

# JOINT INSPECTION OF THE INVESTIGATION AND PROSECUTION OF FATAL ROAD TRAFFIC INCIDENTS

FEBRUARY 2015

HMCPSI  
HMIC



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THE INVESTIGATION  
AND PROSECUTION  
OF FATAL ROAD  
TRAFFIC INCIDENTS**

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## CHIEF INSPECTORS' FOREWORD

Both the police and the Crown Prosecution Service rightfully aspire to delivering high standards of quality, both in investigation and prosecution of road death cases and the service provided to those bereaved by the incident itself. This report seeks to analyse and comment upon the extent to which that public stance is borne out. We have found that in some respects and particularly with regard to communication with victims' families by the CPS, much work needs to be done before a high quality service is provided consistently.

Overall we found that the investigation by police staff of fatal road traffic incidents was professional and thorough. Despite variations in organisational structure and staffing complements in roads policing departments, standards of investigation and evidence gathering were satisfactory. Our recommendations are aimed at improving and standardising the training of all road death investigation officers and especially senior investigating officers and family liaison officers; recognising and supporting the family liaison officer role; and reassuring both victims' families and the public that a road death investigation is not treated as in any way less important than any other homicide.

Turning to the prosecution of cases, we believe that there is some way to go before the CPS can be satisfied that it is truly delivering a specialist prosecutor function in a similar way to the current practice with regard to rape and serious sexual offences. HMCPSI's second thematic review published in 2008 identified a number of key aspects that required implementation, but regrettably many of these recommendations have not been taken forward.

We were satisfied that there was genuine desire to deliver a specialist role and quality of service by prosecutors in CPS Areas and at Headquarters but the structures in place simply did not support it. For example, specialist training of prosecutors had not occurred; there was no process in place to accredit specialists; national guidance was often ignored at operational level; monitoring of performance and casework outcomes was fragmentary or non-existent; and opportunities to set up regional partnerships with the police and other external partners had not been taken.

We urge police forces to move swiftly to adopt the new ACPO/College of Policing training package for road death investigation and make any organisational changes that may be required to improve further their investigation practice.

The CPS must reinvigorate its approach to handling prosecutions arising from fatal road traffic incidents. It appears to be accepted that a specialist prosecutor role is necessary – and we consider that it is – but more work is required to define, support and measure the effectiveness of the role. There are excellent policies and commitments to support and inform victims' families but these lose impact if not implemented consistently. We have made recommendations designed to assist the CPS to deliver on its promises including the current Director of Public Prosecutions' vision. It must do better than it did when addressing the 2008 review.



Michael Fuller  
QPM BA MBA LLM LLD (Hon)  
HM Chief Inspector of the CPS



Sir Thomas Winsor WS  
HM Chief Inspector of Constabulary





# 1 EXECUTIVE SUMMARY

1.1 This is the summary of the joint thematic inspection by Her Majesty's Crown Prosecution Service Inspectorate (HMCPsi) together with Her Majesty's Inspectorate of Constabulary (HMIC) of the investigation and prosecution of offences arising from fatal road traffic incidents (FRTIs) by the police and the Crown Prosecution Service (CPS) respectively.

## Background

1.2 The number of people killed or seriously injured on the roads in England and Wales has continued to fall so that when measured against the 2005-09 average, there has been a decrease of 39%.<sup>1</sup> However in 2013 (the last year for which comprehensive statistics are available) a total of 1,713 people lost their lives as a result of road traffic incidents and the public has remained vigilant when considering how those whose driving causes the death of others are prosecuted and punished.

1.3 HMCPsi published its first thematic review of the handling of these cases by the CPS in 2002<sup>2</sup> and followed it up by a second review in 2008.<sup>3</sup> A total of 11 recommendations were made in the second review<sup>4</sup> in order to improve performance and it identified six aspects of CPS activity that were regarded as good practice.

1.4 On 18 August 2008 the new offences created by the Road Safety Act 2006 were brought into operation with the exception of the offence of causing serious injury by dangerous driving which came into force on 3 December 2012. The most commonly used of these new offences is that of causing death by careless driving.

1.5 In September 2012 the CPS launched a public consultation on its policy and practice in prosecuting driving offences, including those arising from a fatal incident. The resulting CPS *Guidance on Charging Offences arising from Driving Incidents* was published in May 2013.<sup>5</sup>

1.6 Despite the increased range of available offences with which an offending driver could be charged, public concern remains that prosecutors may not always have selected the most appropriate charge and so we have included a review of charge selection in our findings on CPS decision-making.

## Purpose of the inspection

1.7 The full scope of the inspection was to:

- assess the impact of the new offences introduced by the Road Safety Act 2006 including causing death by careless driving;
- assess the impact and application of the new CPS guidance on driving offences published in May 2013;

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1 See table at paragraph 2.14.

2 [www.justiceinspectorates.gov.uk/hmcpsi/inspections/cps-road-traffic-fatalities-thematic/](http://www.justiceinspectorates.gov.uk/hmcpsi/inspections/cps-road-traffic-fatalities-thematic/)

3 [www.justiceinspectorates.gov.uk/hmcpsi/inspections/cps-road-traffic-fatalities-second-thematic/](http://www.justiceinspectorates.gov.uk/hmcpsi/inspections/cps-road-traffic-fatalities-second-thematic/)

4 These are set out in full in chapter 7 where we comment on the progress made by CPS towards implementation.

5 [www.cps.gov.uk/legal/p\\_to\\_r/road\\_traffic\\_offences\\_guidance\\_on\\_prosecuting\\_cases\\_of\\_bad\\_driving/](http://www.cps.gov.uk/legal/p_to_r/road_traffic_offences_guidance_on_prosecuting_cases_of_bad_driving/)

- assess the potential impact of the CPS structural changes and its “refocusing agenda” on the responsibility of prosecutors for decision-making in FRTI cases; looking at quality and timeliness;
- consider the impact of reduced budgets on the capacity of police collision investigation units to carry out effective and high quality investigations into FRTIs;
- assess the quality of CPS decision-making both at the charging stage and subsequently;
- measure the quality of service provided to bereaved families by the police and CPS;
- assess the effectiveness of engagement by the police and CPS with groups or organisations representing victims’ families at local or national level, as well as organisations representing road users more generally;
- consider the availability and effectiveness of any specific training for police and prosecutors;
- examine what local or regional arrangements exist between the CPS and police in terms of service level agreements and area strategy groups dealing specifically with FRTI cases;
- evaluate the impact of the revised role for coroners and the recently issued memorandum of understanding signed by the Association of Chief Police Officers (ACPO), CPS, Chief Coroner and the Coroners’ Society of England and Wales;<sup>6</sup>
- identify any good or innovative practice by the CPS or police;
- monitor and report on the level of progress made by the CPS towards implementation of the 11 recommendations in the 2008 review.

### Structure of the report

- 1.8 The report is structured in a chronological way so that after a more detailed contextual introduction, it commences with a review of how police investigations are conducted and supervised. There follows a detailed evaluation of CPS case handling divided into sections dealing with the structures in place to deliver this specialist role, the quality of decisions made by prosecutors and then how prosecutions are managed from charge to disposal.
- 1.9 Of particular interest was the way in which the bereaved families of deceased victims are treated both by police and CPS staff and so we have included a chapter dealing specifically with the level of service to victims’ families provided by both organisations.
- 1.10 We then looked at how the police and CPS work together on these cases and how each liaises with charities and campaign groups active in this sector.
- 1.11 Finally, we assessed how the CPS had responded to each of the original recommendations made in the 2008 review.

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<sup>6</sup> [www.cps.gov.uk/publications/docs/mou\\_cps\\_acpo\\_chief\\_coroner\\_june\\_2013.pdf](http://www.cps.gov.uk/publications/docs/mou_cps_acpo_chief_coroner_june_2013.pdf)

## Findings

### *The police investigation*

- 1.12 We found several different structures in place across the six police force areas we visited although each operated with a core team of investigating officers, forensic collision investigators and family liaison officers. The management and leadership of each unit varied, as did their operational models, but we found that all shared the characteristic of passion and commitment to the work they were asked to do.
- 1.13 Where we found more variation than seemed appropriate was in the way in which those called to be the first police response at the scene of an FRTI were equipped and trained. On some occasions it was clear that officers who were not experienced in roads policing were dispatched to a scene simply because they were closer than anyone else, but were not always properly resourced to preserve and manage the scene of a collision.
- 1.14 Most forces had provided training for roads policing staff but there were a range of courses available of uncertain quality and relevance. We were not satisfied that officers had received the most up to date learning resources either through classroom courses or online products. The College of Policing have worked with ACPO since 2013 to develop a bespoke training package available to all forces and this includes the investigation of road deaths. This has recently been made available in a phased release from April 2014 and we welcome this development.
- 1.15 Although we found good practice in one force there was a lack of robust quality assurance by supervisors of investigations, especially while they were still ongoing. Also, we were not assisted in examining police files by the absence on many occasions of strategy and policy logs completed by senior investigating officers. Separating these documents from prosecution files should be avoided wherever possible.
- 1.16 We were impressed overall with the dedication and commitment of family liaison officers (FLOs) but considered that their role was not always valued by the forces where they worked. Working practices differed but we consider that this role should be prioritised by managers over other less sensitive duties and that mandatory referrals to occupational health departments should be in place to ensure that their welfare is properly monitored. More consistency and professionalism in the training they receive is required.

### *The CPS prosecution*

- 1.17 We examined the role of the specialist prosecutor as recommended in the 2008 review and whether it had remained viable as a result of significant organisational changes within the CPS since 2010. All Areas believed that this role was still necessary and this was reinforced by CPS Headquarters. Nonetheless, it is true that the combination of merging Areas, significant staffing reductions and a falling caseload has created challenges for the CPS in meeting the requirement.
- 1.18 Despite the recommendations made in the 2008 review, little progress has been made towards a coherent model for providing a specialist service that allows prosecutors with the necessary knowledge and experience to demonstrate the quality of decision-making and appropriate communication skills. A set of eligibility criteria for the role, a suggested structure to deal with caseload and a bespoke training package would all play an important part in giving the specialist prosecutor, and by implication the work itself, the high priority it merits.

- 1.19 We believe that the CPS at national level shares our concerns and the appointment of a lead Chief Crown Prosecutor is an indication of this. A clear link between operational prosecutors and national policy advisors is essential to provide assurance that published guidance is being applied consistently.
- 1.20 The method of provision of pre-charge decisions (PCDs) lacked uniformity in terms of how this was accessed by the police, the extent of early investigative advice and the stage at which a completed investigation file was provided by police. The completion of a standardised protocol with the police would make the PCD process more efficient and measurable.
- 1.21 Inspectors assessed compliance by prosecutors with the *Code for Crown Prosecutors* (the Code) as part of the file sample selected from all six areas visited. They found that prosecutors complied with the Code at the PCD stage in 88.9% of cases although all 12 of the decisions not to charge the suspect with any offence were judged to be correct. This compares unfavourably with the overall Annual Casework Examination Programme<sup>7</sup> (ACEP) 2013 results for all files of 91.0%.
- 1.22 The quality of management and oversight of these cases as they were conducted from initial court appearance until disposal was also analysed by inspectors. In most respects it was no better than the quality found with all “volume case” preparation as set out in the ACEP results, but inspectors agreed with 90% of the CPS decisions to accept or reject offers by defendants to plead guilty to lesser charges in FRTI cases. This is an improvement compared with the ACEP figure of 85%.
- 1.23 Similarly the quality of the CPS’s decision record, or MG3 was judged to be good or better in less than half the 72 cases analysed (43.1%). Common failings included poor case analysis and strategy and inadequate references to sentencing guidelines.
- 1.24 We considered carefully whether the current requirement for all charging decisions and decisions either to accept pleas or discontinue cases to be authorised by a Deputy Chief Crown Prosecutor (or other senior prosecutor nominated by their Chief Crown Prosecutor) was necessary and added value to the process. We considered that this be further reviewed by the CPS and if it is to be retained, that those whose responsibility it is to authorise decisions be obliged to undergo a specific training programme.
- 1.25 The review decisions made by prosecutors after charge complied with the Code in 86.7% of cases as all those cases which failed the test at charging were allowed to continue at the post-charge stage. We also had concerns about the quality of review as we found that over half (55.9%) did not meet the standard expected or simply had not been recorded.
- 1.26 Of particular note was the fact that in 58.3% of cases, there was not sustained continuity of prosecutor and the standard of recording hearing outcomes was fully met by prosecutors in only 47.2% of cases.

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7 HMCPSI has undertaken an annual programme of examining casework from across the CPS against a range of quality measures in order to provide an independent assessment of performance. This programme is known as “ACEP” and includes judgements on compliance with the *Code for Crown Prosecutors* by the CPS when making decisions at the charging and subsequent review stages. ACEP includes all categories of casework including all types of homicide. Thus, comparisons with the fatal road traffic incident cases selected for this inspection are available in the table at Annex 7.

- 1.27 Inspectors were disappointed to find that there was no systematic procedure for monitoring and analysing performance by CPS Areas in respect of FRTIs. As a minimum requirement, we have called for distinct flagging of new cases on the case management system, completion of advocate's reports on jury acquittals and adverse case reports in all other unsuccessful outcomes (including those cases where a guilty plea is accepted as an alternative to a more serious count). Only by collecting such data consistently can improvements in performance be measured and informed responses made to legitimate media interest.

#### **The service to bereaved families**

- 1.28 All prosecution files within our sample were examined to assess the extent of communications with bereaved families as well as their quality and timeliness. However, inspectors also invited families to respond to a questionnaire requesting views on the service they had received from police and CPS personnel. These questionnaires were distributed through two of the leading organisations working with families in this field to their members. Selected extracts from those questionnaire responses have been used in this report to illustrate our findings.
- 1.29 Firstly, the police service response was considered and the role of family liaison officer examined. Although most families were positive about the contact they had experienced from their FLO, a few expressed reservations about the level of information about the ongoing investigation into the incident. Predominantly, families felt they had been supported at such difficult times.
- 1.30 Indeed families in general preferred to receive information throughout the process from the FLO rather than from the CPS prosecutor even where the FLO was simply conveying a prosecutor's decision. Providing support at court hearings did however prove more difficult to manage. Changes to the date or location of a hearing or its purpose were often a source of frustration and we found that more could have been done to coordinate the timely and accurate delivery of information.
- 1.31 The CPS has done much in the last ten years or so to improve its service to victims of all types but inspectors' own judgements from case file examination were replicated by the views of many bereaved families about the standard of communications they received.
- 1.32 In spite of clear guidance issued by CPS Headquarters, prosecutors notified families of charging decisions in only 16.7% of cases where they had made the PCD, as they preferred to leave it to the FLO to communicate their decision. The CPS performed poorly in discharging their responsibility to notify families of court hearings and their outcomes and an acceptable standard was achieved in only 26.7%.
- 1.33 Inspectors found that prosecutors fared better in respect of consulting victims' families about accepting pleas or discontinuing cases where there was evidence of consultation in 61.1% and 63.6% of cases examined respectively. However when the CPS held a meeting with a family in order to explain a decision or outcome, details of that meeting were recorded in only five out of 20 instances.

- 1.34 When a defendant appeals against a conviction or sentence imposed at court, it is very important that the victim's family is notified promptly and accurately by the CPS. Appeals are handled by a Headquarters team of prosecutors known as the Appeals and Review Unit (ARU) instead of the Area where the case was heard. Similarly, in cases where the Victims' Right to Review (VRR) Scheme allows a victim's family to review a CPS decision, the ARU assumes conduct of the case.
- 1.35 Inspectors found that the ARU prosecutors achieved in general a much higher standard of communication than local Area staff. However, the ARU practice of creating a separate file on the CPS case management system (CMS) was considered to be unnecessary. The ARU file records were not accessible to Area staff who relied upon notifications from ARU which they needed to re-enter on the original file. This requires simplification so that there is one electronic case file only.
- 1.36 Taking all these factors into account, we found that the overall standard of communications by the CPS with the bereaved family was poor in 75% of cases. There was no evidence of any specific monitoring by managers of the quality of communications or whether there had been compliance with the guidance.

#### **Liaison and partnership working**

- 1.37 Police force area representatives reported a range of effectiveness in forging and maintaining cohesive links with CPS specialist prosecutors. Historical arrangements which had been developed in the former smaller CPS Areas had not survived the move to larger regional groupings or the departure of many experienced prosecutors.
- 1.38 When we visited the police force areas it was clear that the CPS were starting to review service level agreements or protocols, although some had made more progress than others. There were pockets of good practice but no regular liaison meetings or joint analysis in order to drive improvements in practice.
- 1.39 Inspectors concluded that a standardised protocol should be adopted by all CPS Areas with each police force in their region and that this should be subject to periodic review.
- 1.40 Both the CPS and police worked closely at a national level with charities and campaign groups which represent bereaved families but these relationships were not evident at local level. We saw examples of specific road safety campaigns initiated by the police, for example in London.
- 1.41 The nature of liaison between coroners and local police forces has always been close and effective. This was found to be the case in those areas we visited. However the corresponding relationship with local CPS prosecutors was much more distant. A memorandum of understanding between the Chief Coroner, Coroner's Society of England and Wales, CPS and ACPO was signed in 2013 and it is expected that this will act as a catalyst for closer working relationships between all agencies. This is long overdue and must be rolled out nationally.

### **CPS response to HMCPSI 2008 thematic review**

- 1.42 This review made a total of 11 recommendations designed to improve performance in the handling of prosecutions arising from FRTIs. We examined how much progress had been made towards their implementation. Although all these recommendations remained relevant it was disappointing to find that only one of these had been completely achieved, representing excellent progress; one more had been partially achieved representing good progress; a further three were assessed as fair progress but the remaining six could only be assessed as poor.
- 1.43 Little or nothing had been done by the CPS to address over half of the recommendations made six years ago.
- 1.44 Overall, the CPS must carefully re-assess the place within its priorities that the handling of these cases should rightly occupy. At the time of this inspection, the perception that these cases no longer enjoyed the priority that they had in earlier years was hard to resist. Policies and guidance documents were of good quality and readily accessible but no systems existed to monitor compliance. Inspectors consider that the prevailing attitude opened the organisation to the risk of being unable to defend criticism of its approach to decision-making and victim care. Much of this could be addressed by improved record keeping, monitoring and data analysis.

### **Recommendations**

#### ***The police***

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- 1 Police disclosure officers must ensure that all disclosure schedules prepared include policy and strategy logs (paragraph 3.15).

