The second thematic review of Crown Prosecution Service decision-making, conduct and prosecution of cases arising from road traffic offences involving fatalities

Executive Summary

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Promoting Improvement in Criminal Justice

HMcpsi
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Introduction

This is the summary of Her Majesty's Crown Prosecution Service Inspectorate's (HMCPSI) report on the second thematic review of Crown Prosecution Service (CPS) decision-making, conduct and prosecution of road traffic offences involving fatalities in England and Wales.

Background

HMCPSI published a thematic review of the advice, conduct and prosecution by the CPS of road traffic offences involving fatalities in November 2002. The report made a total of 17 recommendations and four suggestions, most of which are still relevant. It also identified two aspects of CPS performance that might be regarded as good practice and commended three.

The CPS responded by preparing an action plan indicating whether the recommendations and suggestions were accepted and, for those that were, setting out the proposals to address them with timescales for achievement.

Since that time there has been considerable public attention focussed on fatal road traffic motoring incidents and this has been reflected in a number of initiatives by government, including changes in the substantive law. These made it an opportune moment to revisit the issue.

Following a public consultation carried out by the Home Office in 2005 the Road Safety Act 2006 was passed, which introduced new offences of causing death by careless driving and causing death while driving unlawfully on a road. The new offences were brought into operation on 18 August 2008. On 16 July 2008 the Sentencing Guidelines Council issued new guidelines for driving offences where there has been a fatality, including the new offences, following a public consultation by the Sentencing Advisory Panel.

The CPS launched a public consultation on its policy and practice in prosecuting bad driving in December 2006 and the summary of responses was published in September 2007. The resulting CPS policy for prosecuting cases of bad driving was published on 20 December 2007. New legal guidance has also been issued to complement the publication of the policy (in January 2008, updated that August).

The number of people killed on the roads in England and Wales (and Scotland) has been falling over the past two decades: by 7% from 3,172 in 2006 to 2,946 in 2007, and in 2007 was 17.7% below the 1994-98 average. The numbers are still high and subject to government targets for reduction. There remains great public interest in how fatal road traffic collisions are dealt with and particular concern to see those whose driving causes the death of others being suitably prosecuted and punished.

Purpose

The purpose of the inspection was to analyse and assess the quality of the decision-making, conduct and prosecution by the CPS of road traffic offences involving fatalities; and to assess progress against the relevant recommendations and suggestions made in the previous report.

The full scope of the inspection was to:

- assess progress against the recommendations and suggestions of the 2002 review;
- assess the implementation of good practice identified in the 2002 review;
- assess the impact of the revised guidance on policy and practice taking account of the time lags associated with policy and, where applicable, legislation;
- consider the impact of new initiatives, for example statutory charging, direct communication with victims, witness care units, the Prosecutors' Pledge, Victims' Code, and Victim Focus scheme;

- assess the quality and timeliness of decision-making, including the selection of charges in cases which are prosecuted;
- assess the quality of case preparation and handling;
- examine the treatment of victims' families and witnesses;
- make recommendations for improvement; and
- identify good practice.

Methodology

The areas visited were a representative sample of rural and urban environments from which to draw evidence.

Inspectors examined a total of 114 files. Of these 107 (54 magistrates' courts, 44 Crown Court and nine advices to take no further action) were finalised cases. The remaining seven (four magistrates' courts and three Crown Court) were 'live' trials, identified in conjunction with the areas, which inspectors observed at the relevant court centre. They observed the conduct of 13 road traffic fatality cases in court (eight in the magistrates' and five in the Crown Court).

Inspectors interviewed CPS staff and met or received comments from police officers, police staff dealing with witness care, other representatives of criminal justice agencies and organisations representing victims' families. Information was also received from coroners, individually and through questionnaires, through the Coroners' Society of England and Wales.

They also met a number of individuals who provided HMCPSI with details of their own experiences as relatives of victims who had been killed in road traffic collisions.

