with:
66.	☐			Police having primacy.
67.	☐			Relevant Enforcing Authority having primacy.
				OR
68.	☐			Police withdraw – relevant Enforcing Authority take primacy.

Scene release / retention

	Done	Review	Police Only	It is acknowledged that the relevant 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. Retain the scene under seal without police guard. Release the scene. And In the event of being in attendance – hand the scene to them. In the event of the investigation and scene being passed to the relevant Enforcing Authority and the Police withdrawing from the matter, arrangements should be put in place to ensure continued liaison and cooperation between the parties. Should this be the case the relevant 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 Procedure (MIRSAP) and where the appropriate the Road Death Investigation Manual (RDIM).
69.	☐			
70.	☐			
71.	☐			
72.	☐			
73.	☐			

APPENDIX 4: SPECIAL CONSIDERATIONS

Special considerations

	Done	Review	Police Only	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.
74.	☐	☐	☐	Investigation Management Structure – To include police, HSE/local authority /ORR or other Investigating or Enforcing Authority to ensure all interests are represented.
75.	☐	☐	☐	Joint Media Policy – To ensure effect media management via an agreed strategy in accordance with the policy record.
76.	☐	☐	☐	Forensic Strategy – To take account of the wider range of scientific services and technical expertise available to police, HSE/local authority/ORR or other Investigating or Enforcing Authority acting in co-operation.
77.	☐	☐	☐	Evidence Management – To agree arrangements for sharing evidence between investigating parties and for the retention and disclosure of material.
78.	☐	☐	☐	Determine Lines of Enquiry – To ensure investigation takes account of evidential needs of all agencies subject to the Joint Investigation.
79.	☐	☐	☐	Financial Management – To ensure that adequate budgetary provision is made by the parties to the investigation.
80.	☐	☐	☐	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.
81.	☐	☐	☐	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.
82.	☐	☐	☐	Family Liaison Officer – 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, eg action to be taken to prevent recurrence of a similar incident.

APPENDIX 5: WHERE POLICE HAVE PRIMACY

Where police have primacy

	Done	Review	Police Only	
83.				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 relating to the investigation of serious offences. The relevant Enforcing Authority should be involved within that process to ensure full consideration is given to all the relevant related legislation.
84.				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 not to 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 relevant Enforcing Authority has primacy. Arrangements would need to be put in hand to ensure the case transferral to the relevant 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 or inquest.

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