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- 2 Police forces should ensure that the most effective and appropriate resources are deployed to the scene of collisions which involve or may involve a fatality by arranging that:
  - officers dispatched to the scene have the necessary training and equipment to perform the role effectively; and
  - specialist resources required are readily available to the senior investigating officers at the scene (paragraph 3.17).

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- 3 Police forces should ensure that police officers performing the role of family liaison officer have adequate time to perform their role effectively (paragraph 3.26).

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- 4 Police forces should ensure that family liaison officers involved in road death investigations have regular mandatory checks by occupational health departments (paragraph 3.28).

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### *The College of Policing*

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- 1 The College of Policing should include road death investigation within the Professionalising the Investigation Process (PIP) levels of investigation and make the training programme accessible and relevant to all road death investigators (paragraph 3.20).

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- 2 The College of Policing should develop and promote:
  - an accreditation process for all road death investigators; and
  - national training standards for all road death investigation personnel (paragraph 3.34).

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### *The CPS*

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- 1 CPS Headquarters should prescribe minimum standards and a common model organisational structure for handling fatal road traffic incident cases in every CPS Area, which should promote the role of specialist prosecutors by setting out eligibility criteria, accreditation and continuing professional development requirements (paragraph 4.6).

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- 2 CPS Headquarters should appoint a specialist fatal road traffic incident coordinator in each CPS Area including CPS Direct, and set clear expectations for the role and what it is expected to deliver (paragraph 4.8).

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- 3 CPS Headquarters should commission a skills audit and the development and delivery of a bespoke training programme to equip specialist fatal road traffic incident prosecutors, and those senior prosecutors designated to authorise key casework decisions, with the knowledge and skills they need to make appropriate decisions and communicate with bereaved families (paragraph 4.18).

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- 4 CPS Headquarters should issue guidance to prosecutors on the circumstances in which it is appropriate to charge assaults that arise from driving a motor vehicle (paragraph 4.37).

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- 5 CPS Headquarters should now review the requirement for approval of all decisions on charging to be made by Deputy Chief Crown Prosecutors or other senior lawyers and if it is to be retained, all senior prosecutors so designated must undertake the programme recommended at paragraph 4.16 (paragraph 4.47).

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- 6 CPS Headquarters should add a reference to the Criminal Practice Direction on acceptance of pleas in its guidance on charging driving offences (paragraph 4.70).

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- 7 CPS Headquarters should facilitate the flagging of all fatal road traffic incident cases on the case management system (CMS) as a separate case category and mandate the collection of statistical and performance data at Area level, publishing this on a regular basis so that future training programmes can be informed by learning points derived from case reviews (paragraph 4.80).

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- 8 CPS Headquarters should modify the Appeals and Review Unit's (ARU) practice of creating a separate case file on the case management system (CMS) where an appeal or Victims' Right to Review (VRR) referral has taken place as it unreasonably restricts access by the CPS Area staff to all records of review and other case material (paragraph 5.62).
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- 9 CPS Headquarters should require all Areas to agree a standard protocol with minimum content with each police force in their region and meet regularly to review its effectiveness (paragraph 6.12).
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### **Good practice**

1.45 In addition we found five aspects of good practice.

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- 1 In Hampshire there was a useful action plan that police staff used when responding to a confirmed fatal or life threatening collision. The action plan clearly laid out the categories of fatal collisions and the type of senior investigating officer (SIO) who would be appointed, for example a road death investigation team member or a force accredited roads policing SIO (paragraph 3.13).
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- 2 Monitoring the welfare of police staff dealing with fatal road traffic incidents varied. In some police forces including Lancashire, Kent and Hampshire the family liaison officers (FLOs) had an annual mandatory referral to their force's occupational health department, and in one area they were unable to perform the role of FLO until they had attended this referral (paragraph 3.27).
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- 3 In order to promote consistency, Lancashire Constabulary had produced clear guidance for officers as to the content and format of fatal collision files (paragraph 3.36).
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- 4 A regular meeting between a police inspector within the Kent Serious Collision Investigation Unit and a senior CPS South East Area prosecutor was used to review the outcome of specific cases, including the effectiveness of the trial advocate (paragraph 3.37).
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- 5 In some Areas police investigating officers expedited the decision-making and consultation process with the CPS in cases where the only suspect was the partner or close relative of the victim and the degree of blame was slight (paragraph 5.20).
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## 2 INTRODUCTION, CONTEXT AND BACKGROUND

### Introduction

- 2.1 In both 2002 and 2008 when HMCPSI published thematic reviews into the way in which the CPS handled the prosecution of offences arising from fatal road traffic incidents it was necessary for the interaction between investigator and prosecutor to be considered and evaluated, but all recommendations made were addressed to the CPS.
- 2.2 This inspection is therefore significant and timely, affording the first opportunity for the strategy and performance of both agencies to be analysed simultaneously and to suggest ways in which greater cohesion and information sharing could deliver a more efficient service in terms of delivering appropriate casework outcomes. Later in this report, we go on to discuss the service offered by both the police and CPS to bereaved families throughout the investigation and where any prosecution ensued.
- 2.3 The main purpose of this inspection was to provide assurance that the investigation and prosecution of FRTIs are of high quality. We scrutinised the quality of investigations into such incidents by the police and prosecution of appropriate cases by the CPS. We also looked at how those professional roles and the manner in which they were performed were perceived by the relatives of those who lost their lives in these incidents.
- 2.4 We examined how well the police and CPS worked together and also considered their relationships with charities or other groups which campaign on behalf of bereaved families or other affected groups. The 2008 review was confined to CPS activity. Eleven recommendations were included which were designed to improve performance; we measured the progress the CPS has made towards implementation of those recommendations.
- 2.5 Few topics in recent years have generated more debate both in Parliament and the news media generally than how to respond to road deaths. At the same time as the total numbers of those killed on our roads has fallen, the pressure brought to bear by their families has increased. To some degree, this pressure has successfully influenced legislators to change both the law and sentencing policy. Naturally victims' families wish to see proportionate and just outcomes for those who cause the death of their relatives and a professional and painstaking approach to an investigation and potential prosecution should in most cases avoid increasing their distress.
- 2.6 Before we collected our evidence and assessed current performance, the following questions were identified as central to the purpose of the inspection:
  - i) In the light of the continuing concern about road traffic incidents involving fatalities, despite the introduction of new offences in 2008 and the annual decline in casualty figures, can the public be reassured that the quality of police investigation and CPS handling of such cases remains high?
  - ii) Does the quality of the service offered to bereaved families by the police and CPS throughout the investigation and prosecution of these cases consistently meet those families' expectations?
  - iii) How successfully has the CPS implemented the recommendations made in the 2008 HMCPSI thematic review?

## Context and background

- 2.7 At the time of and after the publication of the 2008 HMCPSI review, significant legislative changes were made introducing new offences of causing death by careless driving and by drivers who were uninsured, unlicensed or disqualified. These were introduced by the Road Safety Act 2006 and related to offences committed on or after 18 August 2008.
- 2.8 New guidelines were published by the Sentencing Guidelines Council for the use of sentencers in road death cases which have affected how decisions are made about whether the magistrates' court or Crown Court is the most appropriate venue in which to proceed. *Causing Death by Driving: Definitive Guideline* was published in July 2008 and applies to offences committed on or after 4 August 2008.<sup>8</sup>
- 2.9 The CPS launched a public consultation in September 2012 inviting comments about its published policy and guidance dealing with road death cases. As a result in May 2013 it published new *Guidance on Charging Offences arising from Driving Incidents*.
- 2.10 The 2008 HMCPSI review included the views and experiences of police force representatives dealing with road death incidents, but was largely confined to the liaison arrangements with the CPS. The quality and process of investigation was not covered in any detail.
- 2.11 The 2010 Government Comprehensive Spending Review reduced resources available both to police forces and the CPS. Additionally, the CPS has significantly restructured the provision of charging advice and other aspects of casework. It is important to ascertain whether these changes have affected the quality of investigation and CPS decision-making.
- 2.12 Although the overall numbers of people killed or seriously injured on Britain's roads have declined in broad terms since 2008 (see table), public concern about how these cases are investigated and prosecuted remains high, especially among victims' families and groups which aim to represent their views and/or campaign on their behalf.
- 2.13 In June 2014 the Department for Transport issued statistics outlining casualty figures for 2013 including the numbers of individuals killed or seriously injured in England and Wales. The figures are further broken down to show how many were car drivers, motor cyclists, cyclists and pedestrians. Overall the trend over five years has shown a drop in all categories of casualties.
- 2.14 The table summarises the key statistical data:<sup>9</sup>

National statistics (June 2014)	2011	2012	2013	Difference (+ or -) from 2005-09 average
Total number of people killed	1,901	1,754	1,713	- 39%
Total number of people seriously injured	23,122	23,039	21,657	- 6%
Car occupant fatalities	883	801	785	- 44%
Pedestrian fatalities	453	420	398	- 35%
Pedal cyclist fatalities	107	118	109	- 16%
Motor cyclist fatalities	362	328	331	- 39%

<sup>8</sup> [www.sentencingcouncil.org.uk/publications/item/causing-death-by-driving-definitive-guideline/](http://www.sentencingcouncil.org.uk/publications/item/causing-death-by-driving-definitive-guideline/)

<sup>9</sup> More detailed information is available from [www.gov.uk/government/statistics/reported-road-casualties-in-great-britain-main-results-2013](http://www.gov.uk/government/statistics/reported-road-casualties-in-great-britain-main-results-2013)

- 2.15 We selected several police forces and the aligned CPS Areas. We looked closely at the investigations and prosecutions in those Areas and talked to practitioners and managers about their work. Our conclusions are founded upon our assessments and judgements of what was taking place in those Areas but are applicable nationally.
- 2.16 Before collecting our evidence, we identified several objectives that we expected to achieve through our inspection. The list in Annex 2 sets out those that were considered most important.
- 2.17 A new comprehensive Victims' Code was published in December 2013<sup>10</sup> which has implications for both agencies in discharging their responsibilities to all victims, their families or other representatives. We assessed the extent of practitioners' knowledge of and compliance with the Code.
- 2.18 The number of fatalities suffered by the cycling community (especially in London) has attracted much media attention. It was hoped that this inspection might produce evidence about the way in which road deaths involving cyclists are treated compared with those affecting other road users. However the way in which the CPS registers its cases by the name of the defendant or suspect rather than the victim has made this impracticable. Neither does the CPS collect data that allows them to identify categories of road user either as offenders or casualties. We have made a recommendation later in this report about the monitoring and analysis of CPS data.

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10 *Code of Practice for Victims of Crime* [www.gov.uk/government/publications/the-code-of-practice-for-victims-of-crime](http://www.gov.uk/government/publications/the-code-of-practice-for-victims-of-crime)



### 3 THE POLICE INVESTIGATION

3.1 During our inspection, we spoke to more than 100 police officers and civilian staff responsible for investigating road deaths in the six selected police force areas, including:

- first responders;<sup>11</sup>
- investigating officers;
- senior investigating officers (SIOs);
- forensic collision investigators (FCIs);
- vehicle examiners;
- family liaison officers (FLOs); and
- senior managers.

3.2 Most have the unenviable and challenging job of investigating a collision that has resulted in a death and dealing with the inevitable trauma that surrounds such an event. They have many responsibilities which frequently include some or all of the following:

- to ensure that the public are safe at the initial scene of any collision;
- to secure and preserve any physical evidence;
- to identify and speak with witnesses;
- to inform bereaved families and keep them updated with the progress of an investigation;
- to liaise with the coroner;
- to identify who is culpable (if anyone) and gather all relevant evidence; and
- if appropriate, to prepare a file of evidence for submission to the CPS and to work with them throughout the course of any resulting prosecution.

3.3 Some of these investigations are complex and time consuming and most of those we spoke with had a number of investigations running simultaneously. All of them were found by inspectors to be passionate and committed to providing an excellent service for those involved, especially the bereaved. One investigating officer told us “*I am proud of what we do*” and “*I know that we have done as much as we can do to find out what has happened for the families*”.

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11 “First responders” are police staff who attend the scene of a collision in response to an emergency call.

### **Leadership and management**

- 3.4 In each of the forces we visited, there was a senior police officer who had overall responsibility for roads policing and investigating road deaths and the majority of staff we spoke with knew the name of their chief officer lead. Each force also had a senior police officer responsible for delivery of the roads policing strategy, although in some cases this was aligned with other protective services, such as firearms and public order.
- 3.5 There were several examples of collaboration between forces, including jointly managed units in Hampshire and Thames Valley and in Durham and Cleveland. There were more informal arrangements in place between Kent and Essex, and Devon & Cornwall and Dorset. There were still some differing working practices between collaborated forces, but we were told this did not generally cause any issues in respect of investigating road deaths.
- 3.6 However, many of these arrangements between police forces cut across larger CPS Areas. This presented some complications when trying to broker service level agreements between the police and CPS setting out mutual expectations concerning file quality, availability of pre-charge advice and liaison arrangements. For example, the link between Hampshire and Thames Valley involved the separate CPS Areas of Wessex and Thames & Chiltern, both of which also included other police forces not involved in the collaborative link. As the CPS begins to adopt a standardised protocol with police forces these issues should lessen in impact.
- 3.7 The structure of the police teams responsible for investigating road deaths varied across all forces. There was, however, a specialist team of investigators available in every area to attend the scene and investigate road deaths. The exact make up of these teams ranged from dedicated units who, apart from the initial response, were generally self-contained to departments performing other protective services as well as road death investigation.
- 3.8 Most used the title of “Serious Collision Investigation Unit” or something very similar and all deployed officers in the roles identified in paragraph 3.1. Whether these roles were exclusively attached to the units depended upon the structure in place. For example, in the Metropolitan Police Service (MPS), the Serious Collision Investigation Unit provided specialist resources to deal with all fatal and life changing collisions.
- 3.9 Some police forces had devolved roads policing to local policing areas which were responsible for tasking those resources and were themselves supported by roads policing staff. Elsewhere the roads policing function remained centrally managed and resourced, whilst in two forces a number of roads policing vehicles doubled up as armed response vehicles.
- 3.10 All the areas we visited had FCIs, who in some areas were all police officers and in others a mix of officers and police civilian staff. In the areas where there was a mix of staff those we spoke to thought that it worked well, previous police experience was not essential and that a combined team could be equally effective. Some forces had forensic vehicle examiners (FVEs), who were all police staff and tended to examine vehicles once they had been recovered from the scene. Despite these different structures, we found no evidence that either of the two models was more effective than the other.



- 3.11 Most areas we visited had recently reviewed their operational models in order to accommodate reduced expenditure, with each adopting a different solution. We saw little evidence that this had negatively impacted on the investigation of road deaths but we were assured that this will continue to be closely monitored by forces.

#### **Responding to fatal road traffic incidents**

- 3.12 The speed with which trained and experienced officers can be deployed to the scene of a road traffic collision is vitally important. Where the collision has involved the death of one or more individuals or where serious life threatening injuries have been sustained, the preservation of potential evidence is critical. Set against this, however, the length of time during which a public road remains closed to traffic can cause wider disruption and attract significant public criticism.
- 3.13 In Hampshire there was a useful action plan that staff used when responding to a confirmed fatal or life threatening collision. The action plan clearly laid out the categories of fatal collisions and the type of SIO who would be appointed, for example a road death investigation team member or a force accredited roads policing SIO. Inspectors considered that the use of this plan in Hampshire was an example of **good practice**.
- 3.14 Once at the scene roads policing officers generally reported no issues in getting specialist resources there, for example an SIO or FCI in periods where the relevant staff were rostered to be on duty. We discuss below the impact of non-continuous cover.
- 3.15 Inspectors had intended to examine policy and strategy documents completed contemporaneously by SIOs in specific cases, but in most selected for examination on-site these documents had been detached from the evidential material itself, so that they were not readily available for viewing. Detaching these documents from prosecution files creates the risk that the prosecutor may not be aware of the existence of relevant unused material if charges are brought. This in turn could lead to the correct application of the prosecution's duty of disclosure of unused material being frustrated.

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#### **RECOMMENDATION**

Police disclosure officers must ensure that all disclosure schedules prepared include policy and strategy logs.

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- 3.16 Due to factors such as geography and availability of roads policing resources, in some areas the first responder was often a local response officer, with little or no roads policing experience or equipment. They were expected to manage and protect the scene and preserve evidence, whilst awaiting specialist roads policing resources. In others (Kent and Hampshire), many first responders had received training in road incident management and carried equipment such as cones and signs to protect the scene. There were also procedures in place to ensure the most appropriately trained and equipped resource was assigned to incidents on the roads. Sending officers to the scene who are not properly trained or equipped should be avoided whenever possible.

- 3.17 With the exception of the MPS the forces we visited did not provide continuous cover and had an on-call system out of core hours. In one force FCIs were on duty between 0700hrs and midnight, with no on-call system in place to provide overnight cover. The force had to rely on the good will of staff to make themselves available. Staff in that force told us, however, that there had been recent occasions when no FCIs were readily available which delayed their attendance at the scene, creating the risk of evidence being lost and subsequently delaying the re-opening of the road.

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### RECOMMENDATION

Police forces should ensure that the most effective and appropriate resources are deployed to the scene of collisions which involve or may involve a fatality by arranging that:

- officers dispatched to the scene have the necessary training and equipment to perform the role effectively; and
  - specialist resources required are readily available to the senior investigating officers at the scene.
- 

### Role of senior investigating officers

- 3.18 The term senior investigating officer implies seniority in rank. However in those police forces we visited, when a road death investigation is initiated and an SIO appointed, they were generally not of senior rank but had the necessary skill and experience to manage and lead the investigation. There is a perception from victims' families that a crime investigation will be managed by a higher ranking officer than the officer appointed to lead a road death investigation, which creates the perception of a two-tier service. Victims' families are understandably anxious that this perception does not become the reality. The following extract is taken from one of the responses by bereaved families to the survey which was designed to capture their view of the level of service they received from both the police and the CPS: *“My first direct contact with a police officer was on the night of the incident and was totally inappropriate. This officer was later introduced as the SIO, implying he was a senior officer, this was not the case, I later found out he was a PC.”*
- 3.19 The College of Policing and ACPO have developed a package called Professionalising the Investigation Process (PIP).<sup>12</sup> This process has been split into four areas, depending on the level and complexity of the investigation. The College of Policing's Authorised Professional Practice (APP) on Investigating Road Deaths (table opposite) outlines the PIP requirements for investigations designated as category B and above, requiring PIP level 2 or 3. The most common route for officers to become PIP level 2 or 3 trained is through initial detective training, known as the Initial Crime Investigation Development Programme.

