

Work-related deaths: liaison with police, prosecuting authorities, local authorities, and other interested authorities including consideration of individual and corporate manslaughter / homicide

OC 165/9

**Target Audience:
All HSE Inspectors**

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Summary

This Operational Circular should be read in conjunction with the relevant sections of the Enforcement Guide (England and Wales) and the Enforcement Handbook (Scotland) under Work Related Deaths and replaces OC 165/8. Further guidance and information is in HSE's operational procedures, and its associated guidance, and in the Investigator's Guide.

This OC:

- describes the current arrangements for liaison between HSE, police forces (including transport police), local authorities, the Office of Rail Regulation (ORR), the Crown Prosecution Service (CPS), and the Crown Office and Procurator Fiscal Service (COPFS) following work-related deaths;
- outlines the Work-Related Deaths Protocols agreed between HSE and relevant organisations, and the mechanisms for regional and national liaison;
- sets out the similarities, and the differences, between the English/Welsh and the Scottish Protocols (see para 2 and Appendix 1);
- contains advice on the recording of information and key decisions and guidance on disclosure of information between the signatory organisations and other interested parties;
- gives guidance on the law relating to individual manslaughter and culpable homicide, and on the new (2007) law of corporate manslaughter and corporate homicide, - and the role of HSE in their investigation and prosecution (see Appendix 2).

Introduction

1 In February 2003 the Work-related Deaths Protocol (WRDP) for England and Wales was revised and updated, and in October 2006 a Scottish WRDP was issued. This OC details the main changes to the E/W Protocol, and indicates the areas where the Scottish Protocol differs. The principal changes in the 2003 edition include:

- i) the addition of 2 new signatory organisations to the E/W Protocol; the Local Government Association, a body promoting the interests of English and Welsh local authorities, and the British Transport Police (see para 2 for information on signatories to the Scottish version),
- ii) the Protocol covers not only cases when there has been a death, but also when there is a strong likelihood of death (see para 6),
- iii) the initial attendance of police officer of supervisory rank remains, but the Protocol no longer specifies that this should be a detective (see para 15),
- iv) the provision for joint, and jointly-managed, investigations with closer co-operation and information sharing between investigating authorities,
- v) the need to record key decisions (see para's 23 to 25),
- vi) changes in how we are expected to deal with new information discovered by HSE during our investigations (see para 26)

Scotland

2 Scotland has its own version of the Work-related Death Protocol addressing procedures for liaison with the police (ACPO Scotland), Crown Office and Procurator Fiscal Service (COPFS), and the British Transport Police. The Convention of Scottish Local Authorities (COSLA) and ORR have indicated their support for the Protocol and are expected to become signatories in October 2007. Additional guidance may be found in Operational Procedures and the Scottish Enforcement Handbook. Many parts of the text of the Scottish Protocol are identical to the text of the English/Welsh Protocol, and generally only depart from the E/W version where the Scottish legal/administrative system requires it. The liaison principles apply equally in both versions, as does the new corporate manslaughter and corporate homicide law. The differences are principally about the prosecution and fatal accident inquiries processes, and how the role of the COPFS differs from the role of the CPS. Appendix 1 sets out the principal similarities and differences between the English/Welsh and Scottish versions. Reference is made also at relevant points in the text of this OC. In particular, it should be noted that a reference in the text to HSE decision to prosecute should, in Scotland, be taken to mean the HSE decision to refer the case to the COPFS for consideration of prosecution. Where reference is made to 'the Protocol', without specific reference to just "England/Wales" or to just "Scotland", then it is intended to be a reference to both.

Rail - and other (non-signatory) bodies

3 Following the establishment of the Office of Rail Regulation (ORR) as the combined health, safety and economic regulator for the railways, ORR became a signatory of the WRDP on 1 April 2006. Inspectors from ORR will attend such incidents involving railways, tramways and guided transport systems and will follow the principles for liaison set out in the Protocol.

4 Some other organisations, which are not signatories to the Protocol, may be involved in investigating work-related deaths. These include the Fire and Rescue Services, and the CFOA (Chief Fire Officers Association) Board has, following discussions between CFOA, HSE and HM Fire Service Inspectorate (now known as the Department for Communities and Local Government), indicated their agreement to follow the principles in the Protocol. Other organisations, such as Maritime and Coastguard Agency, Marine Accident Investigation Branch, Civil Aviation Authority and Air Accidents Investigation Branch have also acknowledged the Protocol and its principles of liaison. Memoranda of Understanding entered into between HSC/E and these, and other, organisations exist to promote joint cooperation and to minimise duplication of effort.

Operational procedures

5 HSE's Operational Procedures set out how we go about our activities and, similarly, the police and other organisations have their own internal procedures and instructions, e.g. the ACPO 'Murder Investigation' Manual 2006. The Protocol is not intended to replace the instructions contained in HSE's procedures, and HSE staff should continue to follow the procedures. For example, the Protocol does not seek to set down whether or not we investigate any particular death, (that is covered by our incident selection procedure and other relevant guidance, such as the section 3 policy etc), but merely sets down the framework for liaison with other organisations in those cases where we do decide to investigate. The following guidance, (providing guidance and background information on the main issues and key objectives of the Protocol), has been divided into parts, which follow the same order as the parts within the Protocol.

Part 1: The protocol – statement of intent

6 The Protocol sets out the principles for effective liaison between the organisations responsible for investigating work-related deaths and should be followed for all investigated work-related deaths (including deaths within the signatory organisations). It applies to any incident arising out of, or in connection with work, resulting in one or more fatality, or injuries so serious there is a clear indication, according to medical opinion, of a strong likelihood of death. The addition of cases where injuries are likely to lead to death are to facilitate early liaison, discussion and involvement of all relevant organisations in the initial stages of such cases. The inclusion of the words "clear indication" and "according to medical opinion" mean that HSE staff are not placed in the position of having to make a judgement on the clinical outcome of any injuries, and we can rely on information provided by medical experts. In Scotland, the Procurator Fiscal (PF) is responsible for obtaining

medical opinion and directing the police, and advising HSE on whether to implement the Protocol because death is likely.

HSE involvement

7 The Protocol refers to investigations being conducted jointly, with one of the parties taking the lead, or having primacy, as appropriate. The police will, in most circumstances, assume primacy in investigations of work-related deaths where a serious criminal offence such as manslaughter is suspected. This does not mean the police should investigate alone, or that only manslaughter, or other serious offences (other than health and safety offences) should be investigated. Where the police have primacy they will also have responsibility for the management of the overall investigation but HSE, and other relevant authorities, should remain actively involved in key decisions, such as: how the investigation will proceed, who should be interviewed, the content and timing of interviews, what physical evidence is needed, the arrangements for communicating with victims and others including the media, the nature of any prosecution etc.