HMCPSI was assisted by a lay inspector who examined the way in which the CPS related to the victims' families and the application of the public interest test contained in the Code for Crown Prosecutors (the Code).

Findings

Overall, the quality of decision-making in fatal road traffic cases is good and cases are handled well after charge.

There were a few difficult cases in the sample where the decision on level of charge was very much in the balance and it could properly have tipped towards the more serious charge. Although inspectors would not go so far as to describe them as "wrong", these cases could also justify being prosecuted as causing death by dangerous driving, rather than the careless driving selected. It would seem that in these cases prosecutors tended to select the lower, rather than the higher, of the feasible charges.

Again there were also a few cases where prosecutors had concluded that there was insufficient evidence to prosecute, which inspectors considered could equally properly have been brought before the court.

The 2002 report recommended that the guidance in relation to fatal road traffic cases and the driving offences standard be reviewed. The CPS revised the standard and incorporated it within the legal guidance on driving offences, which was reissued at the end of 2004. The CPS policy for prosecuting cases of bad driving was published in December 2007 and the CPS has provided revised guidance to complement it. Inspectors consider that the guidance should be expanded to provide further assistance on what constitutes dangerous driving.

The CPS has worked hard to improve its care of victims' families since the 2002 report and has demonstrated a high level of commitment to delivering the Justice for All government targets. This commitment has improved the standard of care provided to families, although there is still room for improvement.

Some good work is being carried out in relation to working with the other agencies and community groups representing victims' families. There remains a need, however, to formalise some working relationships, to develop links with coroners, and for greater engagement with community groups on a local level.

An effective prosecution

The 2002 report recommended that areas nominate one or more lawyers to handle fatal road traffic cases and that they should receive appropriate training. All areas have now nominated specialists but there is no national, or nationally approved, training for specialists. The majority are assigned to such cases by virtue of their general skill as experienced prosecutors.

There is no consistent approach to case handling after charge and specialists do not all retain conduct of the case throughout the proceedings. There is a need for continuity of handling, including conducting the trial in the magistrates' courts, by a specialist or suitably experienced prosecutor working under the supervision of a specialist.

There is no network for the specialists which would facilitate the sharing of experiences and casework lessons. Although cases are handled well in the main a more coordinated approach would bring further improvements.

Timely access to pre-charge advice and decisions

The statutory charging arrangements provide for duty prosecutors to give pre-charge advice to the police and make decisions whether to charge in more serious and contested cases. This is done face-to-face at charging centres in relation to most types of cases. Pre-charge advice in fatal road traffic cases is usually made by way of written advices to the police, rather than through the duty prosecutor scheme. Prosecutors are thereby able to devote the time required to consider these sensitive cases. Areas have not lost sight of the need for early consultation and case building and inspectors were pleased to note that generally there is discussion with the police, and frequently the prosecution expert, before the formal advice is given.

Areas generally have special arrangements with the police for urgent advice, with some decisions being made by prosecutors outside of office hours. As is the case with all charges, the police are also able to seek charging decisions from prosecutors in CPS Direct.

Timeliness of charging decisions has declined since 2002: from an average of 21.4 days between receipt of a file and the decision being made in 2002 to 27.0 days. Although prosecutors made their charging decisions promptly in 63.2% of cases, they took longer than 14 days in just over a quarter of cases. The delay in prosecutor decision-making from the time of receipt of the evidence needs to be addressed. The fact that significant time often elapses between the date of a collision and submission of a report by the police to the CPS (which to some extent arises from the nature of the cases) makes it important that they should proceed from that stage with the minimum delay, consistent with thorough and careful handling.

The quality of decision-making

In the main the quality of decision-making in these cases is good and the presentation of advice to the police is of a high standard.

Prosecutors are making public interest decisions in accordance with the Code, although they are not always considering the views expressed by the victims' families.