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12 [www.college.police.uk/en/10093.htm](http://www.college.police.uk/en/10093.htm)

Category A+	Assessed as likely homicide investigation or where complexity requires the deployment of a nationally registered SIO.	Major investigations (PIP classification - Level 3)
Category A	Confirmed fatality - one or more vehicles failed to stop and/or drivers decamped or other factors are present that significantly increase the complexity of the investigation.	Serious and complex investigations (PIP classification - Level 2)
Category B	Confirmed fatality - all drivers/riders are known or can be immediately identified.	Serious and complex investigations (PIP classification - Level 2)
Category C	Confirmed fatality - driver/rider only killed, no third party involvement - inquest only.	Volume and priority investigations (PIP classification - Level 1)
Category D	Confirmed fatality - driver/rider only killed, death due to natural causes, may involve a third party - no inquest necessary.	Volume and priority investigations (PIP classification - Level 1)

- 3.20 With the exception of the MPS, whose SIOs were trained detectives, the vast majority of SIOs did not have a detective background and were not PIP level 2 trained. In Hampshire investigators within the road death investigation team had undergone interview training up to PIP level 2, but had not completed the whole PIP process.

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## RECOMMENDATION

The College of Policing should include road death investigation within the Professionalising the Investigation Process (PIP) levels of investigation and make the training programme accessible and relevant to all road death investigators.

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### Role of family liaison officers

- 3.21 The role is voluntary, undertaken by officers in addition to their normal duties. There are two distinct types of FLO, one dealing exclusively with families bereaved by a fatal collision on the road, the other with deaths arising out of other circumstances than a road traffic incident, most commonly described as a crime FLO. The FLOs we spoke with told us the two roles differed, in that as a road policing FLO they had much less of an investigative function.
- 3.22 There were differing practices as to when an FLO would be deployed and who deployed them. All areas had a family liaison coordinator (FLC) responsible for overseeing FLO deployments. However, often an on duty FLO was deployed by the control room without reference to the FLC. This could result in an uneven workload for some FLOs because the duty officer did not have the necessary overview of all current deployments.

- 3.23 All the FLOs we met were committed to, and passionate about, their role and often had contact with families whilst off duty to ensure families had the information they needed. All FLOs are volunteers and are free to step down whenever they chose. Despite this and the importance of their role and the value it provides to families, many felt it was undervalued by the force. This was supported by some of the working practices we found.
- 3.24 None of the forces visited assigned officers to FLO roles on a full-time basis and many were undertaking other roles, such as first responders to crime reports or traffic duties. This hampered FLOs in providing a flexible or on-demand service to the families they supported and could prevent them making a commitment to be at key events, such as meetings with agencies, the inquest or other court dates.
- 3.25 Those who were also tasked to other duties felt under pressure to juggle FLO commitments with other routine policing tasks. In one area all officers, including FLOs, were required to meet targets for detection of road traffic offences such as speeding or use of a mobile phone, with no adjustment made for time spent on FLO work.
- 3.26 This had put FLOs under significant pressure leading to resignation from the role by some post-holders. One officer with whom we spoke had been working with a number of bereaved families at the same time, but was still expected to meet the same performance targets as colleagues who were not FLOs. The lack of commitment to working practices that support this important aspect of victim care is a significant concern and one that requires urgent attention. This practice should be changed in order to give FLOs the time they need to perform their role effectively.

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#### RECOMMENDATION

Police forces should ensure that police officers performing the role of family liaison officer have adequate time to perform their role effectively.

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#### Staff welfare

- 3.27 Monitoring the welfare of staff dealing with fatal road traffic incidents also varied. In some forces including Lancashire, Kent and Hampshire the FLOs had an annual mandatory referral to their force's occupational health department, and in one area they were unable to perform the role of FLO until they had attended this referral. Inspectors considered this to be **good practice**.
- 3.28 In other areas there were no mandatory referrals for any grades or roles with officers having to self-refer if they felt it necessary. An annual mandatory referral is undoubtedly more resource intensive, but self-referral carries risks that individuals will not recognise when they need help or will not self-refer for fear of reassignment to other duties, or of being seen as unable to cope.

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#### RECOMMENDATION

Police forces should ensure that family liaison officers involved in road death investigations have regular mandatory checks by occupational health departments.

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## Training

- 3.29 At the time of our inspection we found that there was limited learning and training provision locally and gaps in national standards and accreditation. However we were pleased to note that the College of Policing published training standards and resources in April 2014, which include a focus on the roles of the road death SIO, FCI, IO and FLO.
- 3.30 In the forces we visited all staff involved in the investigation of road deaths had received some training in the role, but the quality, source and timing of the inputs varied between forces. SIO training was developed and delivered in-force or by an external company. We did not review all of this training material but were told that, although the training was based on the College of Policing's APP on Investigating Road Deaths<sup>13</sup> (previously Road Death Investigation Manual), there was no national training material linked to this online resource.
- 3.31 Training for FLOs also varied with some forces delivering a course aimed specifically at those deployed following road deaths, whilst in other areas road death FLOs were trained on the same course as FLOs used in other homicide investigation. Many of the roads policing FLOs we spoke with believed that training alongside crime FLOs was unhelpful, as they believed the two roles were different. Although we were unable to compare the content and methodology of FLO training, forces should consider the differences between the roles and ensure that each is effectively supported by initial and refresher training.
- 3.32 All of the FLOs we spoke with did nevertheless state that their training had been sufficient for them to carry out their role effectively. In some areas, including Lancashire and Hampshire, staff were accredited to perform the role against a locally set criteria but, as with SIO training, there was no national training and accreditation process.
- 3.33 We also spoke with FCIs and there was much greater structure and consistency in the basic courses they had undertaken. Most of them had also taken more specialist courses. Although they tended to list these courses at the opening of all witness statements that they compiled, inspectors felt that a short resume of their experience of attending scenes of fatal road traffic incidents and their court room experience would be of more value to prosecutors and others charged with assessing the weight of their evidence or opinion, such as judges and juries.
- 3.34 In most areas there were opportunities for staff to undertake continuous professional development assignments. However, staff did not generally view this as refresher training and views on its effectiveness varied. SIOs in one force told us that they would benefit from regular refresher training on road death investigation.

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## RECOMMENDATION

The College of Policing should develop and promote:

- an accreditation process for all road death investigators; and
  - national training standards for all road death investigation personnel.
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13 [www.app.college.police.uk/app-content/road-policing-2/investigating-road-deaths/](http://www.app.college.police.uk/app-content/road-policing-2/investigating-road-deaths/)

### Quality assurance

- 3.35 In all the areas we visited there were quality assurance checks of road death investigations. However, the effectiveness and frequency of these varied considerably. There was a good quality assurance and review process in Lancashire, where a dedicated review officer (an experienced SIO who had undertaken review training), reviewed every live investigation against a standard template document, which included all aspects of the investigation. Reviews were conducted throughout investigations and included file quality. Learning from this process was fed back to the SIO who found this to be a supportive process, which enhanced the level of the investigation and provided a clear audit trail.
- 3.36 In order to promote consistency, Lancashire Constabulary had produced clear guidance for officers as to the content and format of fatal collision files. In another force SIOs told us that despite a review process being in place lessons were not being learned. We consider that the practice deployed by Lancashire is an example of **good practice**.
- 3.37 Across all the areas visited inspectors looked for evidence of quality assurance of investigations, both at the end of the process and at key stages as it progressed. Again, there was a wide variation in the approaches adopted by forces. Inspectors regarded ongoing review by supervisors throughout an investigation as a valuable tool for the monitoring of quality as it encouraged 'real time' intervention in investigations that could effect improvements. A regular meeting between a police inspector within the Kent Serious Collision Investigation Unit and a senior CPS South East Area prosecutor was used to review the outcome of specific cases, including the effectiveness of the trial advocate. This is also a **good practice** point.

## 4 THE PROSECUTION OF OFFENCES ARISING FROM FATAL ROAD TRAFFIC INCIDENTS

### The role of the specialist prosecutor

- 4.1 All CPS staff interviewed agreed that it was a proper use of resources to allocate all road death cases to specialist prosecutors. In the broadest of terms such a specialist should handle all allegations involving fatal road traffic incidents (FRTIs) and wherever practicable continue to have responsibility for the case throughout. What is not so clear is the process which can deliver this specialist function and how the CPS should define and quality assure the role of specialist prosecutor.
- 4.2 The CPS acknowledged that only Crown Prosecutors<sup>14</sup> who possess the necessary skills and knowledge should be allocated FRTI cases because of their sensitivity and importance. These cases can present complex evidential and technical issues that require a significant degree of expertise.
- 4.3 The CPS needs to evaluate and promote the role of specialist prosecutor and devise a list of eligibility criteria that must be satisfied in order to achieve the designation. Without some form of nationally accredited training package (which is not available), prosecutors were only able to put forward their experience and general competence together with a self-assessed aptitude for or interest in this type of work. Inspectors found that in some teams of prosecutors this experience was hard to gain because the number of cases was declining in line with the national fall in road deaths. There was a tendency to restrict the work to a limited number of prosecutors who had established effective relationships with police investigators over many years.
- 4.4 The 2008 thematic review reinforced the view originally expressed in 2002 by HMCPSI in its first review that specialist prosecutors were an essential tool to help maintain quality standards. Those recommendations were accepted by the CPS but our analysis of the arrangements in place in the six CPS Areas that we visited in this inspection gave cause for concern that the arrangements were not sufficiently robust.

### CPS restructuring

- 4.5 All the Areas visited were restructuring.<sup>15</sup> This was manifested in many different ways but of significance to this inspection was the merger of three or more separate CPS case handling units formerly attached to counties or the old 42 Areas. This move towards greater centralisation involved the movement of staff, some rationalisation of accommodation and the reassessment of how specialist services might be delivered. FRTI cases were either assigned to prosecutors working in Crown Court units or Complex Casework Units. As a result, a variety of different models have developed but none of these provides an unequivocal structure that can be replicated across the country.

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14 The term “Crown Prosecutor” means any suitably qualified lawyer who is authorised by the Director of Public Prosecutions to institute and conduct proceedings for any offence.

15 The CPS has Headquarters in London and York and operates in a structure of 13 Areas across England and Wales. Each CPS Area now includes more than one police force area. Before 2011 each CPS Area was aligned to one police force, except CPS London which has always included the MPS and City of London Police.

- 4.6 Despite public commitment to enhanced levels of care and service from the CPS, the attention paid to FRTI work has diminished with the reduction in cases generally and the dismantling of the former county-based Areas and attrition of experienced prosecutors. The CPS must give the work the necessary resource and profile that other serious casework categories enjoy if it wishes to counter criticism from families and others that it is not delivering on its public promises.

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#### RECOMMENDATION

CPS Headquarters should prescribe minimum standards and a common model organisational structure for handling fatal road traffic incident cases in every CPS Area, which should promote the role of specialist prosecutors by setting out eligibility criteria, accreditation and continuing professional development requirements.

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#### Appointment of Area coordinator or “Single Point of Contact”

- 4.7 The 2008 review recommended<sup>16</sup> that each of the then CPS Areas should appoint one specialist to assume the task of “*coordinating area cases and providing a focal point for ongoing consideration of legal developments in relevant law and practice*”. The CPS has made little progress in respect of this recommendation. A few specialist prosecutors have managed to fulfil the coordinators role but once they either moved to another post or left the Service they have not been replaced.
- 4.8 We consider that this coordinating role is now even more crucial than it was six years ago. Coordinating the delivery of this casework across several old CPS Areas with their associated police forces is an appropriate way in which to guarantee improvements in quality. A list of subject areas that would usefully be undertaken by such a coordinator is included at Annex 4.

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#### RECOMMENDATION

CPS Headquarters should appoint a specialist fatal road traffic incident coordinator in each CPS Area including CPS Direct, and set clear expectations for the role and what it is expected to deliver.

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#### Role of CPS Headquarters

- 4.9 The CPS has a Headquarters-based core of legally qualified staff<sup>17</sup> who provide advice and guidance to the Director of Public Prosecutions (DPP) over a range of topics. Their remit includes the dissemination of new policy and guidance to CPS Areas. Most recently, the approach had been to appoint a Senior Policy Advisor (SPA) for one or more subject areas including road traffic. Valuable work has been achieved through the SPA process including the revision of policy guidance on driving offences following wide ranging public consultation exercises.

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<sup>16</sup> See Recommendation 2, paragraph 3.17, page 17.

<sup>17</sup> Strategy and Policy Directorate (SPD).



### **Role of lead Chief Crown Prosecutor**

- 4.10 Similarly, a number of subject areas have been allocated to individual Chief Crown Prosecutors (CCPs) who are expected to take a national lead role in these subjects and act as a link between Headquarters staff and operational Area staff. Liaison at national level with key external stakeholders such as ACPO would also fit neatly within this job profile but at the time of our inspection had yet to be established.
- 4.11 A CCP lead on road traffic was in place at the time of publication of the 2008 review but after this person left the Service in 2010 the post remained vacant until the end of 2013 when, as the preparations for this inspection were getting underway, a further appointment was made. We consider this role should continue to occupy a prominent place within the CPS strategy for the delivery of a coherent approach to the prosecution of fatal road traffic incidents.

### **Comparison with Rape and Serious Sexual Offences Units**

- 4.12 We have commented at paragraph 4.5 about the challenges to handling arrangements posed by greater centralisation of operational units as a result of refocusing and the closure of a number of CPS offices. The CPS has faced similar challenges when dealing with its approach to the prosecution of rape and serious sexual offences (RASSO) as this work also requires the training and deployment of specialist prosecutors, although the caseload in this category of offence is much higher.
- 4.13 The current position of the CPS in relation to RASSO cases is that within each of the Areas it has been decided that there should be one Area-wide unit under the control of a lawyer manager, staffed by prosecutors who have achieved the necessary qualifications to merit specialist status.
- 4.14 In larger geographical Areas the unit may be split between more than one location but it will be managed by one Unit Head. Moreover in order to achieve specialist status a prosecutor is required to comply with a set of skills and specifications designed to ensure that the individual has gained a minimum level of knowledge and experience, as well as having completed satisfactorily a suite of bespoke training.
- 4.15 It is also instructive that RASSO Units maintain and publish regular data based upon caseload and outcomes, which at least in part provides comparative performance information for the CPS at national level. There is no equivalent system in place for fatal road traffic incidents because these cases are mostly handled within teams dealing with a wide range of casework and in a way that does not allow for performance monitoring.

### **Training**

- 4.16 Staff expressed the view that some form of training programme was desirable in order to ensure that those prosecutors allocated fatal road traffic cases were all given a consistent and comprehensive set of skills and knowledge and that their decision-making would thereby be enhanced. Inspectors endorse this view which was recommended in the 2008 review. All specialists should receive training to incorporate these elements:
- CPS legal guidance and policy;
  - communication skills;
  - media handling;
  - coroners' inquests; and
  - expert evidence.

- 4.17 With the possible exception of coroners' inquests, which have assumed less significance for the CPS since the Road Safety Act 2006 offences were implemented,<sup>18</sup> all of these issues would still be likely to feature prominently in any new training programme if it were to be rolled out now.
- 4.18 No training courses or e-learning modules have been developed although inspectors were pleased to note that in one CPS Area (outside those visited during our fieldwork phase) a training programme had been delivered locally to prosecutors. We were not directed to any other similar programmes.

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## RECOMMENDATION

CPS Headquarters should commission a skills audit and the development and delivery of a bespoke training programme to equip specialist fatal road traffic incident prosecutors, and those senior prosecutors designated to authorise key casework decisions, with the knowledge and skills they need to make appropriate decisions and communicate with bereaved families.

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### Referral criteria and gatekeeping

- 4.19 The *Director's Guidance On Charging 2013 Fifth Edition* (May 2013)<sup>19</sup> states that the police must submit all cases involving a fatality to the CPS for a decision to be made on charging unless the police conclude that the evidence available against any potential suspect is not sufficient to meet the test in the *Code for Crown Prosecutors*.<sup>20</sup> We found this to be well understood by police officers dealing with these cases and we did not identify any cases that had not been submitted to the CPS for a decision when they ought to have been.
- 4.20 Conversely we saw instances of cases being submitted for CPS advice when they need not have been; including some where the driver apparently "at fault" had died. No purpose would be served by involving the CPS in the decision to take no further action (NFA). In one CPS Area the lawyer manager overseeing the prosecution of these cases had encouraged the police to submit all road traffic cases involving a fatality where there was a surviving third party irrespective of the application of the Code test.
- 4.21 Whilst previous experience had led to the CPS Area imposing this requirement it does not comply with the Director's Guidance which requires the police to swiftly stop cases which do not meet the evidential stage of the Code test and added disproportionately to the FRTI caseload in the Area. This created unnecessary work for the police and CPS in case management, with the potential for delay, and imposed additional responsibilities on the CPS to notify victims' families directly.

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18 Fewer inquests are now held before the conclusion of criminal proceedings because the use of purely summary offences (which can only be heard in the magistrates' court) to prosecute a fatal road traffic incident case is much less likely. The availability of the offence of causing death by careless driving, which can be tried in the Crown Court, means that the majority of cases are now heard there. Coroners must adjourn inquests until criminal proceedings are concluded.

19 [www.cps.gov.uk/publications/directors\\_guidance/dpp\\_guidance\\_5.html](http://www.cps.gov.uk/publications/directors_guidance/dpp_guidance_5.html)

20 [www.cps.gov.uk/publications/code\\_for\\_crown\\_prosecutors/index.html](http://www.cps.gov.uk/publications/code_for_crown_prosecutors/index.html)

### Pre-charge decision-making

- 4.22 We found that the methods used by the CPS to discharge their statutory duty to authorise charges according to the Director's Guidance varied considerably.
- 4.23 Additionally the way in which the police secured the advice and guidance of specialist prosecutors varied. In some of the Areas visited the process was confined to delivery of a completed prosecution file at the end of the investigation with (in most cases) no prior involvement from CPS prosecutors.
- 4.24 One Area was still operating a face to face appointments system allowing police officers to meet with prosecutors after submission of the file, although the recent closure of local CPS offices was likely to threaten the continuation of that practice. This was just one example of the challenges posed by combining the working practices of several old Areas into one.