8 The overall investigation should be conducted jointly in a way that will best serve the public interest, and enable there to be a sound criminal investigation of all the relevant circumstances surrounding the death, including health and safety aspects. The aims of this joint investigation will include:

- establishing whether prosecution is warranted, and if so whether for manslaughter (or other serious criminal offence), HSWA offence, or both and;
- gathering evidence where prosecution is warranted.

9 Where one authority has primacy, it will lead the management of the investigation. A vital part of that management role will be to ensure discussions take place and agreement is reached with the other enforcing authorities on how the investigation should be progressed and, in particular, the items covered by paragraph 3.3. of the Protocol (para 18 in the Scotland version).

Road traffic incidents

10 The police will take the lead in most road traffic incidents (RTI) on the public highway. The exception, where HSE is likely to be involved and possibly to have primacy, includes accidents involving the carriage of dangerous goods, work vehicles manoeuvring in, out and in close proximity to the work premises or other work on or near the public highway, such as construction or roadwork activities. HSE may also be involved in aspects of some RTI cases, e.g. where there is indication of significant underlying health and safety management failings. For all other work-related RTIs HSE staff should not normally have 'on the road' presence during the initial investigation. Further guidance can be found in OM 2003/103, and in HSE's policy and guidance on section 3.

Work-related death arising out of police activity

11 Not all incidents involving the police are investigated by HSE, but we do investigate some of them where it is appropriate for us to do so. (See HSE's policy and guidance on section 3). If an investigated incident involves the police as a dutyholder, then a separate police force may be asked to investigate. In Scotland, the PF has a duty to investigate cases of possible criminal offences by the police. For serious cases the fiscal is likely to ask another police force to carry out the investigation. This does not, in any way, affect the principles of liaison in the Protocol. HSE will continue to liaise, under the terms of the Protocol, with whichever force is investigating manslaughter, or homicide, or other charges in relation to the death. We would also continue to communicate with the police force involved in the incident, as we would with any other dutyholder and/or suspect. There may be cases where there is no separate investigating police force, or there may be cases involving the Independent Police Complaints Commission (IPCC), or internal police disciplinary or criminal investigations. Whatever form these take, we should ensure that possible health and safety offences are properly and promptly investigated, and we would maintain the liaison and joint-management principles of the Protocol, and liaise with whoever is conducting any criminal inquiry, as envisaged by the Protocol.

Deaths in healthcare

12 Deaths in premises used for healthcare, or during medical care, can be particularly complicated, and there may be a number of interested investigation bodies, regulators and enforcers. These organisations can change, and merge, over time and if there is any doubt or concerns over the roles and responsibilities of these organisations then advice may be sought from the public Services Sector. There is considerable potential for overlap and for conflicts of interest, and consideration should be given to HSE's section 3 policy and guidance. In addition, in England, HSE has joined with ACPO and Department of Health in a Memorandum of Understanding between ACPO, HSE and NHS Trusts (and their executive agencies e.g. Healthcare Commission, Medicines and Healthcare products Regulatory Agency etc.) in relation to the investigation of serious incidents affecting patients, which may be relevant. Inspectors should refer to the MoU's associated guidance.

Investigators guide

13 The Investigators Guide is a supplementary guide intended to be read in conjunction with the English/Welsh Protocol. It was written by police officers representing ACPO in England and Wales, and was subsequently agreed for issue by the National Liaison Committee (NLC). It is not a mandatory guide but was produced with the aim of assisting those tasked with investigating work-related deaths. It provides a practical step-by-step approach with its main focus on the duties of the first person attending the scene - which, in most cases, will be the police. This is therefore very much aimed at the early police actions in an investigation. It lists a series of actions for the police officer to take. Of particular relevance to HSE/LAs are the actions required of the officer: to notify a Senior Investigating Officer (usually a Detective Inspector or above); to consider primacy and

HSE/LA involvement under the Protocol; to consider protection and retention of the scene, and to consider the investigation management issues listed in para 3.3 of the English/Welsh Protocol (para 18 in Scotland). Although not appearing to offer a great deal for immediate and direct HSE use, it may be used by police officers and HSE staff should be aware of it and its potential use and limitations. It is not expected that it will be used by police forces in Scotland, but colleagues in Scotland may wish to be aware of it in case they are involved in an investigation in England or Wales. Separate guidance to accompany the Scottish Protocol is being prepared.

Part 2: Initial action at scene

14 The police officer first attending the scene of a work-related death will, subject to any ongoing emergency service or rescue activity, take control of the scene, advise a senior officer, and seek to establish contact with the health and safety enforcing authority e.g. HSE, LA or ORR. Annex A of the Protocol gives general guidance to the police on enforcement demarcation under the Health and Safety (Enforcing Authority) Regulations 1998 (OC 124/11).

15 The Protocol requires that a police officer of supervisory rank should attend the scene and assume responsibility for the overall investigation. In the previous version of the Protocol, the requirement was for this to be a 'detective' of supervisory rank, but this has not been repeated in the current Protocol – however, in most cases, it will be a detective, and often will be a Detective Inspector or above.

16 Whilst HSE may not be first on the scene, early conversations, by telephone if necessary, with the police can greatly assist with the preservation of the scene and retention of important evidence in relation to health and safety offences. Where HSE is informed of a work-related death at a site where the conventional police forces do not operate, e.g. nuclear sites where the Civil Nuclear Constabulary and MoD Police have jurisdiction, the WRDP should be brought to their attention and the principles followed as closely as possible. A range of police forces (other than the usual area constabularies), e.g. MoD police, Ports police etc, have been advised of the Protocol and although not formal signatories, they have stated their acceptance of the principles and expectations of the Protocol and that they aim to work and liaise within them.

17 It is strongly advised that HSE inspectors take a spare copy of the Protocol with them when first attending site. Past experience has indicated the importance of ensuring that, at an early stage, the police officers involved in the investigation are aware of the Protocol and that it has been produced by ACPO (England and Wales) and ACPOS (Scotland). It may help, at the initial formative stages of the investigation, in explaining HSE's presence, involvement and shared interest.

Part 3: Management of the investigation

General

18 The investigation should be managed and conducted jointly, with one party taking the lead/primacy. In the initial stages this will usually be the police (at least until due

consideration has been given to possible manslaughter enquiries). However, it's important that a clear decision is made on initial primacy, and that this is recorded. It should involve discussion between the police, HSE/LA (as the health and safety investigating and prosecuting body), and any other enforcing authority that may have an interest. The Investigators Guide refers to this as a 'critical review', and points out that there may need to be further such reviews as the investigation progresses. As indicated in paragraphs 7 to 9 above, the continuing investigation should be one that is jointly managed and conducted, irrespective of which authority has primacy at any given point in time. The primacy/lead may change more than once during the course of an investigation, e.g. where the initial Police lead has been transferred to the HSE/LA, if new information comes to light the lead may be passed back to the police – or vice-versa (para 26 refers).

