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| | **RSD Internal Guidance** | RIG-2014-02 |

**ORR policy & process for investigation of fatalities including suspected suicides and trespass related deaths.**

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| **Date of issue/ last review** | December 2016 | **Date of next review** | December 2018 |
| **RIG postholder/owner** | | Natalie Widdrington-May | |
| **RIG cleared by** | | Johnny Schute Deputy Director, Policy, Strategy & Planning | |
| **RIG type** | | Policy ☒<br>Information ☐<br>Procedure ☒ | |
| **Target audience** | RSD ☒<br>RPP ☐ | Policy ☐<br>Inspectors ☒<br>Admin ☒ | |

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| **Keywords** | Suicide Trespasser Fatal Investigation |
| **Summary** | ORR's policy is that all fatalities on the railway should receive a proportionate inquiry to determine whether there is a potential breach of health and safety law and (if so) to arrange for a full investigation. Our policy is underpinned by our commitment to the Work Related Death Protocols.<br><br>Work-related deaths: A protocol for liaison (England and Wales<br><br>Work-related deaths: A protocol for liaison (Scotland)<br><br>ORR policy is implemented via the Mandatory Investigation policy and guidance guidance on mandatory investigations<br><br>This Rail Guidance Document provides a policy and process to be followed to demonstrate consistent decision making in relation to inquiry into possible H&S breaches revealed by fatalities, including those classified as suicides on the railway. It applies in England, Scotland and Wales. |
| **Original consultation** | John Gillespie, Sally Williams |
| **Subsequent consultation** (reviews only) | Sally Williams, Natalie Widdrington-May, W&W Route team |

**Detail**

## Policy:

- All fatalities notified to ORR should receive a proportionate inquiry to determine whether there has been a breach of H&S law;
- ORR will keep a record to demonstrate that proportionate inquiry has been undertaken; and
- the Principal Inspector shall make arrangements for a proportionate inquiry to be carried out and records kept of decisions.

## Guidance:

1. For **all** fatalities, a decision is needed on whether there is a potential health and safety breach that merits investigation.

2. For **all** fatalities, that decision will need to be taken, in the first instance, on the basis of facts revealed by the report of the event and some initial enquiries.

3. Where we find that the circumstances of the death fall to another enforcing authority, we will pass the details to them immediately by telephone and confirming by e mail/fax, making a record that we have done so in an investigation non-case folder.

4. Where another investigating authority is involved i.e. BTP or RAIB, this does not remove the need for us to make proportionate enquiries in order to meet our obligations to establish whether there have been serious breaches of H&S law.

5. For some fatalities, such as the death of a worker in the course of their employment, a passenger on the network, there is a presumption that a proportionate investigation will be required following the investigation process investigation process map and Work Related Deaths Protocols.

6. The Principal Inspector should put in place a process that achieves the objectives. A suitable process is set out below:

- ORR (IA or office admin officer) receives a notification of a fatality on the railway, usually via telephone, the NR Daily Log or a BTP

report;

- a MOSAIC/ORRganise case should be immediately created in the accident investigation folder and the case allocated to one or more inspector(s); **except**

8. **Suicides, or other non-suspicious deaths such as adult trespass and natural causes**, should be recorded in the **Investigation Non Case** sub folder of Regulatory Functions – Investigation. If we later determine that a full investigation is required, then this should be converted to an **investigation case** folder;

- for mainline incidents, the IA or office admin officer should identify the incident in the NR daily log to obtain fuller details;
- the IA or admin officer may decide to make further enquiries either by phone or by visiting the site, for example, to look at site fencing;
- all cases of suicide and other non-suspicious deaths should be referred to the Principal Inspector together with evidence collected by the IA or admin officer and a recommendation to further investigate or not i.e. is there a possibility of a significant breach of health and safety law;
- the Principal Inspector should examine all the evidence from the proportionate inquiry and decide whether further investigation would be warranted;
- If an investigation is indicated, then the investigation process must be followed, starting with an investigation plan ;
- When the Principal Inspector makes the decision not to fully investigate an event that falls within the criteria for a mandatory investigation e.g. the death or serious injury of a minor trespassing on the railway, it is important that the rationale is clearly recorded and signed off at a higher grade. Part A of the Decision Record Form should be completed as soon as possible and forwarded to a line manager at Grade A or above. If approved, the completed form should be attached to the mosaic/ORRganise record and the link sent to RSD admin.

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| **Action** | Principal Inspectors to arrange for teams to follow this guidance and monitor compliance.<br>IAs and admin should note the use of investigation non-case folders for any work-related fatality where we are not carrying out a full investigation. |