### Early investigative advice

- 4.25 In three of the six Areas we visited some specialist prosecutors encouraged police investigators to contact them at an early stage to discuss the nature of an investigation that was likely to generate a prosecution file. However our examination of case files in those Areas failed to reveal any evidence of these discussions being recorded, or even of a file being opened at that stage. In other Areas the police would rarely contact the CPS until their investigation was complete, which could often be as long as six months after the incident had taken place.
- 4.26 In the recently issued East Midlands Protocol, police senior investigating officers are required to give consideration to inviting a CPS prosecutor to a briefing to assist in providing early investigative advice where a case is judged to be "*particularly complex or sensitive*". The protocol also requires any advice given to be recorded in writing and saved on the CPS case management system (CMS). These provisions seem to be proportionate and should be applied to all CPS Areas asked to provide early advice in FRTI investigations.

### CPS Direct

- 4.27 Although there might be circumstances in which the police wished to detain a suspect in custody after charge it was agreed by all those interviewed that these instances would be rare. Despite the fact that the availability of CPS Direct (CPSD)<sup>21</sup> to provide a charging decision was recognised by police colleagues, there was a clear reluctance on their part to engage CPSD if there were local arrangements allowing for a prosecutor with whom they had previous dealings to provide the decision.
- 4.28 This approach was accommodated in at least one CPS Area where contact details of a small number of lawyers were made available to the police for exceptional cases. However convenient for individuals in both agencies these ad hoc local arrangements might be, they cannot be replicated nationally and might inevitably lead to the perception that different levels of service out of hours are available from one place to another; this perception should be avoided.

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<sup>21</sup> CPS Direct is a scheme to support Areas' decision-making under the charging scheme. Lawyers are available on a single national telephone number so that advice can be obtained at any time. It is available to all Areas.

**Code test compliance at charging**

- 4.29 CPS staff were committed to providing a quality service to those most closely affected by fatal road traffic incidents. They were aware of the impact that their decisions would have on victims’ families. However we found that the standard of decision-making did not always measure up to these expectations. See the table below showing our findings.
- 4.30 Inspectors examined 72 finalised cases. In 12 of these (16.7%), the decision was correctly made that the case did not pass either the evidential or public interest stage in the *Code for Crown Prosecutors* and no further action was directed. In eight of the remaining 60 cases (13.3%), where charges were directed against one or more suspects, the Code was not applied correctly.
- 4.31 There was an overall Code compliance rate of 88.9%. This is below that found in HMCPSI’s 2013 Annual Casework Examination Programme where the rate was 91.0%. Although it is better than the 85.7% for all homicide cases (including FRTIs) examined as part of that programme, it is significantly worse than the equivalent rate for RASSO cases of 95.2%. It is arguable whether the specialist prosecutor label is truly deserved where such a high proportion of decisions are in conflict with the Code. The CPS must give prompt attention to how it might address this level of failure; we comment below on the lack of effectiveness of the measures currently in place to quality assure charging decisions, which failed to prevent any of the Code test failures from proceeding. The following table illustrates the comparative performance:

Quality of charging decisions	FRTI sample all cases		% ACEP 2013 all cases	% ACEP 2013 FRTI and homicide	%ACEP 2013 RASSO cases
	%	cases			
Code compliant	88.9	64	91.0	85.7	95.2
Code non-compliant	11.1	8	9.0	14.3	4.8
Total	100	72	100	100	100

- 4.32 Six of the eight Code test failures involved the prosecution of drivers for causing death by careless (CDBCD) or dangerous (CDBDD) driving where there was insufficient evidence to provide a realistic prospect of conviction. In one of the six the initial charge of CDBDD was discontinued and a charge of CDBCD substituted, in respect of which there was a realistic prospect of conviction. In the other two cases assault charges were directed in respect of injuries sustained by victims who were casualties in incidents where another victim had been killed. Inspectors concluded that the necessary intentional or reckless state of mind could not be established; the standard of the defendant’s driving was only careless as reflected by the principal offence<sup>22</sup> charged of causing death by careless driving. Only one of these eight cases resulted in an acquittal by a jury; the remaining seven cases were stopped by the prosecution at various stages before trial.
- 4.33 Four of the eight cases arose from a pedestrian being killed by a car driver during the hours of darkness. The ability of the driver to see the pedestrian early enough for him or her reasonably to be expected to be able to avoid a collision was poorly assessed in the decision-making. In other words prosecutors and police investigators (to some extent) imposed an unrealistic standard of driving on the suspects in these cases.

<sup>22</sup> By agreement between the CPS and HMCPSI any case is treated as a “Code test failure” where at least one charge against one defendant fails the test even though other charges may satisfy it. This accords with paragraph 4.4 of the Code.

**Overall quality of the recording of the charging decision**

- 4.34 When making their decision as to whether to charge any suspect and if so, with what offence or offences, a prosecutor must record that decision on a document called an “MG3” which is used to communicate that decision to the senior investigating officer. This document also constitutes an audited electronic record that remains on the CPS file throughout the life of the case.
- 4.35 Inspectors assessed the quality of MG3s as part of their file examination. As well as the correctness of the charging decision itself other key aspects are taken into account as listed in the table set out below

MG3 quality*	Fully met	Partially met	Not met
The MG3 included proper case analysis and strategy	40.3%	36.1%	23.6%
All factors relevant to mode of trial/allocation considered	45.7%	30.4%	23.9%
Due regard was paid to relevant sentencing guidelines	35.6%	22.0%	42.4%
Proper account was taken of CPS guidance on driving offences	47.2%	30.6%	22.2%
The overall quality of the MG3		Excellent	1.4%
		Good	41.7%
		Fair	30.6%
		Poor	26.4%

\* excluding not applicable responses

**Selection of the driving offence to be charged**

- 4.36 Since the implementation of the Road Safety Act 2006 prosecutors have had a range of offences from which to select the most appropriate charge or charges where a fatal road traffic incident has occurred. The table at Annex 6 sets out these offences and the penalties which are available on conviction. Of those cases in our file sample where decisions to charge were made the principal offence charged was most frequently causing death by careless driving (50%). In a further 35% of cases causing death by dangerous driving was the principal offence charged while 8.3% featured causing death by careless driving whilst affected by drink or drugs. There were four cases where other offences were selected.
- 4.37 Inspectors assessed the appropriateness of the offences selected for charging as part of their overall judgement in relation to the quality of the decision itself. As stated above when considering Code test failures, there were two examples among our sample of the mistaken use of assault offences in order to reflect injuries sustained by victims who survived collisions where the offending driver was only guilty of causing death by careless driving. Since December 2012 the new offence of causing serious injury by dangerous driving became available in such circumstances but there is no equivalent if the standard of driving is adjudged to be no more than careless. Thus there remains a risk of similar misjudgements unless the guidance is amended.

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**RECOMMENDATION**

CPS Headquarters should issue guidance to prosecutors on the circumstances in which it is appropriate to charge assaults that arise from driving a motor vehicle.

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### Timeliness of decision-making

4.38 The 2008 thematic review recommended that once a complete file of evidence had been received from the police, the CPS prosecutor ought to provide a charging decision within 21 days. This target was not met in 54.2% of cases in our file sample although several Areas have agreed longer local targets of 28 days. The recording of timeliness was not subject to regular monitoring in most Areas and although the police were able to provide good data recording numbers and categories of incident, this was not routinely shared or discussed with CPS managers. Reciprocal commitments to exchange information within agreed timescales should be mandatory in regional or national protocols or service level agreements.

### Approval or authorisation of decisions

- 4.39 Sensitive to earlier criticism about the quality of its decision-making, the CPS has adopted various methods of quality assuring decisions. For a period of time following the implementation of the new offences created by the Road Safety Act 2006, prosecutors were required to submit all decisions to charge an allegation contrary to either section 1 or section 2 (causing death by dangerous or careless driving) to the Director of Public Prosecutions' Principal Legal Advisor<sup>23</sup> for approval.
- 4.40 Subsequently, this requirement changed to requiring approval by the Area CCPs although this too became impracticable as restructuring and refocusing of the Service began to take effect. When the guidance on charging driving offences was re-issued in 2013, the appropriate section imposed this obligation on the reviewing lawyer: "*To ensure consistency of approach, charging decisions in all fatal collision cases should be approved by a Chief Crown Prosecutor (CCP), Deputy Chief Crown Prosecutor (DCCP) or nominated senior decision maker (who will have been nominated for this role by their CCP/DCCP).*"
- 4.41 In most cases examined, where we could tell, the approving prosecutor has been at Deputy Chief Crown Prosecutor (DCCP) grade although in some earlier prosecution files, the CCP gave authorisation.
- 4.42 Areas appeared reluctant to nominate senior decision-makers below the DCCP grade which can create an unnecessary tier of bureaucracy into the process. In larger Areas where the reviewing lawyer might be graded at Senior Crown Prosecutor, in order to refer the case to the DCCP at least two other lawyers become involved in some form of case review as they passed the case upwards. This can cause delay and tends to introduce differing opinions about the strength of the available evidence before the DCCP views the file. In interview, senior lawyers to whom we spoke had mixed views on the efficiency of this system of referral and some believed that it was an unnecessary measure.
- 4.43 Inspectors examined files in order to see whether there was evidence of approval of the charging decision at the appropriate level as required by the CPS *Guidance on Charging Offences arising from Driving Incidents*. In only 54.2% of the charging decisions were inspectors satisfied that there was compliance with this requirement. The standard of endorsement and added value to be gained from the decision by the approving manager varied considerably. We did not accept a third hand reference by the reviewing lawyer that approval had been obtained as full compliance but instead looked for an independent record that could be audited and easily located.

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23 A senior lawyer appointed to provide expert advice to the Director of Public Prosecutions and to undertake advocacy for the prosecution in important casework.

- 4.44 There was significant divergence of practice in how the approval obligation was discharged. Interviews with senior lawyer managers showed that some always took time to examine the file or at least certain key aspects of it, for example the police collision investigator's report, before making their decision. Others by contrast would evaluate the reviewing lawyer's MG3 and then assess whether any further and more in-depth analysis was necessary.
- 4.45 Some would simply include their decision in an email to the reviewing lawyer whilst others had inserted their decision into the MG3 prepared by the reviewing lawyer. Others endorsed the paper file.
- 4.46 Some managers recalled instances where they had called for the case file and asked the police to carry out further investigative work before approving a decision. There was little evidence on the case files we examined of this level of intervention. Some police investigators expressed reservations about the system as they found that additional delay could be built into the process, although this too was not borne out in our file examination. One possible explanation for delay was the cumbersome process which some Areas were using to secure the approval because of their internal management structure.
- 4.47 Where the decision to charge was not in accordance with the Code the approving lawyer endorsed the flawed decision, so the purpose of the process was confounded. We have found little evidence that this requirement has added much value to the process and we urge the CPS to review its operation and, if such a requirement is to be retained, then those prosecutors who approve or authorise the reviewing lawyer's decision should have been trained to the same standard as any other FRTI specialist prosecutor. We discuss below case handling and decisions to drop charges or cases, but it was apparent that there was also inadequate quality assurance of those aspects. We call for stronger quality assurance throughout the life of FRTI cases.

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## RECOMMENDATION

CPS Headquarters should now review the requirement for approval of all decisions on charging to be made by Deputy Chief Crown Prosecutors or other senior lawyers and if it is to be retained, all senior prosecutors so designated must undertake the programme recommended at paragraph 4.16.

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### Post-charge decision-making

- 4.48 Each of the eight cases that failed the Code test at the charging stage also failed at subsequent review stages. Seven of the eight cases were eventually discontinued or otherwise stopped by the prosecution although some of these decisions were taken at, or very soon before, the time of trial. The other case was a jury acquittal. The post-charge Code test compliance rate (86.7%) is significantly below the ACEP 2013 rate (90.4%).
- 4.49 Wherever possible inspectors analysed the quality and content of any reviews carried out by the allocated prosecutor with conduct of the case, or any other lawyer to whom the case had been transferred, including a Crown Advocate deployed to present the case at court. In cases where no review could be found either on CMS or the paper file, we assessed the expected standards as being "not met". Approximately one quarter of the cases (25.4%) had reviews

which fully met the standard, a further 18.6% were partially met but over half the reviews (55.9%) did not meet the standard either because there was no recorded review completed or because the review itself was of poor quality.<sup>24</sup>

#### Continuity of prosecutor

- 4.50 The HMCPSI 2008 review recommended that “*area specialists should be responsible for making pre-charge decisions in all road traffic cases involving fatalities and they should, wherever feasible, retain conduct of the case including advocacy or attendance at significant hearings such as trial or sentencing in the magistrates’ courts, until the conclusion of the proceedings*” [in bold type for emphasis].
- 4.51 Moreover, the *Homicide Cases – Guidance on CPS service to bereaved families* (2011)<sup>25</sup> provides that “*Wherever possible the same prosecutor (ideally the reviewing lawyer) should be allocated throughout the life of the case and should be present at all relevant court hearings and subsequent meetings with family representatives. However, it is acknowledged that this continuity of contact for the bereaved family may not always be possible, particularly where the defendant elects, or the Magistrates direct that a case be committed to the Crown Court*” [in bold type for emphasis].
- 4.52 In the file sample the same prosecutor retained conduct in 38.3% of the cases and it was not possible to determine case ownership in 3.3% (two cases). Therefore in 58.3% of cases there was not the required continuity. There may be many practical issues that lie behind this result including the restructuring of CPS Areas and units, the movement of staff internally and the reduction in staff resources.
- 4.53 In the majority of cases it ought to be possible to preserve continuity of prosecutor in accordance with the CPS guidance, including where a Crown Advocate or external counsel is instructed to present the case at court.
- 4.54 It was clear from some of the responses we received from bereaved families to our questionnaire that where a number of court hearings took place, bereaved families were reassured by the regular attendance of the same prosecutor, as this indicated commitment on the part of the CPS and that the individual would be familiar with all aspects of the case.
- 4.55 We discuss in chapter 5 how families are influenced in their view of how their cases have been handled by the treatment they receive and the conduct of prosecutors they meet at court.

#### Case progression and preparation for trial

- 4.56 Inspectors examined how promptly the CPS responded to any court directions or Crown Court judges’ orders for the service of pre-trial casework material, or any other requirement imposed for the more efficient management of the case.
- 4.57 All but two of cases examined were dealt with at the Crown Court.<sup>26</sup> In those cases where orders were made inspectors concluded that 61.5% were fully complied with, 21.2% partially and there was no compliance with the remaining 17.3%.<sup>27</sup>

24 The equivalent ACEP 2013 figures were: fully met 52.3%, partially met 29.4% and not met 18.2%.

25 [www.cps.gov.uk/legal/v\\_to\\_z/homicide\\_cases\\_-\\_guidance\\_on\\_cps\\_service\\_to\\_bereaved\\_families/](http://www.cps.gov.uk/legal/v_to_z/homicide_cases_-_guidance_on_cps_service_to_bereaved_families/)

26 The two remaining cases were dealt with in the magistrates’ court as they involved offences only triable summarily.

27 The equivalent figures for all files in ACEP 2013 show that in 55.1% of cases where orders were made they were fully complied with, 32.4% partially and there was no compliance in 12.5%.



- 4.58 Inspectors assessed the quality of written instructions prepared for either the Crown Advocate or external counsel briefed to conduct the case management hearing and/or the trial in relevant cases. We found that in 31.0% those instructions fully met the standards expected in specialist cases of this nature; 55.2% partially met the standards but the remaining 13.8% were inadequate.<sup>28</sup>
- 4.59 All investigations generate evidential material that can be used by the prosecution as part of its case. The remaining material is known as “unused material” in relation to which the prosecution is under a statutory obligation to act responsibly and efficiently by making appropriate decisions whether to disclose or withhold that material from the defence, in order to secure a fair trial for each defendant.
- 4.60 An overall assessment was made by inspectors in each case where the disclosure obligations arose as to the quality of the prosecution’s compliance with the duty. This was assessed as good in 42.6% of cases, fair in 31.5% and poor in the remaining 25.9%.<sup>29</sup>

#### Recording of progress and outcomes

- 4.61 Inspectors assessed how well the CPS had recorded the outcome of court hearings, communications sent and received, uploading of casework material from police colleagues and decisions affecting case progress. Firstly, the accuracy and completeness of the use of CMS as a means of recording electronically the case history was measured and 56.9% of cases fully met the standard, a further 29.2% were partially met and the remaining 13.9% did not meet the standard at all.<sup>30</sup> Missing or unrecorded items included key decisions such as those resulting in a case being discontinued and so the absence of audited records seriously restricts the ability of managers to exercise proper oversight.
- 4.62 The totality of endorsements made on the paper file or electronically of the outcome of court hearings was also examined. Particular attention was paid to records of hearings where significant casework decisions were taken, discussions took place with bereaved families or witnesses and where trials and sentencing occurred. In this respect 47.2% of files fully met the standard expected, a further 29.2% partially, but almost a quarter (23.6%) did not meet the standard.<sup>31</sup>
- 4.63 Inspectors were hampered in their ability to understand why certain decisions were taken or verdicts reached by the absence of full records of hearings. When evidence is being heard or submissions considered in the course of a contested hearing, it is of some concern that the CPS has no clear record available of the proceedings from which to learn lessons if appropriate.
- 4.64 By way of example, one case was considered involving the fatal collision between a car and a motor cycle at a traffic light controlled junction. The motor cyclist was seriously injured and admitted to hospital where he died some days later. The driver of the car was charged with causing death by careless driving and there was a Crown Court trial.

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28 The equivalent fully met figure for ACEP 2013 cases was 27.9%, 49.6% were partially met and 22.5% inadequate.