19 Experience has shown that an early face to face meeting between HSE and the police is valuable, and helps set the investigation off on the right foot. The meeting should discuss primacy, and also agree a way forward on the issues listed in para 3.3 of the Protocol (para 18 of the Scottish version), to set milestones (para 3.2 of the Protocol, and para 17 in Scotland) and to agree to a further meeting to review jointly the emerging findings and the next steps. In most cases it will be appropriate to continue to meet periodically to plan, review and agree each successive stage in the investigation. [Note: For major incidents the Investigation Team Leader is responsible for tactical liaison at the site – see Major Incident operational procedures Step 4.5, and the Investigation Manager liaises at a strategic level – see Step 4.2].

20 Early involvement of CPS, or COPFS, can be of great assistance to an investigation, e.g. to advise on: the law of manslaughter or culpable homicide, issues surrounding the admissibility of evidence, media strategies etc. Investigations into gross negligence manslaughter, culpable homicide, or 'corporate manslaughter/homicide' are relatively rare, and the offences are in complex areas of the law. In such cases it may be prudent and helpful to seek early advice from CPS/COPFS.

21 It is the responsibility of the authority with primacy to lead the management of the investigation, and a vital part of that management role is to ensure discussions take place and agreement is reached with the other authorities on how the investigation should be progressed, ensuring all interests are represented. In particular, the points covered in paragraph 3.3 [para 18 in Scotland] of the Protocol will need to be addressed. These are:

(a) Resources –

(i) The police, HSE/LA and other investigating authorities will have access to a wide and varied range of specialist and expert resources. The investigation team should take account of the expertise within all these organisations, consider what they can each bring to the investigation, and decide how best use can be made of available expertise to effectively progress the joint investigation and avoid duplication. For example the police have access to police forensic scientists and scenes of crime officers who may be able to assist HSE. Similarly, HSE may be able to provide specialist scientific and technical assistance from Specialist Inspectors and HSL, covering not only mechanical, electrical, occupational health etc expertise, but also expertise in matters such as human factors, or visual display services.

(ii) The investigation team may also have to consider the different evidential needs of the police and HSE/LA. For example, to prove manslaughter there has to be evidence of the cause of death, which may require forensic evidence. Health and safety offences do not need proof of cause of death because an offence under HSWA only requires the defendant to have failed to take certain steps to properly control a risk. It is not necessary to prove that death resulted from this risk (although if death was a consequence of a breach then that would be an aggravating factor in any sentencing).

(b) Evidence disclosure/sharing –

(i) Arrangements should be made for sharing evidence between investigating parties (e.g. by providing copies of statements and documents routinely) and, subject to legal restrictions, for the retention and disclosure of all material. Confirmation should be sought from the police that should HSE assume primacy all material will be passed on; likewise HSE should provide to the police any material collected in the course of our investigation. An investigation handover document has been produced to assist in the exchange of relevant material between the police and HSE/LA when primacy for the investigation is handed over (an example of the handover document can be found on the Legal and Enforcement webpage). In general there is no bar to the sharing of information, including evidence and statements, between criminal investigators, where the purpose is to further a criminal investigation, or to aid the prevention and detection of crime, and it is proportionate to do so. (Relevant legislation includes the Anti-Terrorism, Crime and Security Act 2001 - section 17 - which allows for the disclosure of information in connection with criminal investigations and prosecutions between public authorities provided it is proportionate to what is sought to be achieved by disclosing it. Under this provision inspectors are no longer prohibited from disclosing evidence obtained as a result of using section 20 powers. Further guidance is in the Enforcement Guide). See [Part 5](#) below, for information on the subsequent disclosure of relevant material.

(ii) It should be noted that where an investigation involves equipment that is supplied throughout the EU a notification to the European Commission is required; this will ensure that we comply with relevant European Product Safety Legislation. In order to comply with this requirement we may need specific information from other authorities, including the police, CPS and COPFS before the case is taken to court or handed back to HSE. The information required can be obtained from the Local Product Safety team. The NLC has issued an addendum to the England/Wales Protocol that explains the need for this information and what will be done with it. Since this is to facilitate compliance with European law, this principle will apply in Scotland, for which a slightly modified version is being prepared.

(c) Interviewing witnesses and suspects –

(i) All investigating parties should discuss potential suspects and key witnesses and agree the content of interviews before they take place. The Senior Investigating Officer (SIO) for the police and the inspector leading the HSE investigation should

agree the interviewing strategy and ensure that interviews are planned, coordinated and conducted in a way that best meets the overall needs of the joint investigation. The police SIO and lead HSE inspector should agree who are possible/likely suspects and key witnesses for both manslaughter/homicide and health and safety offences – and also for other non-manslaughter offences that may be investigated by police forces, e.g. some road traffic offences. Suspects may include companies and other bodies corporate, as well as individual persons. Consideration should be given to what HSE can bring to the interview by way of knowledge and expertise in certain areas, e.g. technical, scientific, H&S management systems etc. The ultimate responsibility for determining the interviewers for any particular interview will rest with the senior investigating officer of the organisation having primacy at the time, but should be arrived at through a process of consultation and discussion with all other investigating authorities.

(ii) Generally, it will be advantageous for manslaughter/homicide and health and safety matters to be dealt with in the one interview, since the evidence required for both offences is likely to be linked inextricably. This will save time and resources and avoid the need for repeated interviewing, which could be viewed by the court as being oppressive. It must be made clear from the start of the interview that the suspect is being questioned both in relation to manslaughter and health and safety offences and that replies might be used in connection with the investigation and/or prosecution of either.

(iii) For joint interviewing the police and HSE should be clear on, and agree, their respective roles and responsibilities. Interviewers should clearly identify themselves to all parties present at the interview. This is of particular importance for interviews with suspects, including those under caution. Either party may take the lead in witness interviews whilst the other contributes to the questions. However, it will be appropriate for the police to take the lead when interviewing suspects for manslaughter offences or where the suspect has been arrested.

(iv) A range of options is available and interviews can be conducted by police officers, or by HSE/LA inspectors, or done jointly. Where there are shared interests in the outcome of an interview then conducting it jointly should be considered. Where a joint interview is not possible or appropriate then other means should be provided to ensure that all interests are dealt with. This could involve, for example, providing a remote monitoring, e.g. audio link, so the non-interviewing investigating authority can listen to the interview and give feedback to the interviewers during appropriately planned breaks. Alternatively, the organisation not present at the interview can provide the interviewer(s) with questions, or with details of areas to be covered in the questioning.

