CPS Policy Directorate HQ
United House
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31st May 2002

Dear

RE: WORK-RELATED DEATHS – A PROTOCOL FOR LIAISON

As you may know, the National Liaison Committee that oversees the protocol governing work-related deaths has, through the creation of a working group, undertaken a review of the protocol. The draft of the new protocol is now ready to be circulated as part of the consultation process, for the comments and views of various interested groups, such as your own. There is a similar letter on the HSE website so that anyone accessing the site can also contribute an opinion.

We realise the importance of getting the contents of the protocol right, and have listened very carefully to those views already expressed to us before formulating the draft document. But we would like to call on you for assistance again, and should be grateful to receive any comments you may have about the draft. I have enclosed a copy with this letter, and have included certain specific questions upon which I would welcome your views.

By way of background information, the new draft protocol has been devised by representatives from the Health and Safety Executive (HSE), the Association of Chief Police Officers (ACPO), the British Transport Police (BTP), the Local Government Association (LGA) and the Crown Prosecution Service (CPS). The LGA and BTP are to be signatories to the new protocol for the first time. The protocol sets out the principles governing liaison between the signatory parties in relation to work-related deaths in England and Wales. In particular, it deals with incidents where the crime of manslaughter or corporate manslaughter may have been committed.

As you will be aware, each of the signatories has a particular role within the investigation and prosecution process, which although not specifically reflected in the draft, will form part of the introduction to the protocol when formally introduced. Similarly, an annex to the protocol will seek to highlight specific areas of enforcement responsibility undertaken by the HSE and Local Authorities.
Other enforcing authorities, such as the Maritime Coastguards Agency and the Civil Aviation authority, will not be signatories to the protocol, but will be asked to confirm

whether they will abide by the principles contained within it, and it is intended that the introduction and annex will provide clear and detailed information about this.

The principles underlying the protocol remain more or less unchanged, and are:

- an appropriate decision concerning prosecution will be made based on a sound investigation of the circumstances surrounding work-related deaths;
- the police will conduct an investigation where there is an indication of manslaughter, and the HSE, Local Authority or other enforcing authority will investigate health and safety breaches. Where appropriate, there will be a joint investigation, but even where this would not be appropriate, there will still be liaison and co-operation between the investigating parties;
- the decision to prosecute will be co-ordinated, and made without undue delay;
- bereaved families and witnesses will be kept suitably informed;
- the parties to the protocol will maintain effective mechanisms for liaison; and
- this protocol is available to the public.

Many of the comments the working group received during the initial consultation were about defining to which fatalities the protocol would apply, and the group discussed this at length. Our conclusions will be included in the introduction, and are as follows:
" For the purposes of this protocol, a work-related death is a fatality resulting from an incident arising out of, or in connection with, work. The principles set out in this protocol also apply to cases where the victim suffers injuries in such an incident that are so serious that there is a clear indication, according to medical opinion, of a strong likelihood of death.
There will be cases in which it is difficult to determine whether a death is work-related within the application of this protocol; for example, those arising out of some road traffic incidents, or in prisons or health care institutions, or following a gas leak. Each fatality must be considered individually, on its particular facts, according to organisational internal guidance, and a decision made as to whether it should be classed as a work-related death. In determining the question, the enforcing authorities will hold discussions and agree upon a conclusion".

The working group also received suggestions that the protocol should include, or have annexed to it, a guide to the law of manslaughter and the Health and Safety at Work Act, 1974. We have decided that it would be inappropriate to do this, because the protocol is designed to be about liaison and co-operation rather than a detailed guide to law and procedure; and there are other sources of this information, such as that found in internal operational guidance, which are readily available to investigators and prosecutors. Also, the law and case law evolve, and any changes would have the effect of rendering the protocol out of date.

We look forward to receiving your observations about the draft document and related questions by 31st July 2002.

Please send your written responses to me at the above address, or by e-mail to protocolreview-nlc@hse.gsi.gov.uk

Yours faithfully,

Neil Masters
Chair, the working group of the National Liaison Committee

Enc.

DRAFT

WORK-RELATED DEATHS:

A PROTOCOL FOR LIAISON

1. STATEMENT OF INTENT

In any investigation it is not always possible to make an early determination of whether an offence of manslaughter has been committed. The parties to the protocol are committed to ensuring that any investigation into a work-related death is thorough and appropriate, and agree to work closely together in order to achieve this. Decisions in relation to the direction and primacy of the investigation should be informed by best evidence and available technical expertise, and should take account of the wider public interest. Should there be any issue as to who is to be involved in investigating any work-related death, then the parties will work together to reach a conclusion.

