Protocol for work related deaths in Jersey

Foreword

The signatories to this protocol are:

- States of Jersey Police
- States of Jersey Health and Safety Inspectorate
- Ports of Jersey Limited
- The Jersey Care Commission
- States of Jersey Fire and Rescue Service
- Government of Jersey Regulation Directorate

The Protocol sets out the approaches to work-related deaths to ensure effective joint investigation of work-related deaths in Jersey.

By signing the protocol, signatories confirm their commitment to the joint investigation approach, appreciating that the public want to be confident that those investigating work-related deaths are doing all that they can to co-ordinate activities, and to cooperate with each other in the best interests of public safety and of those affected by work-related deaths.

Annex A provides a brief guide to the enforcement of manslaughter related offences; the Health and Safety at Work (Jersey) Law 1989 (HSW Law) and related legislation; Shipping (Jersey) Law 1961 and subordinate enactments; the Regulation of Care (Jersey) Law 2014 and related legislation; and the Laws relating to the Fire & Rescue Service. It also includes details of the regulations relating to the safety and construction of buildings, pollution in the environment and food safety and public health overseen by the Regulations Directorate.

In addition to the signatories, the Viscount is the Senior Coroner in Jersey and working together with the Deputy Viscount and States of Jersey Police, is responsible for investigating deaths that might not be from natural causes. This included responsibility for conducting inquests into work-related deaths. As independent judicial officer holders the Viscount is not able to make the commitments made by the signatories but recognises that clear and timely communication between coroners and the signatories is important to ensure that coronial investigations proceed efficiently and without prejudicing criminal investigations or proceedings. A brief outline of coronial legislation in Jersey is included in Annex A.

Application of the protocol

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 following a gas leak. Each fatality must be considered individually, on its particular facts, according to individual 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 without delay.

Signatories

	Alison Fossey Detective Superintendent **States of Jersey Police**	
	Elaine Harbour Director of Health & Safety **States of Jersey Health and Safety Inspectorate**	
PORTS OF JERSEY	Captain William Sadler Harbour Master **Ports of Jersey Limited**	
Jersey Care Commission	Rebecca Sherrington Chief Inspector **Jersey Care Commission**	
	Jason Masterman Head of Prevention and Protection **States of Jersey Fire and Rescue Service**	
	Kelly Whitehead Group Director for Regulation **Government of Jersey Regulation Directorate**	

Statement of intent

Signatories to the Protocol agree to work jointly and adhere to the following underlying principles:

- That in the early stages of an investigation, it is not always apparent whether any serious criminal offence has been committed. Joint decisions will be made on who will assume primacy[1], and the direction it will take. The decisions should be timely, informed by the best available evidence and technical expertise and take account of the wider public interest.

- The police and/or the Fire & Rescue Service will usually be first at the scene of work-related deaths and will contact and inform other relevant enforcing authorities as soon as practicable;

- Whenever there is a suspicion that negligence may have caused a death, the police will assume primacy for an investigation and work jointly with other relevant enforcing authorities;

- The Health & Safety Inspectorate will investigate health and safety offences;

- Port of Jersey Limited will investigate maritime incidents in accordance with its statutory Public Service Obligations and obligations as Harbour Authority;

- The Jersey Care Commission will investigate where a work-related death takes place in a workplace regulated by the Commission

- States of Jersey Fire & Rescue Service will investigate the 'most likely cause' of a fire in matters involving fire with a resultant fatality. They will also investigate potential fire safety, petroleum or explosives offences where a work-related death occurs within these regulated premises and activities.

- That during the investigation, one party will assume primacy;

- that primacy should not be a barrier which hinders the progress of any investigation. All parties to a joint investigation will seek to progress their own investigations regardless of who has primacy;

- that primacy for an investigation can change and the process of handover of primacy should be conducted in an efficient and timely manner;

- The police may reassume primacy in investigations where new evidence of a suspected manslaughter related offence has come to light, or as the result of the Viscount's inquest conclusion of unlawful killing.

- Relevant enforcing authorities will be consulted about pursuing other offences in addition to manslaughter related offences;

[1] Definition of Primacy: One Party to the Investigation takes the lead with the other parties working jointly and in parallel.

- Investigations should be the subject of regular review, and any issues that arise should be discussed and resolved at the appropriate level.

- Investigations should be completed, and any recommendations to the Attorney General made, as quickly as possible, taking into account the nature of the case. All parties should aim to ensure that any prosecution is brought as soon as possible;

- The police and relevant enforcing authorities will agree how the Viscount is to be kept informed on the progress of an investigation;

- The bereaved and witnesses will be kept informed; and,

- The parties to the protocol will maintain effective liaison.

Protocol Liaison Committee: Terms of Reference

The Liaison Committee comprises representatives from the States of Jersey Police, the Health and Safety Inspectorate, the Jersey Care Commission, States of Jersey Fire and Rescue Service, Ports of Jersey Ltd and the Government of Jersey Regulation Directorate. Representatives of non-signatory organisations may also be invited to attend.