(d) Investigating organisational failures – Where lines of enquiry point towards corporate or organisational failures, HSE should discuss with the SIO how, and to what extent, they will be investigated. In most circumstances HSE will take the lead in investigating management failures. However, we may use our powers under HSWA only for our own purposes, and we cannot use our powers solely at the request of, and for the sole purposes of, the police. If we do investigate health and safety management issues legitimately and honestly for our purposes then, having

done so, we may share the information we obtained with the police and other criminal investigators.

(e) Keeping the bereaved and others informed – (i) Where the police provide a family liaison officer (FLO) this is the preferred method of co-ordinating contact with the bereaved. Contact should be made with the FLO and responsibilities for communicating with the family should be agreed, so that all concerned are clear about who will provide information to the family and what that information will be. Even where the police have the lead, inspectors should still offer to meet the family (with the FLO) to explain our role in the joint investigation and provide them with a letter and the 'Bereavement Pack'. If it is not possible to meet the family, providing a written briefing for the FLO to use is likely to be helpful. In the event of the police withdrawing from the investigation, an agreement should be made whether the FLO should continue their role. It should be borne in mind that HSE/LA inspectors are not trained as FLOs and are neither able, nor expected, to take on or replicate the FLO role. Our role is principally to ensure communication with the bereaved so they can be informed of the progress and actions of our investigation, and relevant information on remedial action that has been taken to prevent a recurrence of the incident - in so far as we are able to do so. Whilst, during the period of police primacy, we may be able to communicate with, or alongside, the police FLO, we should remember that, in most cases, the continuing investigation and primacy is often passed back to HSE. We will therefore need to ensure that we have made contact with the bereaved so that we, and our investigation, are known to them and they are aware of our involvement from the very start of the joint investigation. When primacy passes back to HSE we will need to make contact with the bereaved so we can also take their views into account, as required by the Code for Crown Prosecutors (para 5.12), and the Prosecution Code (see OM 2003/106). Guidance on taking Victim Personal Statements can be found in OC 130/12.

(ii) For investigations where HSE has primacy and there is no FLO, inspectors should follow the instructions in OM 2002/105 (OM 2003/105 for Scotland) for keeping the bereaved informed. Specific guidance should be referred to when keeping victims and the coroner (in England and Wales), and those involved in fatal accident inquiries (in Scotland), informed.

(f) Media – There should be discussions with the police, and other relevant authorities, including the CPS/COPFS, on an effective joint media strategy. Advice and support may be obtained from HSE's Press Office, and/or local Government Information Officers. It is advisable to involve them at the earliest available opportunity - taking into consideration the circumstances of the case, including the sensitivities of the bereaved and those involved in the incident.

22 Paragraph 3.4. of the Protocol (para 19 in the Scotland version) refers to a strategic liaison group. It is envisaged that any such group would be set up only as an exception, and possibly for the major investigations involving a number of enforcing and investigating authorities, and possibly also involving difficult and complex technical or legal issues, or a number of potential dutyholders and suspects. The setting up of a strategic liaison group would generally be initiated by the investigation team, and would reflect the major incident procedures of the organisations involved.

Part 4: Decision making– and recording

23 All key decisions made by the HSE throughout the course of the joint investigation and any subsequent enforcement action must be recorded in the Key Decision Log (KDL). Each investigation must have its own KDL. Items that will need to be recorded include:

- the outcomes of discussions covered in [Part 3](#) above (Management of the Investigation), and the use of various powers,
- any initial enforcement action taken by the HSE to require immediate risks to be dealt with, or to ensure continuing compliance (the police should be informed of any enforcement action taken and reassured that it will not affect any subsequent manslaughter case – if in doubt then discuss with the police, and or CPS/COPFS, before taking such action),
- when primacy for an investigation changes between the police and HSE and the investigation handover document is completed and signed,
- when new information, which may assist the police, CPS or COPFS in considering whether a serious criminal offence has been committed, is discovered and passed to the police, CPS or COPFS, in accordance with para 4.3 of the Protocol (para 23 of the Scotland version). See also para 26 below.

24 KDLs are for HSE's decisions, or for decisions affecting HSE and our investigation, only and should be completed at all stages of an investigation, including periods when the police has primacy. It has been suggested, in the past, that HSE should not have its own KDLs. This is not accepted, and any such suggestion should be resisted. It's important that HSE can demonstrate, if challenged, that it conducted a full and proper investigation and that key decisions were both made and recorded appropriately. KDLs form an essential part of our investigation and their continued use during joint investigations is necessary to avoid difficulties should the lead/primacy swap to HSE, or should there be any challenges by others following the investigation. It should be noted that, to date, most joint investigations of work-related deaths are passed over to HSE for primacy and to pursue consideration of health and safety offences. It's therefore important that we maintain, and maintain control of, an appropriate record of our key decisions and actions.

25 Key decisions and reasons for NOT doing something should also be recorded, as should any changes or retractions of previous decisions. On completion of the investigation, a new Note should be created in COIN and the KDL serial number recorded in the Summary field and the hard copy stored safely with the remaining case papers. General guidance on KDLs can be found under Operational Procedures.

26 Special note should be taken of para 4.3 of the England/Wales Protocol (para 23 in the Scotland version). This marks a change in how we are expected to deal with new information discovered by HSE during our investigations, after primacy has passed from the police and they have indicated that there are insufficient grounds for them to continue investigating possible manslaughter/homicide. The original version of the Protocol said that "where, during the HSE investigation, evidence indicates that an offence of manslaughter may have been committed, HSE will refer the matter to the police without delay". Whilst the need to advise police of any such information is accepted and

appropriate, this previous wording seemed to suggest that HSE was in a position to take a view on evidence in relation to manslaughter offences. This is not the case. The police investigate manslaughter and homicide, and only the CPS and COPFS make decisions on evidence, evidential sufficiency, and charges in relation to manslaughter and other homicides. The new wording in both the English/Welsh and Scottish Protocols reflects this, and seeks to make it clear that HSE's role in such circumstances is to pass on relevant new information to the police, or CPS/COPFS, so that they can then take a view as to whether, in the light of the new information, they wish to reopen homicide considerations and reassume primacy. The role of HSE, and the support we can give, in relation to manslaughter and homicide (both individual and corporate) is set down in Appendix 2.