29 The equivalent figures for ACEP 2013 cases were: excellent 2.9%, good 22.8%, fair 45.1% and poor 29.2%.

30 The equivalent figures for ACEP 2013 cases were: fully met 53.1%, partially met 37.6% and not met 9.3%.

31 The equivalent figures for ACEP 2013 cases were: fully met 40.3%, partially met 46.6% and not met 12.8%.

- 4.65 One of the issues in this case was whether or not the driving of the defendant amounted to a sufficient cause of the victim's death or whether the victim's own standard of riding, coupled with his subsequent medical treatment, were the more likely causes of his death. At the conclusion of the trial, the only recorded endorsement on the prosecution file was "found guilty of careless driving" and some details of a financial penalty. It was only through researching separate records held by the relevant Crown Court where the case was tried that inspectors could be sure that the jury had acquitted the defendant of the offence of causing death by careless driving.<sup>32</sup>
- 4.66 Finally, inspectors looked at the extent to which advice or other input from Crown Advocates or external counsel instructed to prosecute the case was clearly added to the prosecution file, so as to be available for examination by anyone dealing with the case at a later date. There were 49 relevant cases and in 30 (61.2%) their input was recorded properly.<sup>33</sup>

#### Acceptance of pleas

- 4.67 We examined 21 cases where the defendant offered to plead guilty to one or more offences if the prosecution agreed not to proceed on the most serious offence or offences charged. For example, there were some cases where the defendant had been charged with causing death by dangerous driving but the defendant's plea of guilty to causing death by careless driving was either accepted or rejected by the prosecutor. There were also examples of cases where the defendant's plea of guilty to the offence charged was put forward on a basis of facts that departed in one or more respects from the facts as set out in the prosecution case.
- 4.68 In 19 of the 21 cases (90.5%), inspectors agreed with the decision taken by the prosecutor.<sup>34</sup> This included decisions to reject offers of pleas as well as to accept them. In respect of the two cases where we did not agree, one involved a decision to pursue a charge which ultimately could not be proved. The other case involved the offer by the defence to plead guilty on a basis which did not in our view adequately meet the seriousness of the offence. There was no evidence that the victim's family were consulted about this decision, as required by the CPS's own policy.
- 4.69 The CPS *Guidance on Charging Offences arising from Driving Incidents* requires that either a DCCP or other nominated senior prosecutor should approve any decision on acceptance of pleas, in the same way that a decision on charging is to be approved. Inspectors examined 19 cases<sup>35</sup> where offers of pleas were considered and looked for evidence of approval having been obtained. No evidence could be found that the required approval had been obtained in nine cases (47.4%). CPS managers considered that there were often practical difficulties in locating the appropriate manager at a time convenient to the prosecutor handling the case where pleas were being considered at or just before a court hearing.
- 4.70 Our attention was drawn by members of the judiciary to the practice direction<sup>36</sup> which allows a prosecution advocate who may be considering a defence offer of a guilty plea to one or more offences on an indictment to refer the offer to a judge for approval. This allows a measure of independent scrutiny but the advocate would then be bound to follow the judge's

32 In such circumstances, it is open to a jury to return a guilty verdict to the simple offence of careless driving.

33 The equivalent ACEP 2013 figure was 76.9%.

34 This is an improvement compared with the ACEP figure of 85.0%.

35 The remaining two cases did not require approval as it was no longer legally possible to proceed with the original charges.

36 Criminal Practice Direction 41, page 69. [www.judiciary.gov.uk/publications/criminal-practice-directions](http://www.judiciary.gov.uk/publications/criminal-practice-directions)

decision. However we were able to confirm the judges' views that the direction was not widely used or even understood by prosecutors.

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## RECOMMENDATION

CPS Headquarters should add a reference to the Criminal Practice Direction on acceptance of pleas in its guidance on charging driving offences.

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### Discontinuing the case (or part thereof)

- 4.71 Although in all cases of this type charges are directed by a specialist prosecutor, it may nonetheless become necessary to consider whether the case (or a substantial part of it) can still be proved in the light of a further review of all the evidence, additional evidential material or other significant developments which might affect the strength of the case.
- 4.72 Subject to appropriate consultation both with the investigating officer and the bereaved family or their representatives, any decision to stop a case must also be approved by the appointed senior lawyer. There were 12 discontinued cases in our sample but we could only find evidence of approval in three.
- 4.73 We acknowledge the potential benefit to be derived from senior managers maintaining an oversight of these cases but we conclude that the system for securing approval is in need of reform by the CPS and questions remain over its value to the quality of decision-making. A clear contrast can be observed between FRTI cases where approval is required and other cases of homicide where it is not.

### Monitoring and analysis of case outcomes

- 4.74 All homicide cases are required to be flagged on CPS electronic registration under the description "fatality". However there is no sub-categorisation within the homicide flag. There is no straightforward method of identifying the number of cases involving fatal road traffic incidents, which would allow for more detailed analysis.
- 4.75 The CPS regards a case as having a successful outcome where any offence against any defendant results in either a guilty plea or a conviction after trial. Thus, a prosecution of a defendant for an offence of causing death by dangerous driving can result in a guilty plea or conviction for the alternative offence of causing death by careless driving. This will be recorded as a successful outcome, but the fact that the prosecution were unsuccessful in securing a conviction for the offence which was considered to be most appropriate at the charging stage cannot be easily determined by checking CMS.
- 4.76 Across the criminal justice system and beyond the handling of fatal road traffic incidents consistently attracts extensive and informed interest. Many observers monitor the outcome of police investigations and what decisions are made by prosecutors in respect of whether to bring charges, what level of charge to choose and, in the event of a successful outcome, the sentence.
- 4.77 Whilst police data and court sentencing outcomes are regularly published in an agreed format, the CPS is unable to provide comparative data. This can leave the organisation exposed when faced with media or private challenges to its performance in this field.

- 4.78 This lack of data means that measuring CPS improvement in performance or trends is not easily accessible. More critically the way in which the specialist work of handling fatal road traffic incidents should be structured cannot be informed by reliable caseload and outcome data. Inspectors discussed with staff in Headquarters and local managers the desirability of having such data available to them and there was an acceptance that more could be done to address this gap.
- 4.79 There were 23 cases in our sample where defendants were acquitted after trial of one or more, but not all, of the charges. In such circumstances there is currently no obligation (although it may on occasions be undertaken) on the trial advocate to provide a report outlining any potential weaknesses in the prosecution case. Such a report was available in only six (26.1%) of the relevant cases. By contrast, in similar circumstances it is mandatory for counsel prosecuting trials of rape cases to provide such a report.
- 4.80 Similarly, adverse case reports were prepared in only four of the 26 (15.4%) cases where there was some category of unsuccessful outcome, including cases dropped by the prosecution after charge. As a result opportunities to learn lessons from these cases were not being seized by managers. We consider that this should be remedied with immediate effect.

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#### RECOMMENDATION

CPS Headquarters should facilitate the flagging of all fatal road traffic incident cases on the case management system (CMS) as a separate case category and mandate the collection of statistical and performance data at Area level, publishing this on a regular basis so that future training programmes can be informed by learning points derived from case reviews.

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## 5 THE SERVICE TO BEREAVED FAMILIES

- 5.1 Those charged with the investigation and prosecution of fatal road traffic incidents bear a heavy responsibility to keep the families of homicide victims informed of what has happened, what is likely to happen in the future and why. Victims of all criminal offences have rightly been accorded a high priority by both the CPS and the police and, above all, those who have lost a loved one in a sudden and violent manner are entitled to special consideration.
- 5.2 Significant resource has been directed over many years by police forces and the CPS to create systems that will secure open and comprehensive communication with bereaved families in these circumstances.
- 5.3 Inspectors found that whilst the performance of police staff has been generally good and often excellent, it is not matched by the CPS and in too many instances it has not matched the minimum standard set by the organisation at national level.
- 5.4 This has come about either because too little priority has been afforded to maintaining systems and processes, or simply through a lack of awareness or a lack of diligence on the part of those responsible for case handling. We also found that internal checks and monitoring were inadequate to offer a reasonable level of assurance to senior managers that compliance had been achieved. This has to improve if the reputation of the CPS, in particular, for good victim care is to be preserved.
- 5.5 The current Director of Public Prosecutions included in her introductory message to CPS staff on her appointment in November 2013 the following statement: *“We need to ensure that the way we explain our decisions and interact with victims is more open, transparent, less formal and defensive, and more direct. Victims and witnesses do not choose to find themselves in the unfamiliar territory of the Criminal Justice System and we should be able to make their experience easier. We need to look carefully at all of our interactions with victims across the life of a case, as well as our communications with witnesses and the wider public – making sure we are always responding quickly, authoritatively and empathetically.”* Our findings in this chapter will show that this commitment is much needed.

### **Our methodology to secure the views of families**

- 5.6 Inspectors examined the way in which the police and CPS have attempted to inform victims’ families of developments and decisions in investigations and cases.
- 5.7 In a small number of cases we were able to capture some of the feedback from the families involved because letters or notes of telephone conversations or face to face meetings had been added to the file, but in the majority inspectors were left to try to imagine how information and explanation might have been received.
- 5.8 We conducted a limited exercise in canvassing victims’ families’ views by inviting clients or members of two of the leading charities and support groups Roadpeace<sup>37</sup> and BRAKE<sup>38</sup> (who have both been active in this field for many years) to complete a questionnaire. This was designed to elicit comments about the service they had received from the police and CPS after losing a loved one as a result of a fatal road traffic incident.

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37 [www.roadpeace.org/](http://www.roadpeace.org/)

38 [www.brake.org.uk/](http://www.brake.org.uk/)

- 5.9 Every contributor's experience is unique but we were able to ascertain some common themes. Not all of these themes covered ground that fell within the remit of this inspection but where they raised relevant and legitimate concerns we have sought to reflect these in this report, whether positive or negative. In order to accommodate as many of the consistent themes as possible we have selected and quoted (anonymously) extracts from the responses of families which illustrate clearly how they were affected by their experience.

#### Police service

- 5.10 As soon as a report of a fatal road traffic incident or one involving serious or life threatening injuries to one or more victims is recorded, one of the first steps taken is the appointment of a family liaison officer (FLO) by the senior investigating officer. The role of the FLO is a challenging one as they will become the principal channel of communication between the officers conducting the investigation and the bereaved family. In many cases, the role has a significant pastoral element ranging from the initial notification to the next of kin of the incident through to supporting families at court hearings, either in criminal proceedings or coroners' inquests.
- 5.11 Inspectors talked to groups of FLOs in all six forces visited and tried to construct a picture of their work and the skills that they needed to possess in order to deliver an acceptable level of quality in providing their service to families. Although there was broad consensus across the forces we visited about the various aspects of the role itself, it was clear that some forces and indeed some FLOs adopted different ways of working when carrying out the individual tasks. Sometimes these variations were necessary because of the unusual circumstances of the family involved in a particular case.
- 5.12 Some FLOs preferred to convey the initial notification of the death of the victim to the family in person, believing that it was important to ensure that only information that had been verified was passed on and that they could then establish the necessary relationship that would help the family come to terms with what had happened.
- 5.13 Others chose to allow operational officers to deliver this message and only meet the family as soon as they judged it appropriate. They explained that families often found it difficult to absorb information at such an early stage and that the 'messenger' was always then associated with the bad news itself. This hindered the building of a constructive relationship.
- 5.14 The comments from families who responded to our survey represent a range of experience and opinions about the service provided by the FLO:

*"My son ...was killed when run down by a speeding HGV lorry. That was at about 8.08pm. The police - a man and a woman - called at his house at some time after 9pm to find only his daughter (my granddaughter) at home. She was then aged 20 but looked younger. The police were reluctant to tell her about her father and only did so after they had ascertained her age. Her mother was then contacted by telephone and returned home soon afterwards. My wife and I were informed of the death at about 10pm and arrived at their house at around 10.30pm. The police had remained there all of this time and were most sensitive to our distress and very helpful about police procedure. I can only praise the manner in which they acted."*

*“Our family liaison officer handled this traumatic situation with sensitivity and compassion.”*

*“FLOs are for the benefit of the Police more than for benefit of the victims. Better victim support is needed. Despite some improvements the MoJ has effectively excluded families of road death victims from receiving support.”*

- 5.15 We were told that as a matter of course bereaved families were issued with an information pack produced by BRAKE. This guide aims to help people who have been recently bereaved in a road crash or are caring for someone in that position. As well as containing practical information about the response they might expect from the criminal justice agencies, a free helpline number is included where emotional support and referrals to other agencies can be accessed.
- 5.16 FLOs explained that they all received training from BRAKE as part of their induction into the role but that they also made use of other local welfare groups who could offer support. Representatives of the charities we contacted for this inspection praised the work of most FLOs but considered that they could continue to direct families to welfare agencies or helplines throughout the process as well as at the beginning.

*“We were first told of the death, face to face, at home by the officer who was allocated as our F.L.O. Incredibly difficult news to receive but I think it was delivered in the most appropriate way. I can’t remember exact details because it was such a traumatic event but I’m fairly sure the police stayed with us for some time, at least until other family members arrived. Our F.L.O. left his contact details with us and also left us a copy of the “green book”.”*

- 5.17 As a police investigation progresses, FLOs are tasked with giving bereaved families regular updates from the senior investigating officer. It was thought to be rare for the family to meet or speak directly with the SIO until the investigation was complete and a file submitted either to the coroner or to the CPS.
- 5.18 Some SIOs preferred to acquaint the family with their views of the likely outcome of a CPS charging decision in the belief that this would prepare the family for what could be disappointing news, either because there would be no prosecution or because the level of charge was less than they felt was justified.

*“My FLO kept in regular contact and she was happy to answer any questions I posed to her. She informed me of any things I needed to know which wasn’t much – but always replied to me promptly when I did contact. She also kept me informed of any updates even if they were going to be away.”*

- 5.19 In those cases where a CPS referral is not required there should not be any substantial delay before the family is notified of the outcome of the investigation. Where a case was referred to the CPS for a decision some SIOs were reluctant to update the family until the investigation was complete, which could take several months.
- 5.20 In some Areas we observed **good practice** where police investigating officers expedited the decision-making and consultation process with the CPS in cases where the only suspect was the partner or close relative of the victim and the degree of blame was slight.

*“D died late at night. The next day (I think) Sergeant P S and TC P C came to our home to carefully explain, in ‘layman’s terms’, everything we needed to know about death as well as the roles of different organisations such as the police, the CPS, and support services. They gave us every opportunity to ask questions, delivered useful relevant leaflets (after first explaining them), and they let us know about helpful charities.*

*If I telephoned or emailed when the officers were not on duty they returned my calls promptly. I felt that my family mattered to them – that nothing was too much trouble, and that we could trust and rely upon them.*

*Again - if I telephoned or emailed when Officer C was off duty, he always returned my calls promptly. I felt that my family mattered to him - that nothing was too much trouble, and that we could trust and rely upon him.*

*These officers sustained us through the most difficult year of our lives.”*

*“Following J’s death ..... we returned home. Communication was always by phone. During the telephone conversations we were informed that the investigation was accurate and ongoing. Later we discovered that this was inaccurate, statements from witnesses were not taken for almost a month after the crash ... It has become apparent that the police have not given sufficient priority to the death of J.”*

- 5.21 FLOs reported that they were often contacted by prosecutors who had made a charging decision and asked to check that all personal details of the victim’s family were correctly recorded before they issued a decision letter. It was the practice of most CPS Areas to provide their charging decision electronically to the police with a request to ensure that the FLO visit the family and deliver their letter explaining the decision directly.
- 5.22 However, some CPS Areas had abbreviated the process by inviting the FLO to tell the family of the decision without a CPS letter. This is in breach of the CPS guidance and is addressed later in this chapter. Such practice places an unreasonable expectation on the FLO and can lead to confusion in the minds of the family, especially where a decision conflicts with what the SIO has told the family they expect the decision to be.



*Communications about court hearings*

- 5.23 Where a prosecution was commenced the FLO would usually assume responsibility for ensuring that the family were notified accurately and in good time of any court hearing. Frequently the offer would also meet the family at court and sit with them through the hearing and support them should there be any discussion of the case with the CPS advocate in attendance.
- 5.24 Information about court hearings originate from the court itself and then the CPS is required to pass this directly to the FLO. In addition the predominantly police staffed Witness Care Unit (WCU) exists within a CPS Area to gather all information concerning court hearings and convey this to witnesses. Although most bereaved families are unlikely to be actual witnesses who might be called to give evidence in any trial of a case arising from a fatal road traffic incident, we were told by those WCU managers to whom we spoke that their staff would always aim to ensure that they were updated appropriately and would use the appointed FLO as the main channel of communication.
- 5.25 Accurate and coordinated communication between the CPS, WCU and the FLO is very important if families are not to be given misleading information, especially where there are late changes to court hearings in terms of date or location.
- 5.26 The occasion of a court hearing where all parties were together in one place was often used by the CPS as an opportunity to discuss key casework decisions with the family. There remained the risk in many cases of the family feeling intimidated by what they found to be a hostile environment on a day when they were already under considerable stress by simply attending the hearing itself. In those circumstances the role of the FLO can be vital to try to make sure that families truly understand what has happened.
- 5.27 The support of an FLO at court was also considered by the bereaved to be of great value because in some courts the availability of suitable separate waiting accommodation for bereaved families, set apart from that occupied by family or friends of any defendant, could not always be guaranteed. As we discussed in chapter 3 police forces must manage the time and other competing commitments of FLOs to allow them to attend court with families.

*“Finally - the seating arrangements (both courts) were inappropriate. At the Crown Court we were forced to sit in the 12 seated public area to one side of the court and this resulted in us sitting close to people accompanying the defendant. I was sitting behind the defendant’s partner – the passenger in her car during the collision. This allowed us no privacy to deal with details of my husband’s injuries and last experiences. Despite both the prosecution and the defence barristers agreeing not to read these details in court, they were delivered by the defendant when she gave evidence that was designed to help her case. It was vile. Anything we said or did could be relayed to the defendant during court breaks. This should not be considered acceptable by anybody.”*

*“We were determined to attend each and every court appearance, from the first Magistrates Court right through to the final Crown Court sentencing. Court dates were very “hit and miss” and seemed to be set to a timetable that suited the defendant. It was difficult to get correct dates for the court hearings, on some occasions we attended court only to find that the hearing had been put back. We had to resort to searching the court listings on-line.*

*We were treated in a compassionate way at court. We were given a private side room to wait in. It was reassuring to be met by our FLO at the more significant court appearances. Although the custodial sentence and driving ban were clear to understand, we were never sure when the driving ban would start, i.e. would he serve a driving ban while in prison?”*

## **Crown Prosecution Service**

### **Overview**

- 5.28 Since 2002 the CPS has committed its prosecutors to the task of telling victims of crime that a case or a particular charge has been dropped or substantially altered and seeking to provide an explanation. In certain more serious and sensitive cases the obligation arises to offer to meet with the victim or their family as well as writing a letter of explanation.
- 5.29 In 2007 it was decided that victims’ families in cases of homicide (including fatal road traffic cases) would receive an enhanced service including more frequent communications and meetings (if required). This was known as the Victim Focus Scheme (VFS) and had been recently implemented at the time of the HMCPSI review of 2008. A compliance review by the CPS in 2010 recommended an extension of the scheme to include post-acquittal meetings, magistrates’ court hearings and Appeal Court hearings.
- 5.30 More recently in 2011 the then Victims’ Commissioner reported to the Government on the provision of services to victims and their families. These reports led to the replacement in December of that year of the VFS by the *Homicide Cases – Guidance on CPS service to bereaved families* (SBF) guidance. This document re-stated much (if not all) of the obligations imposed on prosecutors to communicate with and meet victims’ families, but attempted to draw together into one document the various commitments set out in the Direct Communication with Victims scheme<sup>39</sup> and the Victims’ Code which was itself updated in December 2013 as the *Code of Practice for Victims of Crime*.
- 5.31 As part of the examination of the 72 cases in our file sample, all hard copy documents and CMS electronic records were checked for evidence of compliance with this guidance. It should be noted that a small number of these cases were commenced prior to the December 2011 implementation date of the SBF guidance, but the majority were conducted within the operative period.
- 5.32 As can be observed from our findings detailed below the extent to which the guidance was followed was disappointingly low. Our discussions with CPS prosecutors involved in reviewing and conducting fatal road traffic incident cases and their managers revealed a surprisingly poor understanding of the guidance itself and its requirements. Indeed many were still using Victim Focus Scheme forms and templates as they were unaware of the replacement of the VFS by the SBF procedures.

