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

November 2008

Promoting Improvement in Criminal Justice

HMcpsi
HM Crown Prosecution Service Inspectorate

If you ask us, we can provide a synopsis or complete version of this booklet in Braille, large print or in languages other than English.

For information or for more copies of this booklet, please contact our Publications Team on 020 7210 1197, or go to our website: www.hmcpsi.gov.uk

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

November 2008

Promoting Improvement in Criminal Justice

HMcpsi
HM Crown Prosecution Service Inspectorate

CONTENTS

1 Introduction and methodology 1
Purpose 1
Background 1
Range of offences and charges available 2
Scope of the inspection 3
Methodology 3
Structure of the report 4
Acknowledgements 4

2 Executive summary 5
Background 5
Purpose 5
Methodology 6
Findings 6
An effective prosecution 7
Timely access to pre-charge advice and decisions 7
The quality of decision-making 8
Case preparation 8
The case at court 9
Victims' families and witnesses 9
Partnership working 10
Recommendations 11
Good practice 12

3 An effective prosecution 15
Champions and specialists 15
Background 15
Area approaches to specialist prosecutors 15
Continuity of handling 16
Coordinating the approach 17
Training for specialist prosecutors 17
Legal guidance – the national approach 18

4 Timely access to pre-charge advice and decisions 19
The provision of advice and pre-charge decision-making 19
Early consultation 19
Arrangements for urgent advice 20
Timeliness of pre-charge decision-making 20
Case building 21

5 The quality of decision-making 23
Background 23
Charges and outcomes in the file sample 23
The quality of pre-charge advice and decisions 26
The decision not to prosecute 24
The decision to prosecute 24
Selection of the appropriate charge 24

Acceptance of pleas 26
The quality of decisions to discontinue 27
Consistency of decision-making 27
General trends 27
Evidential decisions 27
Public interest decisions 28
Review endorsements 29
Visits to the scene of the collision 29
Expert evidence 30
Cause of the victim's death 30
Standard of the defendant's driving 30
Unduly lenient sentences 31
Performance management and monitoring 31

6 Case preparation 33
Case progression 33
Disclosure of unused material 33
Instructions to the advocate 34
The magistrates' courts 34
The Crown Court 34
Case and file management 34
File endorsements 35

7 The case at court 37
Introduction 37
The prosecution in the magistrates' courts 37
Choice of advocate 37
The use of agents 37
The prosecution at the Crown Court 38
Choice of advocate 38
Attendance at court by the reviewing lawyer 39
Use of caseworkers 39
Advocacy monitoring 39
Listing 39
Victims' families at court 40
Attendance of victims' families at court 40
The facilities for victims' families at court 40
The prosecutor's responsibilities at court 40

8 Victims' families and witnesses 43
Background 43
Communicating with victims's families 44
Direct communication with victims 45
Letters written to victims' families outside the DCV scheme 46
Quality of letters written to victims' families 46
Timeliness of letters 47
Meetings with victims' families: frequency and evaluation 47
Meetings with victims' families: format 48
Timing of meetings 48
The Victim Focus scheme 49
The victim personal statement 49

9 Partnership working 51
Liaison with the police 51
Liaison with HM coroners 52
Liaison with witness care units 54
Engagement with community groups representing victims' families 55

Annexes

A: New offences of causing death by careless or inconsiderate driving and causing death by driving whilst unlicensed, disqualified or uninsured 57

B: CPS policy on prosecuting cases of bad driving 58

C: Implementation of recommendations and suggestions from 2002 report 60

D: Representatives of criminal justice agencies, other organisations and special interest groups and members of the public who assisted with the inspection 64

1 INTRODUCTION AND METHODOLOGY

Purpose

1.1 The purpose of the review was to:

- analyse and assess the quality of the decision-making, conduct and prosecution by the Crown Prosecution Service (CPS) of road traffic offences involving fatalities; and
- assess progress against the relevant recommendations and suggestions made in the previous report on this topic, which was published in November 2002.

Background

1.2 In 2001-02 Her Majesty's Crown Prosecution Service Inspectorate (HMCPSI) undertook a thematic review of the advice, conduct and prosecution by the CPS of road traffic offences involving fatalities. 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.

1.3 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.

1.4 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.

1.5 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 (sections 20 and 21 – set out in Annex A). 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.