Part 5: Disclosure of material

27 If HSE is taking, or considering, prosecution for health and safety offences then we need to identify what relevant material others have obtained throughout the course of their investigation. We will need access to all such material, so we can, in England and Wales, meet the requirements of the Criminal Procedures and Investigations Act 1996. Although CPIA does not apply in Scotland, disclosure of both used and unused material is an obligation on the PF. In cases where others (police, CPS, COPFS) are taking forward a prosecution, then we should equally be prepared to provide them with all relevant material that we hold. There should generally be no problem in sharing such information for these purposes. Support for this comes from the Anti-Terrorism, Crime and Security Act 2001 – see para 21(b) above.

28 In the event of HSE assuming primacy for the investigation in England/Wales, both used and unused relevant material should be requested from the police, and other authorities who may have such material, paying particular attention to any sensitive material. It will be the responsibility of the Disclosure Officer to categorise the material and to determine, under CPIA, which material in the prosecutor's opinion might reasonably be capable of undermining the prosecution case, or of assisting the case for the accused. Enforcement Guide and Disclosure Training Manual provide further guidance.

Part 6: Special inquiries

29 In some cases, particularly those involving multiple fatalities, the HSC may direct that a public inquiry be held, or under section 14(2)(a) HSWA may authorise HSE to investigate and produce a special report. In such circumstances, it should be agreed with the police, and other investigating authorities, what support and evidence they can provide to assist the investigation. Special care needs to be taken when a public inquiry is set up, and there are parallel and ongoing criminal investigations (para's 6.3 and 28 of the E/W and Scottish versions refer respectively). In such cases, advice should be sought from HSE's Legal Advisers Office (LAO).

Part 7: Advice prior to charge

30 Early liaison between the CPS/COPFS and HSE is encouraged where consideration is being given to prosecution for manslaughter/homicide, or other serious criminal offence, or for health and safety offences as permitted under HSWA s38. Where HSE is considering

prosecution for health and safety offences consideration should be given, in England and Wales, as to whether a solicitor agent or colleague from LAO should be appointed early, before the decision to prosecute is made, to advise and represent HSE at meetings held with CPS.

Part 8: Decision to prosecute

31 The decision to prosecute should be co-ordinated between the police, HSE and CPS/COPFS and must follow the Code for Crown Prosecutors and the Prosecutors Code – and take account of the views expressed by the bereaved (OM 2003/106 refers). For HSE prosecutions, and recommendations by HSE to prosecute, prosecution must also be in accordance with the principles and expectations of the Enforcement Policy Statement, and the framework provided by the Enforcement Management Model. The decision should be made without delay but, in England and Wales, generally not before the Coroner's inquest has been held. In Scotland, account should be taken of the need to report to the PF within 2 months of the death occurring, or where that is not practicable to provide an interim report.

32 When a prosecution decision has been made, all interested investigating and enforcing authorities should be informed as soon as possible and, if necessary, the announcement of any such decision in the media should be co-ordinated between all parties involved. The suspect must be notified of the decision before the bereaved or other victims – and they should be advised of the decision before it is made to the general public.

33 Where HSE has primacy for the investigation, the approval decision should be made by the approval officer within 10 working days from receiving the prosecution report. Whether or not approval is granted, a record must be made in the KDL and the bereaved informed accordingly.

Part 9: Prosecution (mainly England and Wales only)

34 If both the CPS and HSE decide to prosecute for offences arising out of the same incident, HSE (with solicitor agent or colleague from LAO) should meet with the CPS to discuss the management of the case with a view to joint proceedings. Decisions should be made as to who will take the lead responsibility for the prosecution, the wording and nature of the charges and the retention and disclosure of material. The CPS can prosecute health and safety offences, but generally would only do so when prosecuting for manslaughter or other serious criminal offences - although there have been rare examples in the past when they have prosecuted HSWA offences alone.

35 Where the CPS does prosecute, and there is no HSE prosecution, HSE should be kept informed of the progress of the case and notified of the result. The result should be recorded on COIN with the body that instigated the hearing recorded in the 'brought by' field. Manslaughter charges should be recorded as having been 'brought by' CPS with the text 'manslaughter' to be included in the Prosecution Case Summary. In England and Wales, charges (under HSWA and Regs) approved within HSE, and effectively brought by HSE, even if actually taken forward by CPS as an agreed joint prosecution, should be recorded as having been brought by HSE so that HSE's time and effort can be recorded accordingly. If, as is sometimes the case, the HSWA charge is initiated solely by the CPS,

then it should be recorded as having been 'brought by' CPS. In Scotland, all charges are instituted and taken by the Procurator Fiscal Service and should be recorded as having been 'brought by' PF with the text 'culpable homicide' to be included in the Prosecution Case Summary.

36 Where a prosecution case has taken a long time to investigate and prepare, and therefore may subsequently be the subject of a challenge, it is important that we can give a reasoned explanation of why the case took so long. A chronology of events is helpful in setting out how the complex investigation, involving other authorities, was taken forward – and will be helpful in trying to explain and justify the delay.

Part 10: HM Coroner (England and Wales only)

37 Where CPS has decided not to prosecute, HSE should wait for the conclusion of the coroner's inquest before making a final decision on whether to prosecute for health and safety offences. Case law strongly supports health and safety offences, unlike murder and other homicide offences, being heard after the inquest. Further information and guidance is in the Enforcement Guide, and includes the cases of Smith, Beresford, Stanley and Beedie. This is so that if a jury returns a verdict of unlawful killing, the CPS will still be able to consider, and bring, a manslaughter charge. However, if the accused had already been prosecuted for a health and safety offence on the same, or substantially the same, facts before the inquest, then it would not be possible to proceed with the manslaughter charge.

38 HSE aims to help and support HM Coroners, and to provide them with as much information as we can, within the law and our resources. However, we can only use our powers for our own purposes, and we must manage and resource our investigations ourselves, and we need to ensure that there is no prejudice to any future criminal proceedings (by HSE or other prosecutors) through subsequent public disclosure. Advice on these issues is in the Enforcement Guide, and further advice may be obtained from your operational line manager and/or LAO.

Part 11 & 12: National and local liaison

39 The National Liaison Committee (NLC), which is made up of representatives from the signatory organisations, is responsible for the strategic overview of the principles of the Protocol and makes suggestions for improvements as necessary to ensure its continued effective operation. Local liaison groups, which support the NLC in its work, meet regularly to discuss issues of mutual interest and concern from a local standpoint. Heads of Operations, who take on the role of Local Liaison Officer, attend these local meetings. Following the issue of the Scotland version of the Protocol, a local liaison group has been set up in Scotland comprising of representatives of the four signatory organisations.

40 If the principles of the Protocol are not being followed by the police, or other signatory organisation, the matter should be drawn to the attention of the Local Liaison Officer so it may, if appropriate, be brought to the attention of the relevant local representative. Regular feedback by inspectors of bad (and good) practice is encouraged to help ensure effective working relationships and continued compliance with the Protocol for the future.