Inspectors identified a few cases in the sample of 114 where the prosecutor selected a charge of careless driving when the evidence could have justified a charge of dangerous driving. These were all difficult cases which inspectors consider would have benefited from expanded guidance.

There is still a need for the CPS to ensure consistency of decision-making and chief crown prosecutors are now required to approve all decisions on charging and those to accept a plea to a lesser offence. Areas are not routinely keeping records of cases and outcomes, nor are they undertaking any analysis. This is particularly important now that the new legislation has been introduced and inspectors have made a recommendation designed to address this.

Prosecutors need to consider whether there is a need to visit the scene of the collision before making the charging decision. Expert evidence to establish the cause of the victim's death and comment upon how the collision occurred is generally obtained when necessary,

Case preparation

Fatal road traffic cases generally proceed expeditiously through the courts. Prosecutors keep cases under continuous review and undertake the necessary paperwork so that they are ready for the first date of hearing and subsequent hearings. There is, however, a need to liaise with the police to speed up the time between the decision to charge being made and the first date of hearing: there were cases in the sample where there was a delay of three to six months.

Performance in relation to the disclosure of unused material was found to be higher than the national averages in previous HMCPSI inspection cycles and the assessments made in the thematic inspection of disclosure, published in 2008. Prosecutors are handling cases with some care but the failure to complete disclosure record sheets, showing actions taken and the reasons for them, means that it can be difficult to ascertain what has been disclosed and why.

The quality of instructions to counsel was mixed with some being comprehensive and reflecting the seriousness of the case, but others simply comprising the police summary rather than any analysis of the issues.

Case management was generally good with the CPS case management system being properly used and court and file endorsements being better than in cases generally. The 2002 recommendation that file jackets be marked in order to facilitate easier identification has not been implemented in all areas, in particular Crown Court case files are often not marked.

The case at court

On the whole prosecutors take their responsibilities to victims' families very seriously. They are courteous and professional and comply with their obligations under the Prosecutors' Pledge and the Victims' Code, although there are some exceptions. The more inexperienced members of CPS staff would benefit from some training to assist them in the discharge of their duties towards victims' families.

Despite CPS guidance that in fatal road traffic cases the advocate in the magistrates' courts should ideally be the reviewing lawyer, cases are being handled by associate prosecutors and agents. Whilst there may not be any issues as far as the quality of advocacy is concerned, this can result in the victim's family not having the service to which the CPS aspires. As it is likely that the reviewing lawyer will have had a meeting with the victim's family (if CPS commitments have been complied with), the family has to meet another advocate at court who will not be as familiar with the case as the reviewing lawyer.

The overall standard of advocacy we observed was good. Most CPS prosecutors were very good: they were well prepared and empathetic in their interaction with victim's families. Counsel in the Crown Court were also very good. There were concerns, however, in relation to the use of agents in the magistrates' courts, with lack of time to prepare for trial in one instance and a reduced service to the victim's family in another.

Victims' families and witnesses

Since the 2002 report the CPS has introduced victim and witness care arrangements through the No Witness No Justice initiative and has also developed its direct communication with victims scheme (DCV) to explain the situation when a charge is withdrawn, discontinued or substantially altered. The families of victims who have died as a result of criminal conduct are included in these arrangements. In addition CPS guidance issued in 2006 provided for an enhanced provision of information to victims' families in fatal road traffic cases, which includes an offer of a meeting with the prosecutor. This has been extended further with the introduction of the Victim Focus scheme which came into force on 1 October 2007. Under the scheme prosecutors will offer to meet victims' families in fatal road traffic cases to explain the procedures in relation to the prosecution. The scheme includes the offences of causing death by dangerous driving, causing death by careless driving while under the influence of drink or drugs, causing death by careless driving, causing death by driving unlawfully, and aggravated vehicle taking where a death is involved.