2. INITIAL ACTION

2.1 A police officer attending an incident involving a work related death should arrange, according to the officer's own force procedures governing unexplained deaths, to:

i. identify, secure, preserve and take control of the scene, and any other relevant place;
ii. supervise and record all activity;
iii. inform a senior supervisory officer;
iv. inquire whether the employer or other responsible person in control of the premises/activity has informed the Health and Safety Executive (HSE), Local Authority or other enforcing agency; and
v. discuss the incident with the HSE or Local Authority Inspector, and agree arrangements for controlling the scene, for considering access to others, and for other local handling procedures to ensure the safety of the public.

2.2 A police officer of supervisory rank should attend the scene and any other relevant place to assess the situation, review actions taken to date and assume responsibility for the investigation.

Question 1. Does paragraph 2 convey adequately and clearly what needs to be done and by whom at the outset of an investigation?

3. MANAGEMENT OF THE INVESTIGATION

3.1 Investigations should be jointly managed by the police, the HSE, Local Authority or other enforcing authority, with one of the parties taking primacy, as appropriate. An investigation may also require liaison with any other enforcing authority that may have an interest, and may include liaison with the Crown Prosecution Service (CPS). Even where a joint investigation is not appropriate, there will continue to be liaison and co-operation between the parties.

3.2 The police and HSE, Local Authority or other enforcing authority should keep the progress of the investigation under review. Milestones should be agreed and monitored, and policy decisions recorded.

3.3 The police, HSE, Local Authority or other enforcing authority should agree upon:

- how resources are to be specifically used;
- how evidence is to be disclosed between the parties;
- how the interviewing of witnesses and the forensic examination of exhibits is to be co-ordinated;
- a strategy for keeping witnesses and bereaved relatives informed of developments in the investigation.
- a media strategy to take account of the sensitivities for those involved in the incident and the bereaved families, and to encourage consistency of approach in reporting.

3.4 In certain large-scale investigations it may be beneficial to form a strategic liaison group to ensure effective inter-agency communication, and to share relevant information and experiences.

Question 2: Do you agree that suitable emphasis has been put on investigations being jointly managed over and above separately managed?

4. DECISION MAKING

4.1 Where the investigation gives rise to a suspicion that an offence of manslaughter may have been committed, police will assume primacy for the future investigation and will work in partnership with the HSE, Local Authority or other enforcing authority, which may be investigating.

4.2 Where it becomes apparent during the investigation that there is insufficient evidence that an offence of manslaughter has been committed, the investigation should, by agreement, be taken over by the HSE, Local Authority or other enforcing authority. Both parties should record such a decision in writing.

4.3 Where the HSE, Local Authority or other enforcing authority is investigating, and new information is discovered which may assist the police in considering whether an offence of manslaughter has been committed, then the enforcing authority will pass that new information to the police. An enforcing authority inspector may do this, but it may also be from the enforcing authority's solicitors via the CPS.

4.4 There will also be rare occasions where as a result of the Coroners Inquest further consideration of the evidence and surrounding facts may need to be made. Where this takes place the police, the enforcing authority with primacy for the investigation and the CPS will work in partnership to ensure an early decision.

Question 3: Does the protocol clearly explain the relationship between the roles of the police and the individual enforcing authorities, and how and in what circumstances the roles may change?

5. DISCLOSURE OF MATERIAL

5.1 Where there has been an investigation, any material obtained should be shared, subject to any legal restrictions, between the police, the HSE, Local Authority or other enforcing authority and the CPS. Special handling procedures may be necessary in certain cases. The organisation responsible for retaining the exhibits should also be agreed upon.

5.2 Disclosure must always follow the established law and procedure.

Question 4: Has paragraph 5 been written in a suitably general way, so as to allow for the frequent changes that occur in the law and practice governing disclosure?

6. SPECIAL INQUIRIES

6.1 In the case of some incidents, particularly those involving multiple fatalities, the Health and Safety Commission may, with the consent of the Secretary of State, direct that a public inquiry be held. Alternatively, it may require the HSE to investigate and produce a special report.

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

6.3 Complex legal issues may arise when there are parallel public inquiries and criminal investigations or prosecutions. 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.

Question 5: Does paragraph 6 adequately cover all the likely situations that may arise, and how the making and announcing of decisions are timed according to the circumstances?

7. PRE-CHARGE ADVICE

7.1 Early liaison between the police and the CPS and close co-operation are to be encouraged in the best interests of the investigation and prosecution process as a whole. There is no need to wait until a file is ready to be submitted before the police open discussions with the CPS. The police may, at any stage following a work-related death, consult the CPS for advice, not only about the nature of any charges, but also as to the legal and evidential issues surrounding the investigation.

7.2 The police should seek the advice of the CPS before charging an individual with manslaughter arising out of a work-related death.

7.3 The police must consult CPS Casework Directorate for advice before charge when there is any issue of corporate manslaughter.