Cancellation of instructions

41 OC 165/8 – cancel and destroy.

Appendix 1 – Similarities and differences between English/Welsh and Scottish WRDPs

Scotland

Manslaughter and culpable homicide

A1.1. There are differences in the way that the common law offences of manslaughter (England and Wales) and culpable homicide (Scotland) have developed, and how they may be interpreted by the courts. However, these are investigated and prosecuted by others and the implications for HSE, in particular the potential resource demands on front-line staff, apply equally. Guidance on manslaughter and culpable homicide is given in Appendix 2.

Protocols

A1.2 There are 2 Work-Related Deaths Protocols (see para 2 of OC), one for England and Wales and one for Scotland. They are very similar and, wherever possible each uses exactly the same wording as the other. The Scottish Protocol generally only departs from the text of the English/Welsh version where the Scottish legal/administrative system requires it, e.g. there are some differences in the text to take account of the role of the COPFS. (These are mainly in para's 11, 14, 20 and 23 of the Scottish version).

A1.3 The Scottish version also adds para's 15 (reference to the Investigators Guide), and 22 (about sharing information after handover).

A1.4 The main differences are in Parts 9 and 10, (which deal with "The Prosecution" and "HM Coroner – Fatal Accident Inquiries" respectively), to take account of the role of the PF in Fatal Accident Inquiries, and the different prosecution system in Scotland.

A1.5 The table below summarises the similarities and differences in the 2 Protocols:

	England/Wales	Scotland	
Application	unnumbered	9, 10	Same
Statement of Intent	1.1	11	Same* + addition about PF
Initial Action	2.1, 2.2	12, 13, 14, 15	Same* + new para 14/15
Management of the Inv	3.1 to 3.4	16 to 19	Same
Decision Making	4.1 to 4.4	20 to 23	Same* + new para 20, 22
Disclosure of Material	5.1, 5.2	24, 25	Same
Special Inquiries	6.1 to 6.4	26 to 29	Same

Advice prior to charge	7.1 to 7.3	30, 31	Same
Decision to Prosecute	8.1 to 8.8	32 to 38	Same* + new para 33
The Prosecution	9.1 to 9.3	39	Different
HM Coroner – FAIs	10.1 to 10.3	40 to 43	Different
Liaison	11.1, 12.1, 12.2	44	Same* principles
Annex A	Annex A	Annex A	Same

Note: "Same*" = same meaning, and mostly the same wording, with small amendment to refer to PF/COPFS

Appendix 2 - Manslaughter and homicide - Individual and Corporate

Individual

England/Wales – Manslaughter by individuals

A2.1. It must be remembered that the police investigate manslaughter, and the decision on whether a manslaughter charge should be brought rests with the CPS. Manslaughter is a common law offence, and inspectors need to be aware of the legal test for manslaughter for their own information, and so they can engage with the police and CPS who may be considering a manslaughter charge.

A2.2. Each year a significant number of people die in work-related accidents and in many of them one person's death may have been caused by another person's careless, or otherwise blameworthy, conduct and the question arises: is that other person's conduct so bad as to amount to gross negligence warranting a criminal conviction for manslaughter?

A2.3. Allegations of manslaughter which fall to be considered in these types of accident are of the category commonly referred to as "involuntary manslaughter" (i.e. there is no intention to kill or to cause serious injury but the law considers that the person who caused the death is blameworthy in some other way). Within the category of "involuntary manslaughter" is a type of manslaughter known as **manslaughter by gross negligence**, and it is this which will normally be relevant in these kinds of deaths.

A2.4. The legal test for manslaughter by gross negligence has been confirmed by the House of Lords in *R v Adomako* (1995 1 Appeal Cases 171). It is a staged test, and the essential elements to be established are :-

1. the defendant owed a duty of care towards the victim,
2. the defendant breached that duty of care,
3. the breach caused the victim's death, and
4. that breach was such as to amount (in the jury's view) to gross negligence, and therefore a crime

A2.5. In considering whether there was gross negligence, the jury would consider the seriousness of the breach of duty, and how far it fell below what could be expected, **in all the circumstances** in which the defendant was placed when it occurred. The jury's consideration include whether the defendant's conduct was such that it should be judged as being 'criminal'. This is sometimes seen as a high test, which may, in practice be difficult to prove in some work-related cases.

A2.6. A challenge was made against the 4th part of the Adomako test, alleging that it offended against the European Convention on Human Rights, in that there was an element of circularity about the test (i.e. there is a criminal offence if the jury thought that it should be judged as criminal), and there was no certainty and clarity in what constituted the offence. The argument was rejected, and the Court of Appeal affirmed the Adomako test and that the ingredients of the offence of gross negligence manslaughter has sufficient certainty to meet the requirements of the ECHR (R -v- Misra and Srivastava).

Scotland – Culpable homicide by individuals

A2.7. As with manslaughter in England/Wales, the Scottish offence of culpable homicide is also a common law offence, and Inspectors investigating work-related deaths in Scotland should be aware of the legal test for culpable homicide, so they can engage with the police and COPFS, who may be considering it, and who will make the decision on whether a manslaughter charge should be brought.

A2.8. Culpable homicide is a term which covers a number of different types of criminal homicide. They are all part of this one category in that they are "cases where death is caused by improper conduct and where the guilt is less than murder" (Macdonald p.96). Culpable homicide is often broken down into "voluntary culpable homicide" and "involuntary culpable homicide". Voluntary culpable homicide is homicide where the mens rea for murder is present but mitigating circumstances reduce the crime to culpable homicide. Involuntary culpable homicide is homicide where the mens rea for murder is not present but either the independent mens rea for culpable homicide is present, or the circumstances in which death was caused make it culpable homicide. Involuntary culpable homicide may arise in the context of an unlawful act or a lawful act. The mens rea requirement is different in each case. (Copyright Scots Law Courseware Consortium).

Corporate

Corporate Manslaughter and Corporate Homicide Act 2007

A2.9. This is a criminal statute, that brings in a new offence of corporate manslaughter and corporate homicide (CM/CH). As with the above 2 common law offences, CM/CH is investigated by the police and prosecutions are determined, and taken, by CPS and COPFS. HSE and LAs cannot therefore use their HSWA powers to investigate CM/CH, since our powers can be used only for the purposes in HSWA. (See para A2.24 below).