The Liaison Committee will meet at least twice a year to:

- consider the need for changes to the Protocol and to liaison arrangements;
- promote the practice of joint investigation by identifying good practice;
- discuss issues of mutual interest and concern; and
- provide a useful network of contacts.

The Chair of the Liaison Committee will be on a rotation basis, each of the signatories to the Protocol taking the Chair for two years in turn. Each year will run from 1 January to 31 December

All WRDP signatory organisations regardless of their organisation's size and resources should have the opportunity to Chair the Liaison Committee.

The Chair will host four meetings of the Committee during their period of chairing and will circulate minutes of meetings.

The Committee does not oversee individual cases although it may monitor them to identify learning points about the effectiveness of the Protocol.

These Terms of Reference will be reviewed from time to time as necessary.

Working practices

1. **Identification of a work-related death**

In order to determine whether a death is work related, consider:

- 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.

2. **Initial actions**

In most instances, the first person at the scene will be a police officer, or the Fire & Rescue Service, but this may not always be the case and other enforcing authorities should be expected to take appropriate action where they have the powers to do so.

Key actions 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 any other relevant enforcing authority.

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. **Investigation management**

Wherever more than one enforcing authority has an interest in a death, the investigation of all 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.

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.

Investigation Coordination Group

Where appropriate, consideration should be given to calling an Investigation Coordination Group meeting by the agency to whom a work-related death has been referred. This group will provide strategic oversight of an investigation that involves public safety and allows communication, information exchange and coordination of the investigation between all interested parties. Attendees should be sufficiently senior to take investigation management decisions on behalf of the organisation they represent. The chair of the Incident Coordination Group should consider whether the Viscount and/or other representatives' attendance is required in relation to the incident.

Appendix B provides an outline agenda for the Investigation Coordination Group meeting which will allow the police and other relevant authorities to 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 12 Health and Safety at Work Law 1989) 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;

f) what specialist and expert advice is required; for what lines of enquiry e.g. gross negligence manslaughter, or breaches of Law or regulations; 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 e.g. 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 encourage early engagement with the Law Officers' Department. 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 the Viscount's office, 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;

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, any disclosure considerations and to encourage consistent reporting.

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 (e.g. a Memorandum of Understanding between various organisations) of what information will be shared, when and how it will be shared and the legal basis for doing so.

Annex A: A general guide to the enforcement of work-related death offences.

Manslaughter related Offences

Investigations of manslaughter offences i.e. Gross Negligence Manslaughter (GNM) are carried out by **the States of Jersey Police**. The police also have a role in assisting the Viscount in the coronial investigation.

Prosecution of manslaughter offences are carried out by the Law Office's Department on behalf of the Attorney General

Health and Safety at Work (Jersey) Law 1989

Enforcement of the HSW Law and related legislation in Jersey is the sole responsibility of the **States of Jersey Health & Safety Inspectorate**. The Law applies to **all** work activities in the public and private sector and includes Jersey territorial waters.

Prosecution of HSW Law offences is carried out by the Law Office's Department on behalf of the Attorney General

Ports of Jersey Limited

Ports of Jersey is a company limited by shares and is currently wholly owned by the States of Jersey.

Ports of Jersey is currently the sole Harbour Authority in Jersey and is therefore required to discharge the statutory obligations listed at Article 2(4) – (5) of the **Harbours (Administration) (Jersey) Law 1961**. Those obligations include responsibility for policing, safety and security in the harbours in respect of which it has been appointed. In addition, Ports of Jersey has been entrusted with responsibility for designating inshore sea areas for the purpose of sport and recreational activities.

Ports of Jersey is also required to discharge the statutory public service obligations listed at Article 6(1) of the **Air and Sea Ports (Incorporation) (Jersey) Law 2015**. These obligations include the enforcement of shipping legislation in territorial waters.

Both the Harbour Authority obligations and public service obligations are fulfilled in accordance with the terms of a statutory agreement for the purpose between the Minister for Sustainable Economic Development and Ports of Jersey.

Fulfilment of the above obligations may cause Ports of Jersey to investigate maritime accidents in Jersey territorial waters.

In addition to the above, the Minister for Sustainable Economic Development may, but is not obliged to, appoint suitably qualified Ports of Jersey staff to investigate accidents involving Jersey ships worldwide, as well as shipping in Jersey territorial waters, with a view to preventing reoccurrence and to promote maritime safety and prevent pollution. Such appointments are made in accordance with Article 166(1) of the **Shipping (Jersey) Law 2002**. The consequent investigations are conducted in accordance with the International Maritime Organisation (IMO) Casualty Investigation Code.

The additional operational responsibility for the Registry of Ships, coupled with the public service obligation to enforce shipping legislation in territorial waters, causes POJL staff to be concerned with

the application to Jersey registered ships of safety-related Regulations and Orders made under the Shipping (Jersey) Law 2002. These Regulations and Orders focus on

- the avoidance of collisions;
- ship design and construction;
- qualifications and crew training requirements;
- ship survey requirements;
- tonnage and load line measurements; pollution prevention; and,
- legal compensation and access to international fund schemes.