<sup>39</sup> [www.cps.gov.uk/legal/v\\_to\\_z/care\\_and\\_treatment\\_of\\_victims\\_and\\_witnesses/](http://www.cps.gov.uk/legal/v_to_z/care_and_treatment_of_victims_and_witnesses/)

- 5.33 The document is freely accessible as part of the CPS Legal Guidance and is available to the general public on the CPS website. It is therefore disappointing that we found such a low level of awareness amongst prosecutors who deal with these cases.

*Notification of the charging decision*

- 5.34 In all cases where the CPS has made a charging decision this must be notified to the bereaved family as soon as practicable. The purpose of this communication is not only to inform the family of that decision, but also to offer them the opportunity to meet with the prosecutor and ask any questions they may have about the decision and (if appropriate) the anticipated progress of the case.
- 5.35 In almost every case bereaved relatives will have had contact with an FLO. In cases which have been submitted to the CPS for a charging decision liaison between the reviewing lawyer and the FLO is encouraged. Indeed it is required that the prosecutor write to the family via the FLO offering a meeting where the decision can be explained in more detail.
- 5.36 It is envisaged that the family may indicate to the FLO whether they want a meeting when he or she provides the family with the CPS letter. Whatever the views of the family these are to be recorded on a template form and returned to the prosecutor. Furthermore, since the implementation in June 2013 by the CPS of the Victims' Right to Review Scheme<sup>40</sup> these communications are particularly important as they may be the only way to alert the family to their rights under the scheme.
- 5.37 There was a record of the charging decision having been appropriately communicated to the victim's family in only 12 of the 72 cases (16.7%). In a small number of cases the first ascertainable communication to the family was recorded only a few days before a plea and case management hearing in the Crown Court, or even after that time. This is too late.

*"The first contact we had with the CPS was .. in court. That morning we were told he was going to plead guilty and be sentenced. We were left shocked and upset. We weren't prepared for that, other family members weren't there who wanted to be.*

*At that point we didn't know hardly anything about the case and were left not knowing what had just happened."*

*"The first contact with CPS was not helpful. We met at court the day the charges were read out. The shaking of hands and that was about it."*

- 5.38 Overall, the result of our analysis demonstrates a systemic failure to ensure that these communications are undertaken at the right time or at all. We were told by several prosecutors in different CPS Areas that they thought it preferable to allow the FLO to communicate the charging decision because a relationship had been established over a period of time between the FLO and the family.

40 [www.cps.gov.uk/victims\\_witnesses/victims\\_right\\_to\\_review/](http://www.cps.gov.uk/victims_witnesses/victims_right_to_review/)

*“I did not hear from the CPS and on reviewing the handbook realised that I should have heard from the CPS what the driver was going to be charged with. From what I can recall it was the police who informed me of the charge and I was shocked that the driver was not going to be charged with “dangerous driving”. I understood that this was because it was easier to get a conviction for causing death by careless driving than by dangerous driving.....”*

- 5.39 As well as not complying with the CPS guidance such an approach fundamentally misconstrues the purpose of the communication. It is for the decision-maker (in this case the prosecutor) to explain directly to the victim’s family their role and decision and to establish official contact details should the family wish to pursue any further opportunities to meet with the prosecutor. The FLO can, and in most cases should, deliver the CPS communication to the family but however well intentioned a third party’s explanation of a decision made by another agency carries obvious risks of confusion or omission.

#### *Notification of court hearings and outcomes*

- 5.40 In all cases that result in a court hearing victims and their families have a clear and understandable interest in knowing when those cases are going to be heard and what is likely to happen. They also will want to know, as soon as possible, the outcome of any hearing regardless of whether or not they were able to attend the hearing. Particularly in the latter situation an explanation of the outcome of the hearing will be important and an indication of what is likely to happen next in the case.
- 5.41 Again there are potential sources for this information; the FLO, the Witness Care Unit and the CPS prosecutor will all have relevant information to pass to the family, but this shared responsibility may lead to contradictory information being communicated or, worse still, a failure to communicate at all because one party mistakenly believes that another has fulfilled this obligation. These failures can add significantly to the understandable distress suffered by families and need to be avoided wherever possible.

*“We felt cheated by the system. Our prosecutors changed with every hearing and they were very poor – absolutely no consistency. No one really fought for us.”*

*“We attended the first Magistrates hearing and both days at Crown Court. We were well looked after. At the Magistrates our FLO managed to get a witness room for us after that we were in the public areas.*

*The original barrister couldn’t attend the sentencing hearing but his colleague met up with him the day before and they went over the case in detail. The driver had pleaded guilty, so it was about mitigating circumstances, but they still made a lot of effort and were careful to explain everything to us. I was particularly pleased when the barrister went over to talk to my son’s friends after the sentencing. They were very upset and he made the effort to go and talk to them and explain everything, after he had explained it to the family.”*

5.42 Inspectors examined all the case files that resulted in court proceedings and assessed the adequacy of the notifications to the victims' families throughout the life of the case. We concluded that the standards of timeliness and accuracy were fully met in 5.0%, partially met in a further 21.7% and not met in 73.3%. This level of performance is clearly not acceptable. Although FLO communications would not routinely be recorded on CPS files those completed by the CPS or WCU should all be visible.

*Consultation with families over accepting pleas or discontinuing*

5.43 Changes in the strength of the prosecution case or other new information may require the prosecutor to reconsider whether the original charge(s) selected can still continue. Alternatively, those representing the defendant may contact the prosecution offering to plead guilty to a different offence from the one currently faced or to plead guilty to some, but not all, of the charges. Finally, the defendant may wish to plead guilty but on a different basis to that contained in the prosecution evidence, so that any subsequent sentence imposed by the court would reflect the facts admitted by them.

5.44 In all the circumstances described above the SBF guidance requires that meetings will be offered to bereaved families. From time to time the events triggering the need for an offer of a meeting will arise at or immediately before a court hearing and unless the bereaved family has attended the hearing it may not be practicable to arrange a meeting to discuss the prosecution's response before a decision is made. In those cases prosecutors must write to the family explaining the decision within one working day and in that letter offer a meeting at a later date.

5.45 Inspectors examined all those files within our sample where all or part of the case had been discontinued by the prosecution, or where the defendant had offered to plead guilty to a different offence to the original charge. The following data summarises our findings:

- there were 18 cases where the families ought to have been consulted about the decision to accept guilty pleas to other charges or a basis of plea offered by the defendant. In 11 (61.1%) we found evidence of appropriate consultation but the rest were silent on this aspect;
- there were 11 cases where the prosecutor proposed discontinuance of the case either in its entirety or in respect of the principal offence charged. There was evidence of appropriate consultation in seven cases (63.6%); and
- where the prosecutor accepted an offer of pleas or discontinued the case we found that there were only six cases out of 22 (27.3%) where a timely communication of this decision was sent to the family. There were a further 16 cases (72.7%) where either no letter was sent or it was not timely.<sup>41</sup>

5.46 In respect of those communications which were sent and were recorded in the case papers we assessed their quality. Inspectors looked for evidence that the author of the communication understood the case, was able to explain the decision in a straightforward and accurate way, successfully avoided excessive jargon and demonstrated an acceptable degree of empathy with the recipient. We found that only two of the 16 letters (12.5%) fully met this standard, a further five (31.3%) partially met the standard and the remaining nine (56.3%) did not.

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41 The equivalent figures for ACEP 2013 were: 59.4% timely and 40.6% either not timely or not sent.

- 5.47 While there were good examples of consultation and communication scattered throughout the file sample too many cases either contained inadequate communications or simply had not been sent, which is unacceptable.
- 5.48 To learn that a prosecution that represents some public response to the violent death of a loved one is to be or has been dropped would be unwelcome news to any bereaved family. When this news is discovered from a press report or some other unofficial source without any reliable and empathetic context then it can only add to their distress.

#### *Meetings with bereaved families*

- 5.49 The SBF guidance sets out the various circumstances in which the CPS should offer to meet with bereaved families and their representatives. These are set out in detail in Annex 5.
- 5.50 Meetings should be offered unless there are very exceptional reasons not to do so. It is expected that these will normally relate to issues of security and safety, in which case a CCP must make this decision and record the reasons on the case file. There were no instances of this occurring in our file sample.
- 5.51 The guidance recommends that the prosecutor uses the FLO as a key liaison point with the family before arranging any meeting and as a way of identifying those issues which the family wish to discuss. The purpose of the meeting will vary depending upon the circumstances of the case and stage of the proceedings.
- 5.52 There are various provisions dealing with the number and nature of those likely to attend any meeting but broadly speaking it is expected that the prosecutor attends alone or accompanied by his or her manager, the FLO and, if necessary, the senior investigating officer. Families may wish to nominate one representative to attend on their behalf or in some cases other family members will wish to attend, although the total should not normally exceed four.
- 5.53 There is considerable helpful and practical advice for prosecutors who wish to set up a meeting but there is one key requirement regarding record-keeping which states: “*A contemporaneous note of every meeting should be taken. The notes should be added to the file record on CMS. Prosecutors are reminded that any such notes may be disclosable.*”<sup>42</sup>
- 5.54 Inspectors found evidence in 20 cases that a meeting with the bereaved family had taken place at one or more of the key stages in the proceedings. However it was possible to trace a record of the notes of the meeting in only five. During our discussions with CPS prosecutors and other staff we were told that note-takers were not always available and that frequently meetings were held at the court centre when there was a hearing of the case taking place.
- 5.55 These meetings could sometimes be informal and key personnel might not always be present. Managers from the CPS Appeals and Review Unit (ARU), based at CPS Headquarters, were more diligent in their desire to keep records.

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42 *Homicide Cases – Guidance on CPS service to bereaved families.*

### *The Victims' Right to Review Scheme*

- 5.56 With effect from June 2013 the CPS implemented changes to its overall complaints policy and now offers all victims an opportunity to seek a review of certain decisions made by prosecutors with which they disagree. The Victims' Right to Review (VRR) Scheme includes all decisions not to charge a suspect with an offence or to discontinue or otherwise terminate a prosecution. If local resolution fails a review is carried out by prosecutors within the ARU. From that point the ARU prosecutor will assume responsibility for the case and is required to maintain communications with the victim's family in accordance with the SBF guidance.
- 5.57 The VRR Scheme requires the prosecutor to notify in writing the bereaved family of their right to review as soon as the qualifying decision has been made. In practice this is achieved by the inclusion in any letter informing the family of the decision of a paragraph describing the operation of, and how to engage with, the scheme. Our file sample included 16 cases where the VRR Scheme applied. However in only five (31.3%) of these cases was there compliance with the scheme. In the other 11 cases there was failure to send a letter at all, relying upon the police FLO to communicate the decision, or a failure to include any reference to the VRR in the letter that was sent.

### *Appeals*

- 5.58 We identified eight cases in our file sample where a defendant had appealed against the conviction recorded and/or the sentence imposed. It is possible that more of our selected cases were subject to an appeal because the process adopted by the CPS to record details of an appeal and the handling thereafter has changed since 2010. Until that time the CPS had adopted a flexible approach towards handling Appeal Court cases in that many remained with the local office, although others were transferred to CPS Headquarters.
- 5.59 More recently all appeals against conviction and sentence in fatal road traffic incidents have been dealt with centrally by the ARU. The SBF guidance includes stages in the appeals process as times at which bereaved families should be notified and offered the opportunity of a meeting with the prosecutor. It proved to be difficult to follow the progress and outcome of the eight cases at the appeal stage because the recording of actions and correspondence was extremely limited, and in some cases non-existent, on the Area CMS.
- 5.60 We were informed by managing lawyers at the ARU that once they had assumed responsibility from the local Area for a case a new file was opened on CMS and all reviews, actions and correspondence would be added to the new file. Although this file would be identifiable to all CPS staff through the defendant's name, restrictions in place at Headquarters resulted in the vast majority of CPS Area staff being excluded from accessing the case electronically. Although there were exchanges between the prosecutor handling the case in the ARU and the Area prosecutor these were limited in nature and only seemed to have been recorded on the ARU file.
- 5.61 Inspectors examined the relevant ARU files and found good evidence of prompt and accurate communications between the ARU prosecutor and the bereaved family through the police FLO.

- 5.62 However we are not persuaded that the opening of a new case on CMS with such restricted access is necessary or efficient except in highly sensitive cases where confidential material might need to be protected. Indeed, Area prosecutors told us that they retained an interest in many cases which they had prosecuted to conviction but had found it frustrating that they were unable to monitor progress after an appeal was lodged. Although not within the scope of this inspection, we consider that these comments and the following recommendation should equally apply to all cases.

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#### RECOMMENDATION

CPS Headquarters should modify the Appeals and Review Unit's (ARU) practice of creating a separate case file on the case management system (CMS) where an appeal or Victims' Right to Review (VRR) referral has taken place as it unreasonably restricts access by the CPS Area staff to all records of review and other case material.

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- 5.63 Although we did not find any cases in our sample where the Attorney General had been asked to refer the sentence to the Court of Appeal as unduly lenient, the ARU confirmed to us that they also handled all cases of this type. It is anticipated that the same recording considerations will apply to these cases as with appeals by defendants.
- 5.64 We were also assured that meetings were offered to families by the ARU in all cases but were told that in many families took advantage of the offer to speak to the allocated prosecutor by telephone, which avoided the need for a meeting. As the families may be resident in any part of the United Kingdom or even abroad in some cases, the additional inconvenience and expense of a visit to London can be spared. Appeal cases are often heard together, especially where there is a similar issue of law or sentencing involved and this can cause problems for the CPS to manage the care of bereaved families at court.

#### *Overall standard of communications*

- 5.65 Taking all these various factors into account where they were relevant in any individual case, inspectors made an overall assessment of the quality of communications carried out by the CPS with the bereaved family. Based upon our examination of the 72 cases in our file sample we judged that in 54 (75.0%) of them the standard of CPS communications was poor. Only one case (1.4%) was assessed as good with the remaining 17 (23.6%) fair.
- 5.66 Inspectors were unable to identify any systematic process in place to allow managers to monitor the quality and timeliness of communications with families. Other than the occasional capture of an FRTI case in general quality assurance processes, the only opportunity that managers might get to review the content of a case file would be if there was an unsuccessful outcome. However even then there was no guarantee of a review, nor that any review would go beyond the charging decision.



## 6 LIAISON ARRANGEMENTS/PARTNERSHIP WORKING

### The police view

- 6.1 The relationship between the police and the CPS varied across the forces visited and ranged from excellent, with officers having access to early advice either on the telephone or face to face, to poor, with delays in getting advice and decisions. In many cases there was a lack of a clear understanding on the part of the police of the value of seeking CPS advice, when might be the best time to do so and who might be the most appropriate prosecutor to approach.
- 6.2 Some forces had managed to maintain relationships with prosecutors who were attached to former CPS Areas and continued to contact these individuals. Others had lost contact after CPS restructuring and had failed to establish liaison with new teams or units. Officers told us that they had tried to seek advice from CPS offices but were unable to make appointments that were convenient. Yet another force had ceased to ask for early advice except in the most serious of cases but completed their investigation before submitting a file for a charging decision to be made.
- 6.3 There were some good relationships in Kent where the police and CPS met regularly to review individual cases where specific issues had arisen during the prosecution. However, there was no systematic analysis of all case outcomes in order to monitor performance over time and eliminate any poor practice. It is clear that some work is required by both organisations to reach agreement on reasonable expectations that each should demand from the other so that these could be included in a protocol or service level agreement.
- 6.4 Most forces that we visited included road traffic collisions causing serious or life-changing injuries in their road death investigations and so applied the same standards as in FRTI cases. On the other hand, with one exception all the CPS Areas that received casework from these forces screened out serious injury by dangerous driving cases from any specialist FRTI prosecutors, preferring to deal with such cases in their non-specialist Crown Court units. These anomalies need to be resolved through negotiation locally or nationally.
- 6.5 Where the CPS made the decision to take no further action on a case this was generally communicated to families by the family liaison officer and in some cases the senior investigating officer. It was reported in some areas, however, that there were often long delays in getting decisions (three to six months) although these could be as a result of requests by the CPS for additional evidence to be obtained as well as decision-making, or indeed a combination of both.

### The CPS view

- 6.6 Most CPS Areas have struggled to implement a wider protocol or service level agreement that delivers a consistent set of mutual commitments across the two or more police forces within their region. Inspectors were directed by CPS Area managers to a range of different protocols that had in many cases been in existence for several years, or alternatively were still subject to negotiation with senior police colleagues.
- 6.7 Some of these confined the category of incident to those where a fatality had occurred, but others included expressly or impliedly incidents where serious or life-threatening injury had been caused by an offence of dangerous driving.