The ten point Prosecutors' Pledge, introduced by the Attorney General on 21 October 2005, and the Victims' Code of Practice (the Victims' Code), issued by the Home Secretary under the Domestic Violence, Crime and Victims Act 2004 on 4 April 2006, set out commitments and minimum levels of service to be provided to victims. The families of victims who have died as a result of criminal conduct are included and are eligible to be provided with an enhanced level of support.

The CPS has worked hard since 2002 to improve the level of communication with victims' families. Although witness care units are responsible for keeping families informed of case progress, this is usually undertaken by the police family liaison officer. This can work well and inspectors saw many examples of excellent care of victims' families. There can, however, be gaps in communication with families if witness care units are not kept informed of developments in a case.

The overall quality of letters written to victims' families is good and of a much higher standard than found in other inspections. In the main letters were also sent promptly, although there were instances of delay in notifying families of sentences imposed upon defendants.

Nevertheless letters are not always sent in accordance with DCV, although there are few cases to which it applies. CPS policy also requires a letter to be sent to the victim's family once a charging decision has been made and a meeting to be offered. Such letters are not routinely being sent. There is also a mixed awareness of the obligations under the Victim Focus scheme on the part of prosecutors. This may be because there is a lack of clarity in the guidance issued to prosecutors, and there is a need for renewed guidance which covers all the circumstances in which a letter is required and when a meeting should be offered.

Where meetings with families are held they are not always conducted by a lawyer of sufficient seniority (to comply with CPS guidance), nor are they being evaluated as was recommended in the 2002 report.

The purpose of the victim personal statement scheme, which was introduced in 2001, is to give victims and victims' families a voice in the proceedings. Generally interviewees showed a good awareness of the scheme but prosecutors are not always requesting a statement, or an updated one, where necessary. There was no statement present on the file in half the cases within the sample.

Partnership working

Strengthening the relationship between the police and the CPS is key to improving the quality of investigations, charging decisions and the service offered to victims' families. There were good examples of well established links between the police and CPS at operational level, with an impressive extent of liaison in CPS London's dedicated traffic unit. Nevertheless there is a need for an area service level agreement or protocol setting out the arrangements for handling road traffic fatality cases, and inspectors have made a recommendation to address this. There is also a need for more joint work at a strategic level so that issues such as longer term trends and policy developments can be discussed.

Work still needs to be undertaken to promote a dialogue with coroners, in order to keep them informed of progress in fatal road traffic cases. This should contribute to more timely proceedings in both criminal courts and the coroner's court, with obvious benefits for the victims' families. Similarly areas need to ensure that they develop and maintain close and effective working relationships with witness care units so that they can provide timely and accurate information about the progress of cases.

The CPS at a national level, and to some extent locally, has established contacts with a number of groups who represent victims' families. This has extended to groups being consulted during the formulation of the CPS policy on bad driving and to attendance at national conferences and local group meetings. There remains, however, scope for greater engagement at a local level.

Recommendations

Inspectors have made the following 11 recommendations:

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).

Good practice

Inspectors identified the following items of good practice, which might warrant adoption nationally:

1 The continuity of prosecutor from the decision to prosecute to the conclusion of proceedings, including conducting the trial in the magistrates' courts (paragraph 3.12).

2 The formal policy in North Yorkshire whereby there is early consultation (within 72 hours) between the police and the CPS in all fatal road traffic cases in order to inform the way the case is investigated (paragraph 4.6).

3 The practice in CPS London of holding formal advice surgeries once a month for advice to be given in ongoing investigations (paragraph 4.6).

4 The protocol with the Metropolitan Police in CPS London whereby timescales and targets have been agreed for the submission by the police of the full investigative file and the provision by the CPS of advice (paragraph 4.11).

5 The circulation of good examples of letters written to victims' families (paragraph 8.19).

6 The sending of a letter after a meeting with the victim's family in order to confirm the key points discussed (paragraph 8.26).

The full text of the report may be obtained from the Corporate Services Group at HMCPS Inspectorate (telephone 020 7210 1197) and is also available online at www.hmcpsi.gov.uk.

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