A2.10. A corporate body, such as a company, is a legal 'person' and can be prosecuted for a wide range of criminal offences. Until the corporate manslaughter/homicide Act came into force, this included manslaughter by gross negligence. To be guilty of the common law offence of gross negligence manslaughter, there must have been a gross breach of a duty of care owed to the victim. Before a company could have been convicted of manslaughter, a "directing mind" of the organisation (that is, a senior individual who can be said to embody the company in his actions and decisions) must also be guilty of the offence. This is known as the "identification principle", and it made it extremely difficult for organisations, other than the very small ones, to be prosecuted for manslaughter. Although Scots criminal law on culpable homicide differs from the law of manslaughter elsewhere in the UK, the same issues of identifying a directing mind have arisen in Scotland.

A2.11. The government was therefore minded to update the law on manslaughter/homicide as it relates to corporations, and to bring in legislation that overcomes the problems created by the identification principle. This places responsibility on the working practices of the organisation, as set by senior management, rather than limiting investigations to questions of individual gross negligence by company bosses. The new law therefore removes the need to identify the 'controlling or directing mind' of the company, which is intended to make it easier to prosecute a company, or other employing organisation, for a corporate manslaughter/homicide offence.

A2.12. The responsibility for investigating the new offence of 'corporate manslaughter/homicide' rests with the police, and prosecutions are taken by CPS/COPFS in England/Wales and Scotland respectively. In England and Wales proceedings may not be instituted without the consent of the Director of Public Prosecutions.

A2.13. The Act extends equally to England, Wales, Northern Ireland and Scotland. In England, Wales, and Northern Ireland the offence will be called "corporate manslaughter". In Scotland the offence will be called "corporate homicide" [section 1(5)]. It is planned that, other than for deaths in custody (see para A2.16(ii) below) and publicity orders (see para A2.19), the CM/CH Act will come into force on 6 April 2008. It does not apply in relation to things done, or omitted, before that date.

A2.14. An organisation is guilty of CM/CH if **the way in which its activities are managed or organised** causes a person's death, and it amounts to a **gross breach of a relevant duty of care owed by the organisation to the deceased** [section 1(1)]. In making provision for this new offence, the Act abolishes the common law offence of manslaughter by gross negligence to those organisations covered by the new CM/CH Act.

A2.15. The offence is indictable only and, if found guilty, the penalty will be an unlimited fine. In addition, under section 9 of the Act, the courts have the power to impose a remedial order, (similar to that which can be imposed for health and safety offences under s42 HSWA), and to require information about the offence and conviction to be published [section 10].

A2.16. In considering the offence there are 3 particularly important issues, upon which the Act expands :-

(i) **Way in which its activities are managed or organised** – section 1(3) places limitations on this in that it states that “an organisation is guilty of an offence under this section only if the way in which its activities are managed or organised by its senior management is a substantial element in the breach...” The breach should also have caused the death. This does not mean that it was the sole cause, but is generally taken to mean that it would have to have contributed, in more than a trivial way, to the death. Time will tell just how this limitation to ‘senior management’ is interpreted by the courts, and what this means in practice in overcoming the identification principle (para A2.10 refers).

(ii) **‘Relevant duty of care’** - this is defined in s2, and includes duties owed :-

- to employees or other persons working for the organisation;
- as an occupier of premises;
- in connection with supply of goods/services, or construction or maintenance activity, or other commercial activity, or in relation to items of plant and vehicles etc.

Section 2 also includes duties owed to persons in custody, e.g. deaths in prisons, police cells or other custodial facilities. However, application to deaths in custody does not come into force on 6 April 2008 with the other provisions, but will come into effect at a later date, which will require the approval of Parliament.

The scope of ‘relevant duty of care’, which is decided by the judge, is therefore very wide and is likely to include all work-related activities that we enforce.

(iii) **Gross breach** – it is a matter for the jury whether or not there was a gross breach of a relevant duty. Factors for the jury are set down in section 8. The jury **must** consider whether the evidence shows that the organisation failed to comply with any relevant health and safety legislation – and if so, how serious that failure was, and how much of a risk of death it posed.

The jury **may** also consider issues such as “attitudes, policies, systems or accepted practices within the organisation that were likely to have encouraged any failure... or to have produced a tolerance to it”. The jury **may** also have regard to any health and safety guidance – and to “any other matters they consider relevant”. The meaning of ‘health and safety legislation’ and ‘health and safety guidance’ is very wide and goes beyond the HSWA and relevant statutory provisions.

It can be seen from the wide meaning of these 3 elements of the offence (and, in particular, the wide-ranging nature of the factors for the jury), that there are likely to be significant demands upon HSE to help investigate, and to advise upon these wide-ranging health and safety, and management, issues.

Other issues in ‘corporate manslaughter/homicide’ Act

A2.17. **Partnerships** - In Scotland a partnership is a separate legal entity and legal proceedings can be instituted against a partnership in the trading name of the partnership. However, in England and Wales, (other than in the special case of a Limited Liability Partnership), a partnership cannot generally be prosecuted, because it has no legal personality for the purpose of the criminal law. However, section 14 of the Act allows a partnership in England and Wales to be prosecuted in the name of the partnership for

corporate manslaughter, as if it was a body corporate. Any fine for conviction of a partnership under this Act is to be paid out of the funds of the partnership. It should be noted that if, in England and Wales, a partnership is being prosecuted for corporate manslaughter, and health and safety charges are also being brought, that these health and safety charges cannot be laid against the partnership – but must be against the partners. Further guidance on prosecuting partners is in the Enforcement Guide.

A2.18. Remedial orders - Following conviction of an organisation for CM/CH the court may make a 'remedial order', (which is similar to a section 42 order under HSWA), requiring the organisation to remedy the breach of its duty of care, and any matters that the court feels may have resulted from the breach and been a cause of the death. A remedial order may also require the organisation to remedy any health and safety deficiency in the organisation's policies, systems or practices that may be indicated by the breach. Failure to comply with a remedial order, within the time period specified in the order, is an offence punishable on indictment by a fine [section 9].

A remedial order can be made only if the prosecution applies for one and, in its application, specifies the terms of the proposed order. Before making an order the prosecution must consult the relevant enforcement authorities (which may often include HSE/LA) as "it considers appropriate". In practice where an order is being considered and we are the relevant regulator, we can expect to be consulted.

A remedial order may (as well as specifying a time period for compliance), also require the convicted organisation to supply evidence to the consulted enforcing authority that the organisation had carried out the steps specified in the order.

Therefore, although these offences, (including an offence of failure to comply with a remedial order), are investigated by the police and prosecuted by the CPS/COPFS, there will be pressures on HSE/LA, and our resources, to get involved and to be consulted before, and report back after, an order has been served.

A2.19. Publicity orders - An organisation convicted of CM/CH may also be served with a 'publicity order', requiring the organisation to publish, in a manner specified by the court, and within a time period set by the court, the fact that it has been convicted of the offence; specified particulars of the offence; the amount of any fine imposed; and the terms of any remedial order made. Failure to comply with a publicity order is an offence punishable on indictment by a fine [section 10]. The provisions relating to publicity orders will not be implemented on 6 April 2008, but will await the publication of sentencing guidelines.