- 6.8 Inspectors were concerned that one CPS Area did not have any protocol or service level agreement with their road traffic police department.
- 6.9 In 2013 the CPS signed a memorandum of understanding with ACPO, the Chief Coroner and the Coroners' Society of England and Wales which included a series of obligations upon the prosecutor in a homicide case to communicate directly with the relevant coroner, to make them aware of decisions on cases at regular stages. We discuss this further below.
- 6.10 This appears to have operated as a catalyst for the revision of wider protocols with the police on fatal road traffic incidents. The Director of Public Prosecutions has recently welcomed the publication of a protocol between CPS East Midlands and the five police forces covered by the Area and encouraged other Chief Crown Prosecutors to adopt this document as a model.
- 6.11 The availability of a nationally consistent document for this purpose has obvious merit and allows greater transparency for victims' families and the public generally. However the East Midlands document does not make reference to the recording, monitoring or analysis of outcomes, which we consider to be a key gap in the intelligence currently held by the CPS locally and centrally.
- 6.12 Inspectors are convinced that the availability of a protocol in all CPS Areas is a clear priority and that although these need not be identical, all should as a minimum requirement contain provisions dealing with these issues:
- a CPS "Single Point of Contact" for police colleagues;
  - arrangements for the provision of early investigative advice;
  - arrangements for the provision of pre-charge decisions more generally;
  - standards for the police investigation and prosecution file;
  - standards for the timeliness of actions by both organisations;
  - joint collection and monitoring of outcome data;
  - joint media strategy;
  - communication with and treatment of bereaved families;
  - engagement with road safety charities and other campaign groups or charities; and
  - joint training or the sharing of developments in law, policy or technology.

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## RECOMMENDATION

CPS Headquarters should require all Areas to agree a standard protocol with minimum content with each police force in their region and meet regularly to review its effectiveness.

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- 6.13 Many of these items were included in a recommendation addressed to the CPS in the 2008 review but it is disappointing that little progress has been made in the intervening years on several. We report in detail on the CPS response in chapter 7.

### **Adequate police evidence**

- 6.14 Based upon our examination of case files from the six police force areas, we were satisfied that both the CPS and the police shared a common understanding of the requirements that had to be met in order to constitute a satisfactory file of evidence that would allow a prosecutor to make a charging decision. This minimum content comprised:
- all key witness statements;
  - a record of the suspect's interview; and
  - a detailed report by a forensic collision investigator.
- 6.15 On a case by case basis other material might be required, but these additional elements (such as a pathologist's report on the cause of death or an expert opinion on an aspect of the evidence which was technical in nature), tend to be resolved through discussion between the police senior investigating officer and the reviewing lawyer to whom the case has been allocated.
- 6.16 In certain cases and in some of the sites visited early meetings between police and CPS were arranged to facilitate agreement about the scope of the investigation. These meetings sometimes included visits by the prosecutor to the scene of the collision or incident and often involved attendance by the prosecutor at road policing unit premises to view evidential material of a complex or technical nature.
- 6.17 As the two agencies continue to progress towards the digitisation of prosecution files an increasing amount of the police case file is being supplied to the CPS in a digital format, although there remain variations. For instance, the Metropolitan Police Service (MPS) routinely supplied the CPS with a disc containing all casework material whereas in other Areas paper files were still provided in all fatal road traffic incident cases.

### **Working with the voluntary sector**

- 6.18 Both the police and CPS enjoy constructive relationships with leading charities and campaign groups at a national level and both participate where appropriate in discussion groups and consultations sponsored by Government. An example of such a group is the Justice for Vulnerable Road Users Group set up and facilitated by the Department of Transport/Ministry of Justice. Representatives of these groups confirmed to inspectors that they were used as counselling or welfare referral services usually at the outset of an investigation. They also contributed to the training provided for new police family liaison officers. Finally, they were consulted by police at national level during the planning and evaluation of national road safety campaigns.
- 6.19 There was less evidence of involvement by voluntary groups in regional or local campaigns run by police forces or local authorities. Comparative data was generally not available to understand the impact of these campaigns.

### Police road safety campaigns and casualty reduction partnerships

6.20 Making the roads safer and reducing casualties is a key part of the ACPO UK Roads Policing Strategy 2011-2015.<sup>43</sup> This was reflected in all the areas we visited who took part in road safety campaigns, both local and national. We found some excellent partnership working, for example in the MPS an initiative called Changing Places consisted of the police working with Transport for London, haulage companies and cycling organisations.



6.21 An HGV tractor unit had been acquired and marked up with police livery. In an effort to reduce collisions between HGVs and cyclists this vehicle is taken around collision hot-spots and cyclists are given the opportunity to get a driver's perspective from inside the cab and understand the difficulties drivers have with all round visibility. In other areas forces target vulnerable road users with various initiatives which include young drivers, older drivers, motor cyclists and cyclists.

6.22 Other examples of innovative and eye-catching campaigns pursued by police forces included the Almost Home project in Lancashire where a car badly damaged in a road traffic collision was being taken to schools to illustrate the dangers of dangerous driving and the impact on friends and family. This was run in partnership with the County Council. A further programme in the MPS had identified specific routes in London where there was a high incidence of collisions which were then targeted for proactive accident reduction initiatives. Lastly, Hampshire Constabulary had identified specific groups of drivers who were perceived to be most at risk and had developed bespoke strategies designed to reduce those risks.

### Liaison with coroners

6.23 Coroners are independent judicial officers responsible for the investigation of the causes of deaths in England and Wales. The office of Chief Coroner was created by the Coroners and Justice Act of 2009 although the first appointment was not made until September 2012.

6.24 Where there is a suspicion that a criminal act led to the cause of death the coroner will open an inquest and must adjourn it until the outcome of any criminal proceedings is known. It is for the coroner to liaise with the police and the CPS where needed if criminal proceedings are being considered.

6.25 Historically, there have always been strong and established relationships between the police and local coroners and our findings showed that these relationships remain effective.

6.26 On the other hand, the links between CPS prosecutors and coroners have never been well-established, nor was there any significant evidence that these had changed in character or frequency since the HMCPSI 2008 thematic review. As we comment in chapter 7 the recommendations contained in the review that closer liaison be forged by Chief Crown Prosecutors with coroners have not been progressed.

43 <http://library.college.police.uk/docs/ACPO/ACPO-policing-the-roads-2011.pdf>

- 6.27 As referred to above, in 2013 the CPS at national level recognised that this situation needed to be addressed and negotiated a memorandum of understanding (MOU) with both ACPO, the Chief Coroner and the Coroners' Society of England and Wales. Foremost among the obligations of Crown Prosecutors are early contact with the coroner, informing the coroner of charging decisions made against individuals and organisations and also decisions not to charge individuals or organisations, including the legal basis on which the decision was made.
- 6.28 Of the files examined by inspectors only four (5.6%) of the 71 relevant cases contained any evidence that the CPS charging decision had been communicated to the coroner. Those prosecutors to whom we spoke in the Areas we visited had little awareness of the MOU or its requirements that they communicate their decisions to the coroner. A common view was that the police would automatically communicate these decisions.
- 6.29 There were early signs that these obligations might also be included in protocols or service level agreements with the police and inspectors consider that approach to be an appropriate one. Although these obligations were re-stated in the 2013 MOU they were simply preserving long-standing guidance to prosecutors that they should inform the coroner of their decisions.



## 7 CPS RESPONSE TO THE HMCPSI 2008 THEMATIC REVIEW

7.1 The second thematic review of CPS decision-making, conduct and prosecution of cases arising from road traffic offences involving fatalities was published in November 2008. The review made a total of 11 recommendations designed to improve performance and these were broadly accepted by the CPS at the time. In this joint inspection we measured how successfully or otherwise the CPS had implemented these recommendations. We also considered how relevant the recommendations remained in view of intervening structural changes within the organisation and developments within the criminal justice system.

7.2 In the following table we address each in turn, describe what progress has been made towards implementation and provide an overall rating from “excellent” to “poor”. The ratings are scored as follows:

*Excellent progress*

The CPS has either achieved or made real, sustained and successful progress in taking forward its planned actions in relation to the recommendation. Impact has been demonstrated by the required performance improvement having been secured and sustained improvement having been shown.

*Good progress*

The CPS has made effective progress in taking forward its planned actions in relation to the recommendation although this needs to be sustained to realise success. Impact has been demonstrated by performance improvements having been made.

*Fair progress*

The CPS has made some progress towards addressing the recommendation, but progress has either been slow, or has produced mixed or inconsistent results and more needs to be done to realise success. Impact has not been demonstrated; performance improvements have occurred but have not been sustained.

*Poor progress*

The CPS cannot demonstrate that any progress has been made, or it has been largely ineffective. Impact has not been demonstrated and there has been no substantial performance improvement.

Recommendation	Assessment	Commentary
1 Area specialists should be responsible for making pre-charge decisions in all road traffic cases involving fatalities and they should, wherever feasible, retain conduct of the case including advocacy or attendance at significant hearings such as trial or sentencing in the magistrates’ courts, until the conclusion of the proceedings.	Fair progress	All pre-charge decisions were taken by specialist prosecutors; the extent to which prosecutors retained conduct throughout was variable and to some extent was dependent upon the arrangements in place in a CPS Area for the provision of in-house Crown Court advocacy.

Recommendation	Assessment	Commentary
2 Each area should appoint one specialist to assume the role of area coordinator, responsible for coordinating area cases and providing a focal point for ongoing consideration of legal developments in relevant law and practice.	Poor progress	There were isolated examples of individual prosecutors being regarded by a local police force as the individual to whom they should direct their queries and concerns. However no Area had an “area specialist coordinator”.
3 All specialists in road traffic cases involving fatalities should receive training to incorporate CPS legal guidance, national policy, communication skills, media handling, coroner’s inquests, and expert evidence.	Poor progress	There are no current accredited CPS training products designed to develop and maintain the specialist prosecutor role. One local Area had designed a course for its Crown Advocates.
4 Prosecutors should make charging decisions in road traffic fatality cases within 21 days of receipt of sufficient evidence to enable the prosecutor to reach a decision in all but the most substantial cases (time period to include approval by the Chief Crown Prosecutor).	Fair progress	Almost 30% of cases in our file sample were found to comply with this time limit. Many others were outside the 21 day limit but were returned to the police within a further 14 days and complied with local agreements. There were few examples of excessive delays.
5 The Director, Policy should expand the CPS guidance on prosecuting cases of bad driving to include instances of driving that created a significant example of a single bad mistake or error within the bullet pointed examples, as well as the examples of driving cited by the Sentencing Guidelines Council.	Excellent progress	Both the 2009 and 2013 versions of the CPS guidance on the charging of driving offences include this as an example of “bad” or dangerous driving.
6 Chief crown prosecutors should ensure that all fatal road traffic cases are considered after finalisation of proceedings, in order to analyse outcomes, identify any learning points and disseminate any lessons.	Poor progress	We found no evidence to support the view that there was any consistent analysis of outcomes in fatal road traffic incident cases.
7 The CPS should clarify and collate the guidance relating to its commitments to victims’ families in road traffic fatality cases.	Good progress	This was achieved by the publication in 2011 of the <i>Homicide Cases – Guidance on CPS service to bereaved families</i> which replaced the Victim Focus Scheme.
8 The CPS should issue guidance to clarify all the circumstances when letters should be sent to victims’ families and when a meeting with the prosecutor should be offered.	Fair progress	This was achieved by the publication in 2011 of the <i>Homicide Cases – Guidance on CPS service to bereaved families</i> but this inspection has shown that the guidance is not consistently applied nor is it well known to operational prosecutors.



Recommendation	Assessment	Commentary
<p>9 Chief crown prosecutors and area coordinators should agree with the police, or update, an area service level agreement or protocol on handling cases involving road traffic fatalities which deals with:</p> <ul style="list-style-type: none"> <li>• identification of a single point of contact or coordinator in each organisation;</li> <li>• arrangements for obtaining early advice or seeking a consultation with a specialist prosecutor including outside normal office hours;</li> <li>• standards of timeliness and quality covering investigation, file submission, charging, first hearing and other stages; and</li> <li>• grievance or appeal procedure where this differs from standard procedure under statutory charging.</li> </ul>	<p>Poor progress</p>	<p>At the time of our inspection those Areas which had agreements or protocols were either updating them or considering new agreements covering two or more police forces with whom they had been linked because of CPS restructuring.</p>
<p>10 Chief crown prosecutors should liaise with chief constables and establish a strategy group (where it does not already exist) to be the primary forum for review of the area service level agreement or protocol on handling cases involving road traffic fatalities. It should deal with:</p> <ul style="list-style-type: none"> <li>• joint analysis of case outcomes;</li> <li>• press and media handling;</li> <li>• relationships with HM coroners;</li> <li>• joint training of staff;</li> <li>• quality of forensic collision investigators' reports and other expert evidence;</li> <li>• operation of the Victim Focus scheme and victim and witness care in general;</li> <li>• new legislation and policy;</li> <li>• engagement with community groups representing victims' families; and</li> <li>• analysis of outcomes of meetings with bereaved families.</li> </ul>	<p>Poor progress</p>	<p>We were not aware of any such strategy groups having been formed to deal with fatal road traffic incidents.</p>

Recommendation	Assessment	Commentary
<p>11 Chief crown prosecutors should engage with coroners who represent jurisdictions within the CPS area and as a minimum:</p> <ul style="list-style-type: none"> <li>• identify a single point of contact to act as a first line of communication with the coroner’s office in their area;</li> <li>• reinforce to prosecutors the guidance about the timing of inquests in summary proceedings;</li> <li>• notify coroners of all CPS charging decisions in cases involving road traffic fatalities and decisions to take no further action in such cases; and</li> <li>• invite coroners to any area strategy group meetings or events.</li> </ul>	<p>Poor progress</p>	<p>Although in June 2013 a memorandum of understanding between the CPS, ACPO, the Chief Coroner and the Coroners’ Society of England and Wales had been signed and published we found no evidence that it had gained wide currency within the CPS; nor that its requirements on the part of prosecutors were being observed.</p>

**Conclusion**

7.3 We were informed by the CPS that publication of the 2008 review led to the development of an internal strategy paper designed to address all those recommendations which had not already been captured by timely changes to published policy and guidance. Although this paper was circulated within the organisation within a year of publication we have not been able to find any evidence of a real commitment to implement many of the recommendations.

7.4 It is accepted that the diminishing caseload nationally and the reducing incidence of fatal road traffic incidents will have been a factor in any consideration of how to deploy reducing resources. Nevertheless, the falling caseload has in no way reduced the real tragedy of each individual case nor should it lead to any diminution of professional care and diligence which a specialist prosecutor and other staff will wish to apply to a fatal road traffic incident. In fact, it could be argued that a smaller caseload generally and of such cases should allow more time to successfully complete the CPS’s own stated objectives and obligations.

7.5 Overall, the CPS must carefully re-assess the place within its priorities that the handling of these cases should rightly occupy. At the time of this inspection the perception that these cases no longer enjoyed the priority that they had in earlier years was hard to resist. Policies and guidance documents were of good quality and readily accessible but no systems existed to monitor compliance. Inspectors consider that the prevailing attitude opened the organisation to the risk of being unable to defend criticism of its approach to decision-making and victim care. Much of this could be addressed by improved record keeping, monitoring and data analysis.

## ANNEX 1 - DETAILED METHODOLOGY

### File examination

A sample of ten finalised cases involving fatal road traffic incidents was selected from each of six CPS Areas. Wherever possible cases were selected that had been investigated by the police force included in this review, but in two of the Areas it was necessary to select cases investigated by neighbouring forces within the Area. The finalised cases covered a significant period of time from early 2012 until late 2013. Cases with various outcomes were selected including guilty pleas, convictions after trial, acquittals after trial, and those discontinued by the prosecution.

In addition to these finalised cases, a further two cases per Area were chosen where the CPS had decided not to take any action against any suspect.

This created a file sample of 72 cases which were examined against a question set contained within a database designed exclusively for this inspection. Relevant results of the file examination exercise are contained in Annex 7.

Where inspectors considered that a decision by a CPS prosecutor did not comply with the *Code for Crown Prosecutors* a consultation was set up with CPS lawyers nominated by them for this purpose.

Finally a further two case files were examined in each police force area where the decision had been made by the police not to charge any individual with any offence without referring the file to the CPS. These checks were undertaken to ensure that the police were applying the correct test before retaining or referring investigations for a decision.

### Interviews

In each CPS Area inspectors interviewed a cross-section of CPS staff including:

- Deputy Chief Crown Prosecutors;
- Crown Court unit managers or Complex Casework Unit managers;
- specialist fatal road traffic prosecutors; and
- administrative staff dealing with victim and witness care.

At CPS Headquarters we spoke to senior prosecutors in the Strategy and Policy Division.

In each police force area the following groups of police staff were interviewed as well as the senior officer in charge of the force's roads policing strategy:

- senior investigating officers;
- forensic collision investigators;
- first responders; and
- family liaison officers.

At national level we spoke to senior police staff within the College of Policing and Roads Policing Learning Project.

We also spoke to members of the judiciary and interest groups.

### **Views of bereaved families**

A key theme of this inspection was the experience of bereaved families and their treatment by the criminal justice system in its widest sense. A survey was prepared for distribution by two of the leading charities involved in providing advice and support to families. A total of 24 questionnaires were completed and many of the comments and experiences recounted by families have given us eloquent testimony about how many of those most closely affected feel about what happened to them and what is still happening to them every day.

## ANNEX 2 - INSPECTION OBJECTIVES

- To assess the impact of the new offences introduced by the Road Safety Act 2006 including causing death by careless driving.
- To assess the impact and application of the new CPS guidance on driving offences published in May 2013.
- To assess the potential impact of the CPS structural changes and its “refocusing agenda” on the responsibility of prosecutors for decision-making in fatal road traffic incident cases; looking at quality and timeliness.
- To consider the impact of reduced budgets on the capacity of police collision investigation units to carry out effective and high quality investigations into fatal road traffic incidents.
- To assess the quality of CPS decision-making both at the charging stage and subsequently.
- To measure the quality of service provided to bereaved families by the police and CPS.
- To assess the effectiveness of engagement by the police and CPS with groups or organisations representing victims’ families at local or national level, as well as organisations representing road users more generally.
- To consider the availability and effectiveness of any specific training for police and prosecutors.
- To examine what local or regional arrangements exist between the CPS and police in terms of service level agreements and area strategy groups dealing specifically with fatal road traffic incident cases.
- To evaluate the impact of the revised role for coroners and the recently issued memorandum of understanding signed by ACPO, the CPS, Chief Coroner and the Coroners’ Society of England and Wales.
- To identify any good or innovative practice by the CPS or police.
- To monitor and report on the level of progress made by the CPS towards implementation of the 11 recommendations made by the 2008 review.