Question 6: Is the role of the CPS, in terms of the investigation and the prosecution, clearly explained?

8. THE DECISION TO PROSECUTE

8.1 The decision to prosecute for manslaughter, either with or without related HSWA offences, shall be taken by a Crown Prosecutor according to the Code for Crown Prosecutors, and following discussion with the police, and, where appropriate, the HSE, Local Authority or other enforcing authority. There should be no undue delay in reaching the prosecution decision. If there is a delay, then the CPS will notify the police and the enforcing authority and explain the reasons for the delay, and will keep them apprised of the progress of the decision making.

8.2 When the CPS' decision has been made, it must be communicated to the police, HSE, Local Authority or other enforcing authority as soon as practicable, so that the HSE, Local Authority or other enforcing authority can decide as expeditiously as possible whether to prosecute for HSWA offences if the CPS is not doing so.

8.3 Where the HSE, Local Authority or other enforcing authority has primacy for the investigation, then the decision whether to prosecute for HSWA offences shall be taken without undue delay.

8.4 No prosecution decision shall be made public until the accused and the bereaved families have been notified according to the previously agreed strategy.

8.5 The public announcement of the decision shall be made according to the media strategy already agreed.

8.6 Where there is to be no CPS prosecution, the announcement of the CPS decision shall include the fact that the decision of the HSE, Local Authority or

other enforcing authority will be made after the inquest (unless 10.3 (below) applies).

Question 7: Does the protocol demonstrate a commitment by the signatories to openness, and to effective liaison, during the decision making process?

9. THE PROSECUTION

9.1 Where both the CPS and the HSE, Local Authority or other enforcing authority seek to prosecute offences arising out of the same incident, the prosecution shall be initiated and managed jointly.

9.2 There should be an early conference attended by the CPS, the police and the HSE, Local Authority or other enforcing authority to consider the management of the proceedings. In particular, the following issues should be discussed and agreed:

i) who will take lead responsibility for the prosecution;

ii) the nature and the wording of the charges (including, where appropriate, consideration of any alternative charges and acceptable pleas);

iii) arrangements for the retention and disclosure of material;

iv) a time-table for the proceedings;

v) arrangements for keeping witnesses and the bereaved informed;

vi) the announcement of the decision;

vii) arrangements for maintaining contact during the prosecution, and an agreement as to a mechanism for consulting should an issue arise which results in the discontinuance of the proceedings or no evidence being offered;

viii) an agreement as to any specific instructions to the prosecuting advocate; and

ix) any other case management issues.

9.3 Where the CPS is prosecuting, and there is no prosecution by the HSE, Local Authority or other enforcing authority, but an enforcing authority wishes to retain an interest in the case, the CPS will keep that enforcing authority advised of the progress and outcome of the case.

Question 8: Do you believe that there are prosecution issues that ought to be discussed at a conference that have not been included in

the protocol?

10. THE CORONER

10.1 Where the CPS is prosecuting, and the HSE, Local Authority or other enforcing authority has submitted documents or a report to the coroner about a work-related death, the CPS and the police shall also be given a copy. Similarly, where an enforcing authority is prosecuting, and the police or CPS has submitted documents or a report to the coroner about a work-related death, the enforcing authority shall also be given a copy. In all cases, documents or reports may not be disclosed to any party without the consent of the party that originally submitted them.

10.2 The police or the CPS will notify the coroner when an offence of manslaughter has been charged. The coroner may then adjourn the inquest until the end of the criminal prosecution. Also, under section 16 Coroners Act 1988, the Director of Public Prosecutions may ask the coroner to adjourn the inquest where there are proceedings before a magistrates' court that are related to a death.

10.3 Where the CPS has reviewed the case and decided not to prosecute, the HSE, Local Authority or other enforcing authority will await the result of the coroner's inquest before charging any HSWA1974 offences, unless to wait would prejudice the case. Where, following an inquest, it is necessary for the CPS to review or re-review the case, the HSE, Local Authority or other enforcing authority will wait until the review by the CPS has been completed before instigating or continuing its own proceedings.

Question 9: Do you think that the protocol adequately expresses the importance of liaison with the Coroner, and clearly sets out how information may be shared?

11. NATIONAL LIAISON

11.1 The National Liaison Committee comprises representatives from the Police, BTP, the CPS, the HSE and the Local Government Association. It will meet at least twice a year to review the operation of the protocol and consider the need for changes to the arrangements.

12. LOCAL LIAISON

12.1 The Regional Liaison Committees comprise representatives from the signatories, nominated at local levels. These committees will 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.

12.2 The Regional Liaison Committees will be responsible for ensuring that there is an identified and effective line of local communication between the three organizations.

Question10: Is the protocol clearly written and in an appropriate style?

Question11: Are there any ambiguities or inconsistencies?