A court proposing to make a publicity order, must consult the relevant enforcement authorities, as it considers appropriate, about the terms of the publicity order. It may also require the organisation to supply evidence to the consulted enforcing authority that the organisation had complied with the requirements of the publicity order. This is another area where there will be pressures on HSE/LA, and our resources, to get involved and to be consulted before, and report back after, an order has been served.

A2.20. Exemptions – There are a number of situations referred to in the Act where the actions of an organisation or public authority, which subsequently led to the death of an

employee or member of public, shall not be considered as owing a relevant duty of care and are therefore exempt from prosecution for CM/CH. These include, generally, :

- deaths resulting from public policy decision making, the exercise of an exclusively public function or a statutory inspection by a public authority [section 3];
- deaths occurring during, or directly associated with, the operations or hazardous training of the armed forces [section 4];
- deaths arising from some policing or law enforcement activities, including where officers or employees of the public authority come under attack or face the threat of attack or violent resistance [section 5];
- deaths arising from the response by emergency services to an emergency situation [section 6];
- deaths arising from the activities of local authorities, local probation board or other public authorities in relation to child-protection and probation functions [section 7];
- deaths resulting from harm sustained outside the United Kingdom [section 28].

A2.21. Application to Crown bodies – Crown immunity has been removed for CM/CH offences. With the exception of the public body exemptions listed in A2.20 above, the government departments and other bodies listed in Schedule 1 of the Act are bound by the provisions of the Act, and will be treated as owing the same duty of care as if it were a corporation that was not a servant or agent of the Crown [section 11].

A2.22. Health and Safety Offences - The CM/CH Act states that, where there is a charge of corporate manslaughter or corporate homicide arising out of a set of circumstances, then there may also be a charge against the same defendant, in the same proceedings, for a health and safety offence, arising out of some or all of those circumstances – and the jury may return a verdict on each charge. In addition, an organisation that has been convicted of CM/CH arising out of a particular set of circumstances, can be charged subsequently with a health and safety offence, arising out of some or all of those circumstances. (Note, this doesn't apply where the corporate manslaughter/homicide charge has been heard and dismissed).

This means that, even if a CM/CH charge has been laid, or even heard and the organisation convicted, additional health and safety charges may still be taken against the organisation - even if they arise out of the same circumstances. This is unusual, and it means that we must keep contact with any CM/CH case being pursued by CPS/COPFS, and be prepared to review and consider whether it would be in the interests of justice, and in accordance with the EPS, to take additional health and safety charges.

A2.23. Individuals – There is no individual liability arising from the CM/CH Act. Individuals cannot be guilty of aiding, abetting, counselling, or procuring CM/CH [section 18].

A2.24. Coroners Act – Corporate manslaughter is, in England/Wales, added to the list of charges, in section 16 of the Coroners Act 1988, which must be heard before an inquest is held.

HSE's role

A2.25. Points to note:

- It is not for HSE to investigate or prosecute CM/CH, it remains for the police to investigate and the CPS and COPFS to prosecute.
- The meaning of health and safety in the context of the Act is not confined to HSWA and the relevant statutory provisions. It applies in the broadest sense and includes other matters, such as food, marine, rail and air safety etc.

Involvement and powers

A2.26. Not all manslaughter/homicide investigations will involve HSE, or LAs, even if there is a work-related element. There are some areas that others generally deal with, e.g. food hygiene issues, or civil aviation incidents etc. However, where we are involved in investigating a work-related death, then we do so for our own purposes, and we can use our powers under HSWA only for those purposes. We will be able to share appropriate information and evidence with those who are looking into possible manslaughter/homicide issues, and we may also be able to provide specialist expertise on work-related matters, that may be new to the police. The sections under para 21 of this OC discuss the use of our powers, the sharing of information and the provision of specialist help – in accordance with the Protocol.

A2.27. We need to be careful in the use of our powers. Section 20 gives us powers to require information, which is important when investigating corporate suspects. We can use such powers only for our purposes as set down in HSWA, and cannot use them generally for the purposes of others. The police do not have the same general powers as we have in section 20 of HSWA, and there may be occasions when the use of our powers will assist the police investigation. We can use our powers in such circumstances, but only if such use is legitimately and reasonably for our own HSE purposes. In such case we can subsequently share the information that we obtained legitimately. At all times we must stay within our vires when seeking to use our powers.

Resources

A2.28. However, we must be aware of the effect on our resources and we cannot provide an open ended resource for other investigators. We must therefore manage our resources and involvement as best we can – and not take on roles that are better filled by others. Having said that, it is accepted that we shall be expected to support and assist the police and prosecuting authorities, where we can and where it is reasonable to do so – and there will be continuing pressure on HSE to be involved, and commit resources, throughout a lengthy police investigation.

A2.29. It is anticipated that these pressures will increase as a result of the introduction of the CM/CH Act. The pressures may vary from time to time, may vary depending on the activity involved and the public interest shown, and may vary throughout different parts of the country, and may reflect local political interests. There are a number of aspects of the new Act that increase our potential involvement. These include:

- the meaning of the relevant duty of care mentions specifically issues that are covered by health and safety legislation;

- juries have to consider whether there was any failure to comply with health and safety legislation;
- juries may also consider the attitudes, policies, systems and accepted practices in the organisation;
- juries may also have regard to any health and safety guidance made or issued by the health and safety enforcing authority (this includes general guidance as well as previous specific advice to the organisation under investigation; and
- the role of the enforcing authority in relation to 'remedial orders' and 'publicity orders'.

Therefore the potential effect on our front-line resources may be significant. We should seek to manage our input wherever possible, whilst being aware of the need for HSE to be, and be seen to be, as helpful as we reasonably can to those charged with the task of investigating manslaughter/homicide.

Decision making

A2.30. We may also be able to help the police and CPS/COPFS by advising them of current health and safety standards and guidance, and relevant benchmarks, i.e. what we would expect to find in a reasonable and well managed work activity. We can, of course, do this only in the areas that HSE regulates (i.e. not food hygiene, or operational rail safety, or quality of medicinal drugs). This may help them in their consideration of whether, for example, the actions fell so far below what could be expected as to be grossly negligent, or amounts to a gross breach of a relevant duty of care. These are matters solely for the CPS/COPFS, and we must be careful - whilst doing what we can to help by way of indicating relevant health and safety standards guidance and benchmarks – to ensure that such decisions are left to, and made solely by, the CPS/COPFS, without undue influence from HSE.