## ANNEX 3 - RECOMMENDATIONS MADE IN HMCPSI'S 2008 THEMATIC REVIEW

- 1 Area specialists should be responsible for making pre-charge decisions in all road traffic cases involving fatalities and they should, wherever feasible, retain conduct of the case including advocacy or attendance at significant hearings such as trial or sentencing in the magistrates' courts, until the conclusion of the proceedings (paragraph 3.13).
- 2 Each area should appoint one specialist to assume the role of area coordinator, responsible for coordinating area cases and providing a focal point for ongoing consideration of legal developments in relevant law and practice (paragraph 3.17).
- 3 All specialists in road traffic cases involving fatalities should receive training to incorporate CPS legal guidance, national policy, communication skills, media handling, coroner's inquests, and expert evidence (paragraph 3.19).
- 4 Prosecutors should make charging decisions in road traffic fatality cases within 21 days of receipt of sufficient evidence to enable the prosecutor to reach a decision in all but the most substantial cases (time period to include approval by the Chief Crown Prosecutor) (paragraph 4.17).
- 5 The Director, Policy should expand the CPS guidance on prosecuting cases of bad driving to include instances of driving that created a significant example of a single bad mistake or error within the bullet pointed examples, as well as the examples of driving cited by the Sentencing Guidelines Council (paragraph 5.14).
- 6 Chief crown prosecutors should ensure that all fatal road traffic cases are considered after finalisation of proceedings, in order to analyse outcomes, identify any learning points and disseminate any lessons (paragraph 5.60).
- 7 The CPS should clarify and collate the guidance relating to its commitments to victims' families in road traffic fatality cases (paragraph 8.3).
- 8 The CPS should issue guidance to clarify all the circumstances when letters should be sent to victims' families and when a meeting with the prosecutor should be offered (paragraph 8.16).
- 9 Chief crown prosecutors and area coordinators should agree with the police, or update, an area service level agreement or protocol on handling cases involving road traffic fatalities which deals with:
  - identification of a single point of contact or coordinator in each organisation;
  - arrangements for obtaining early advice or seeking a consultation with a specialist prosecutor including outside normal office hours;
  - standards of timeliness and quality covering investigation, file submission, charging, first hearing and other stages; and
  - grievance or appeal procedure where this differs from standard procedure under statutory charging (paragraph 9.5).

- 10 Chief crown prosecutors should liaise with chief constables and establish a strategy group (where it does not already exist) to be the primary forum for review of the area service level agreement or protocol on handling cases involving road traffic fatalities. It should deal with:
  - joint analysis of case outcomes;
  - press and media handling;
  - relationships with HM coroners;
  - joint training of staff;
  - quality of forensic collision investigators' reports and other expert evidence;
  - operation of the Victim Focus scheme and victim and witness care in general;
  - new legislation and policy;
  - engagement with community groups representing victims' families; and
  - analysis of outcomes of meetings with bereaved families (paragraph 9.6).
  
- 11 Chief crown prosecutors should engage with coroners who represent jurisdictions within the CPS area and as a minimum:
  - identify a single point of contact to act as a first line of communication with the coroner's office in their area;
  - reinforce to prosecutors the guidance about the timing of inquests in summary proceedings;
  - notify coroners of all CPS charging decisions in cases involving road traffic fatalities and decisions to take no further action in such cases; and
  - invite coroners to any area strategy group meetings or events (paragraph 9.19).



## ANNEX 4 - SUBJECTS FOR CPS AREA COORDINATORS

- Consistency of early investigative advice and other pre-charge decision-making.
- Analysis of outcomes.
- Agreeing and refreshing service level agreements and protocols with one or more police forces.
- Quality assurance of decision-making aligned to Casework (previously Core) Quality Standards.
- Review of expert evidence.
- Monitoring of advocacy standards.
- Maintaining appropriate liaison with the regional coroners.
- Ensuring that all Area specialists are updated with developments in guidance and policy.
- Feeding back to the Chief Crown Prosecutor lead on road traffic or to the CPS Senior Policy Advisor on local issues.
- Monitoring compliance with the obligations on the CPS to communicate with bereaved families.



## **ANNEX 5 - CPS MEETINGS WITH BEREAVED FAMILIES**

The service to bereaved families guidance requires the CPS to offer a meeting in the following circumstances:

- Prior to or following a charging decision.
- Prior to or following a decision to discontinue or substantially alter a charge.
- Pre-trial or plea.
- Following conviction or acquittal.
- Following a sentencing hearing.
- Following leave to appeal being granted.
- In cases re-referred for consideration of a re-trial following an acquittal.



## ANNEX 6 - AVAILABLE OFFENCES AND PENALTIES

Charge, mode of trial and creating provision	Brief definition	Maximum penalty
Manslaughter (indictable only)  Contrary to common law	Causing death by an unlawful act or by a breach of a duty of care owed to the victim which was grossly negligent.	Life imprisonment. Obligatory disqualification for 2 years. Mandatory extended driving re-test.
Causing death by dangerous driving (indictable only)  Contrary to section 1 Road Traffic Act 1998	Causing the death of another person by driving dangerously.	14 years' imprisonment. Obligatory disqualification for 2 years. Mandatory extended driving re-test.
Causing death by careless driving when under the influence of drink or drugs or having failed either to provide a specimen for analysis or to permit analysis of a blood sample (indictable only)  Contrary to section 3A Road Traffic Act 1998	Causing the death of another person by driving without due care and attention or without reasonable consideration when under the influence of drink or drugs or having failed either to provide a specimen for analysis or to permit analysis of a blood sample.	14 years' imprisonment. Obligatory disqualification for 2 years (3 years if there is a relevant conviction) unless special reasons are found not to disqualify. Mandatory extended driving re-test.
Causing death by careless driving (triable either way)  Contrary to section 2B Road Traffic Act 1998 (as amended by the Road Safety Act 2006)	Causing the death of another person by driving without due care and attention or without reasonable consideration.	5 years' imprisonment. Obligatory disqualification for 12 months. Discretionary driving re-test.
Causing death by driving while unlicensed, uninsured or disqualified (triable either way)  Contrary to section 3ZB Road Traffic Act 1998 (as amended by the Road Safety Act 2006)	Causing the death of another person by driving and, at the time when driving, is committing an offence of driving without a licence, driving while disqualified or driving while uninsured.	2 years' imprisonment. Obligatory disqualification for 12 months. Discretionary driving re-test.
Aggravated vehicle taking where death results (either way)  Contrary to section 12A Theft Act 1968	Taking a vehicle without the consent of the owner, or knowing the vehicle has been so taken driving it or allowing oneself to be carried in or on it, and it being proved that any person's death was caused in certain specified circumstances.	13 years' imprisonment. Obligatory disqualification for 12 months and endorsement.



## ANNEX 7 - FILE EXAMINATION RESULTS

Question	Answer	Total	Percentage	ACEP 2013 percentage
1 What type of vehicle was the defendant driving	HGV	13	18.1	–
	PSV	5	6.9	–
	ESV	0	0.0	–
	Private car/van	53	73.6	–
	Motor cycle	1	1.4	–
	Pedal cycle	0	0.0	–
	Other	0	0.0	–
	Total	72	100	–
2 Was the deceased	Occupant of a motor vehicle	35	48.6	–
	Rider or passenger of a motor cycle	14	19.4	–
	Pedal cyclist	2	2.8	–
	Pedestrian	21	29.2	–
	Other	0	0.0	–
	Total	72	100	–
3 Was the deceased a “friend or family member” of the defendant	Yes	13	18.1	–
	No	59	81.9	–
	Total	72	100	–
4 Where did the fatal collision take place	Motorway	5	6.9	–
	Dual carriageway	18	25.0	–
	Other trunk or main road - urban	13	18.1	–
	Other trunk or main road - rural	15	20.8	–
	Minor road - urban	9	12.5	–
	Minor road - rural	11	15.3	–
	Other	1	1.4	–
	Total	72	100	–

ESV emergency service vehicle    HGV heavy goods vehicle    PSV public service vehicle

Question	Answer	Total	Percentage	ACEP 2013 percentage
5 When did the fatal collision take place	Daylight hours	39	54.2	–
	During the hours of darkness	25	34.7	–
	Twilight hours	8	11.1	–
	Total	72	100	–
6 What was principal offence charged	Causing death by dangerous driving	21	35.0	–
	Causing death by careless driving	30	50.0	–
	CDBC + alc/unfit/FTP*	5	8.3	–
	Causing death while disqualified from driving	0	0.0	–
	Causing death while uninsured/unlicenced	1	1.7	–
	Manslaughter/ other homicide	1	1.7	–
	Dangerous driving	1	1.7	–
	Careless driving	0	0.0	–
	Other	1	1.7	–
	Not applicable	12	0.0	–
	Total	72	100	–
7 If convicted was defendant sentenced	Immediate custody	26	59.1	–
	Suspended custody	10	22.7	–
	Community penalty	6	13.6	–
	Financial penalty	2	4.5	–
	Combination	0	0.0	–
	Not applicable	28	0.0	–
Total	72	100	–	
8 If convicted was there any appeal by defendant	Yes	8	18.2	–
	No	36	81.8	–
	Not applicable	28	0.0	–
	Total	72	100	–

\* see Annex 6 for full list of offences



Question	Answer	Total	Percentage	ACEP 2013 percentage
9 If convicted was there any referral by CPS of the case as an unduly lenient sentence	Yes	0	0.0	–
	No	41	100	–
	Not applicable	31	0.0	–
	Total	72	100	–
10 Did the charging decision comply with the Code test	Yes	64	88.9	91.0
	No	8	11.1	9.0
	Total	72	100	100
11 The MG3 included proper case analysis and strategy	Fully met	29	40.3	49.2
	Partially met	26	36.1	34.4
	Not met	17	23.6	16.4
	Total	72	100	100
12 Were all factors relevant to mode of trial/ allocation considered	Fully met	21	45.7	74.5
	Partially met	14	30.4	17.0
	Not met	11	23.9	8.5
	Not applicable	26	0.0	0.0
	Total	72	100	100
13 Was due regard paid to the relevant sentencing guidelines	Fully met	21	35.6	–
	Partially met	13	22.0	–
	Not met	25	42.4	–
	Not applicable	13	0.0	–
	Total	72	100	–
14 Was there proper account taken of current CPS policy and guidance on driving offences	Fully met	34	47.2	–
	Partially met	22	30.6	–
	Not met	16	22.2	–
	Not applicable	0	0.0	–
	Total	72	100	–
15 Was the decision clearly authorised at the right level within the CPS Area	Yes	39	54.2	–
	No	33	45.8	–
	Not known	0	0.0	–
	Total	72	100	–

Question	Answer	Total	Percentage	ACEP 2013 percentage
16 Was the decision made within 21 days of the submission of a sufficient file of evidence by the police	Yes	21	29.2	–
	No	39	54.2	–
	Not known	12	16.7	–
	Total	72	100	–
17 Rate the overall quality of the MG3	Excellent	1	1.4	0.5
	Good	30	41.7	38.6
	Fair	22	30.6	43.4
	Poor	19	26.4	17.5
	Total	72	100	100
18 Was the quality of any post-charge reviews carried out by the prosecutor sufficient	Fully met	15	25.4	52.3
	Partially met	11	18.6	29.4
	Not met	33	55.9	18.2
	Not applicable	13	0.0	0.0
	Total	72	100	100
19 The lawyer or team complied fully with the duty of continuous review in accordance with the Code test (including any decision to end any charge)	Yes	52	86.7	90.4
	No	8	13.3	9.6
	Not applicable	12	0.0	0.0
	Total	72	100	100
20 Was the case dealt with throughout by the same allocated prosecutor	Yes	23	38.3	–
	No	35	58.3	–
	Not applicable	12	0.0	–
	Not known	2	3.3	–
	Total	72	100	–
21 Was there timely compliance with any court directions (including judges' orders)	Fully met	32	61.5	55.1
	Partially met	11	21.2	32.4
	Not met	9	17.3	12.5
	Not applicable	20	0.0	0.0
	Total	72	100	100

Question	Answer	Total	Percentage	ACEP 2013 percentage
22 Sufficient written instructions were prepared for the advocate	Fully met	18	31.0	27.9
	Partially met	32	55.2	49.6
	Not met	8	13.8	22.5
	Not applicable	14	0.0	0.0
	Total	72	100	100
23 Was any input from counsel or Crown Advocate properly recorded on the file and on CMS as appropriate	Yes	30	61.2	76.9
	No	19	38.8	23.1
	Not applicable	23	0.0	0.0
	Total	72	100	100
24 Rate the overall quality of handling of unused material by the CPS	Excellent	0	0.0	2.9
	Good	23	42.6	22.8
	Fair	17	31.5	45.1
	Poor	14	25.9	29.2
	Not applicable	18	0.0	0.0
	Total	72	100	100
25 The case was correctly recorded on CMS	Fully met	41	56.9	53.1
	Partially met	21	29.2	37.6
	Not met	10	13.9	9.3
	Total	72	100	100
26 File endorsements and housekeeping were accurately and appropriately maintained	Fully met	34	47.2	40.3
	Partially met	21	29.2	46.6
	Not met	17	23.6	12.8
	Total	72	100	100
27 The prosecution was right to accept or reject any pleas offered and/or any basis of plea	Yes	19	90.5	85.0
	No	2	9.5	6.3
	Not applicable	51	0.0	0.0
	Not known	–	–	8.8
	Total	72	100	100

Question	Answer	Total	Percentage	ACEP 2013 percentage
28 Was the decision to accept or reject any pleas authorised at the appropriate level	Yes	10	52.6	–
	No	9	47.4	–
	Not known	0	0.0	–
	Not applicable	53	0.0	–
	Total	72	100	–
29 Was any decision to discontinue or otherwise stop the case authorised at the appropriate level	Yes	3	25.0	–
	No	9	75.0	–
	Not known	0	0.0	–
	Not applicable	60	0.0	–
	Total	72	100	–
30 Was the charging decision communicated appropriately to the victim’s family	Yes	12	16.7	–
	No	60	83.3	–
	Not applicable	0	0.0	–
	Total	72	100	–
31 Were the victim’s family notified in a timely and accurate way of all court hearings and outcomes	Fully met	3	5.0	–
	Partially met	13	21.7	–
	Not met	44	73.3	–
	Not applicable	12	0.0	–
	Total	72	100	–
32 Were the victim’s family consulted appropriately about the acceptance of pleas or changes to charges	Yes	11	61.1	–
	No	7	38.9	–
	Not applicable	54	0.0	–
	Total	72	100	–
33 Were the victim’s family consulted appropriately about any decision to discontinue the case	Yes	7	63.6	–
	No	4	36.4	–
	Not applicable	61	0.0	–
	Total	72	100	–
34 Was there timely Direct Communication with Victims/Victim Focus Scheme communication with the victim’s family	Yes	6	27.3	59.4
	No	16	72.7	40.6
	Not applicable	50	0.0	0.0
	Total	72	100	100

Question	Answer	Total	Percentage	ACEP 2013 percentage
35 The Direct Communication with Victims/Victim Focus Scheme communication was of high quality	Fully met	2	12.5	32.7
	Partially met	5	31.3	45.9
	Not met	9	56.3	20.1
	Not applicable	56	0.0	0.0
	Not known	–	–	1.3
	Total	72	100	100
36 If any meeting was held with the victim’s family, were adequate notes made and recorded on CMS or on the file	Yes	5	25.0	–
	No	15	75.0	–
	Not applicable	52	0.0	–
	Total	72	100	–
37 Were the victim’s family notified appropriately of any appeal against conviction and/or sentence	Yes	0	0.0	–
	No	8	100	–
	Not applicable	64	0.0	–
	Total	72	100	–
38 Were the victim’s family notified appropriately of any reference by the prosecution of a case to the Attorney General as an unduly lenient sentence	Yes	0	0.0	–
	No	0	0.0	–
	Not applicable	72	0.0	–
	Total	72	100	–
39 Where the decision was taken on or after 5 June 2013, was the Victims’ Right to Review Scheme operated appropriately by the CPS	Yes	5	31.3	–
	No	11	68.8	–
	Not applicable	56	0.0	–
	Total	72	100	–
40 Rate the overall quality of communications/liaison with the victim’s family	Excellent	0	0.0	–
	Good	1	1.4	–
	Fair	17	23.6	–
	Poor	54	75.0	–
	Total	72	100	–

Question	Answer	Total	Percentage	ACEP 2013 percentage
41 In any case resulting in an unsuccessful outcome, was there a report from the trial advocate	Yes	6	26.1	–
	No	17	73.9	–
	Not applicable	49	0.0	–
	Total	72	100	–
42 Where the case resulted in an unsuccessful outcome, was an adequate adverse outcome report completed and recorded on CMS	Yes	4	15.4	–
	No	22	84.6	–
	Not applicable	46	0.0	–
	Total	72	100	–
43 Was there any communication with the coroner of CPS decisions	Yes	4	5.6	–
	No	67	94.4	–
	Not applicable	1	0.0	–
	Total	72	100	–
44 Rate the overall quality of communications between the CPS and the Witness Care Unit	Excellent	0	0.0	–
	Good	29	56.9	–
	Fair	20	39.2	–
	Poor	2	3.9	–
	Not applicable	21	0.0	–
	Total	72	100	–
45 Rate the overall quality of liaison between the CPS and the police (including the SIO, FLO and any criminal justice department)	Excellent	0	0.0	–
	Good	49	68.1	–
	Fair	21	29.2	–
	Poor	2	2.8	–
	Total	72	100	–
46 Was the indictment correctly drafted in all respects	Yes	45	77.6	81.6
	No	13	22.4	18.4
	Not applicable	14	0.0	0.0
	Total	72	100	100



HM Crown Prosecution Service Inspectorate  
London Office:  
One Kemble Street  
London WC2B 4TS  
Tel. 020 7210 1185

HM Inspectorate of Constabulary  
6th Floor  
Globe House  
89 Eccleston Square  
London SW1V 1PN  
Tel. 020 3513 0500

Website:  
[www.justiceinspectorates.gov.uk/hmcp/psi/](http://www.justiceinspectorates.gov.uk/hmcp/psi/)  
[www.justiceinspectorates.gov.uk/hmic/](http://www.justiceinspectorates.gov.uk/hmic/)

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