Government of Jersey Regulation Directorate

The Regulation Directorate regulates the safety and construction of buildings, pollution in the environment and food safety and public health.

- Food and Environmental Protection Act (1985) (Jersey) Order 1987
- Food Safety (Jersey) Law 1966
- Food (Jersey) Law 2022 (not yet appointed)
- Planning and Building (Jersey) Law 2002
- Statutory Nuisances (Jersey) Law 1999
- Waste Management (Jersey) Law 2005
- Water Pollution (Jersey) Law 2000
- Food Safety (Miscellaneous Provisions) (Jersey) Law 2000
- Public Health Law 1934 (Loi (1934) sur la Sante Publique)

They would have an interest should a fatal incident involve contamination or poisonous food or disease outbreak, a slurry spill, oil or other chemical spill in high volume or it was a contributing factor of building collapse or explosion.

The Jersey Care Commission

The Jersey Care Commission regulates care services for both adults and children, provided by the Government of Jersey, Parishes, private providers and the voluntary sector to ensure that people receive high quality and safe care.

The services regulated include:

- care homes providing nursing and personal care or personal support for people with a range of health and social care needs
- care provided to people in their own homes
- adult day care services; and
- residential and other services for children and young people.

The Commission is also responsible for:

- Registering health and social care professionals;
- Protecting the public from infection risks by regulating piercing and tattooing businesses;
- Registering and inspecting premises where lasers are used for cosmetic purposes; and
- Registering and inspecting Yellow Fever centres.

Relevant Laws

The Regulation of Care (Jersey) Law 2014

- This is the primary law governing the registration, regulation, and inspection of care services in Jersey.

The Regulation of Care (Standards and Requirements) (Jersey) Regulations 2018

- These regulations provide detailed requirements on care standards and operational practices that care providers must follow.

Capacity and Self-Determination (Jersey) Law 2016

- Ensures services respect individuals' capacity to make decisions about their care and promotes autonomy wherever possible.

These laws and regulations collectively enable the Jersey Care Commission to regulate care services effectively, ensuring high standards and protecting vulnerable populations.

Prosecution of Care Commission regulated offences are carried out by the Law Office's Department on behalf of the Attorney General.

States of Jersey Fire & Rescue Service

In matters involving 'fire', Jersey Fire & Rescue have the powers to investigate the 'most likely cause'.

They also regulate

- fire safety matters in designated sleeping accommodation and embarkation/disembarkation areas of Ports.
- the safe storage of Petroleum Spirit and matters in relation to explosives (importation, use, manufacture, storage, conveyance, sale, purchase, acquisition and possession.

Relevant Laws

- The Fire & Rescue Service (Jersey) Law 2011
- Fire Precautions (Jersey) Law 1977
- Fire Precautions (Designated Premises) (Jersey) Regulations 2012
- Petroleum (Jersey) Law 1984
- Explosives (Jersey) Law 1970

The States of Jersey Fire & Rescue Service would have an interest should a fatal incident occur in a designated premises or in a location where petroleum spirit is stored or activities involving explosives are taking place.

The Viscount

Links to the principal legislation relating to coronial matters are set out below:

- Inquest and Post-Mortem Examinations (Jersey) Law 1995
- Inquest and Post-Mortem Examinations Rules 1995

Under this legislation the Viscount, Deputy Viscount and any Assistant Coroner appointed by the Viscount act as Coroners. The Coroner is responsible for investigating deaths that might not be from natural causes. This includes responsibility for conducting inquests into work-related deaths.

An inquest is a public court hearing, the purpose of which is to find out who the deceased was, and how, when, and where they died. The Coroner is responsible for determining the scope of the inquest and the nature of the evidence that should be presented at the inquest to prove the relevant facts.

The Coroner will be responsible for managing the body of a person who dies in the workplace and determining whether an post-mortem examination should take place and when the body can be released for the funeral.

Where there is a criminal investigation in relation to the circumstances of a death, the inquest will often be opened by the Coroner to enable the funeral to take place, but then adjourned until the criminal investigation and any proceedings have been completed. Further information about the coronial process can be found here: Coroner - Courts.je.

Annex B: Matters to discuss at an Investigation Coordination Group meeting

What should be discussed	What to consider
Nature of the incident(s)	What has happened, when & how? Who is involved?
Reason for meeting, including an explanation from the meeting organiser	Why has the meeting been called? Are there other parties that are or should be involved?
Actions to date, including the outcome of any internal or external investigation or root cause analysis	What has been done to date? Are there any reports available?
Any public safety or ongoing concerns?	If so, what are they? What action is needed to minimise the risks?
Roles & responsibilities of organisations involved and next steps in the investigation	Each organisation to explain what is needs to do next and how will it fit – or conflict – with what others propose to do
Other statutory responsibilities	Do other organisations have other statutory responsibilities that should be considered?
Other professional regulatory bodies	Do other regulatory bodies need to be informed / involved?
Securing and preserving evidence	Has this been done and by whom? What has been preserved & where is it located?
Sharing information	What information is available? When is information required? What can be shared?
Media and communications	What immediate communications are appropriate? Is a communications plan in place?