1.6 In December 2006 the CPS launched a public consultation on its policy and practice in prosecuting bad driving, with the summary of responses published in September 2007. The resulting CPS policy for prosecuting cases of bad driving was published on 20 December 2007 (see the CPS website www.cps.gov.uk. The policy's introduction section and details of how to obtain a copy are set out in Annex B). New legal guidance was issued in January 2008, updated that August, to complement publication.

1.7 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.

Range of offences and charges available

1.8 As in 2002, the range of offences that could lead to a road traffic fatality is large. From the most serious indictable only offences of (very rarely, murder), manslaughter and causing death by dangerous driving to purely summary offences relating to the construction and use of vehicles, (such as defective brakes and speeding) and most commonly, up to 18 August 2008, careless driving. As stated above the range of offences has just been widened, to include two new offences which are triable either way (in the Crown Court or the magistrates' courts): causing death by careless driving and causing death while driving unlawfully on a road.

1.9 Although there are a variety of charges available they still fall into two distinct categories: those where the fatality is reflected in the charge itself and those where it is not.

1.10 Those where the death is reflected in the charge (including the two new offences) are set out below, together with the statutory provisions creating the offence, a brief definition and the maximum penalty available.

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 two years. Mandatory extended driving re-test
Causing death by dangerous driving (indictable only). Contrary to section 1 Road Traffic Act 1988	Causing the death of another person by driving dangerously	14 years' imprisonment. Obligatory disqualification for two 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 1988	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 two years (three 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 1988 (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	Five 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 1988 (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 or while disqualified or while uninsured	Two 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	14 years' imprisonment. Obligatory disqualification for 12 months and endorsement of licence

1.11 The potential charges available that do not reflect the death in the statement of the offence are varied. Dangerous driving is probably the most serious and it is triable either way, but the majority of other offences most commonly appropriate are purely summary (triable in the magistrates' courts only), such as careless driving and excess speed.

1.12 The inspection work was undertaken before the introduction of the two new offences. As a result, the charge selected in just under half of our file sample was that of careless driving – 55 cases out of 114.

1.13 Dangerous driving is committed when the way a person drives falls *far* below what would be expected of a competent and careful driver and it would be obvious to a competent and careful driver that driving in that way would be dangerous. Careless driving is committed when a person's driving falls below the standard expected of a competent and careful driver.

1.14 The CPS guidance reminds prosecutors that the manner of driving must be seen in the context of the surrounding circumstances in which it takes place. It also provides prosecutors with examples of decided cases which are typical of what is likely to be regarded as dangerous or careless driving.

1.15 Public concern remains about whether prosecutors are selecting the correct level of charge and we considered this issue during the course of the inspection. Although the introduction of the new offence of causing death by careless driving brings with it an increased level of sentence, it remains essential for prosecutors to select the correct charge. The comments we make, therefore, about decision-making in relation to the level of charge remain relevant.

Scope of the inspection

1.16 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

1.17 The purpose of a thematic inspection is to paint a picture about how a given subject is dealt with throughout England and Wales. This inspection considered the practice and performance of the CPS based on evidence drawn from a number of its areas.

1.18 Eight areas assisted us in our work: Devon and Cornwall, Dyfed Powys, Kent, Lancashire, London, North Yorkshire, Sussex and West Mercia. They represent a cross-section of areas in England and Wales and provide a mix of rural and urban environments from which to draw evidence.

1.19 The 2002 report made a total of 17 recommendations. In the course of this inspection, we have assessed the extent to which these have been implemented and what progress has been made; a synopsis is included at Annex C.

1.20 Files from all eight areas were examined and six visited: Kent, Lancashire, London, North Yorkshire, Sussex and West Mercia.

1.21 We examined a total of 114 files against a set database of questions. Of these, 107 (54 magistrates' courts, 44 Crown Court and nine advices to take no further action) were finalised cases from the eight. The remaining seven (four magistrates and three Crown Court) were 'live' trials, identified in conjunction with the areas, which we observed at the relevant court centres during our on-site visits.

1.22 We observed the conduct of 13 road traffic fatality cases in court (eight magistrates' courts and five Crown Court) in five areas. This enabled us to assess the performance of CPS staff and prosecution advocates and the care afforded to victims' families.

1.23 We interviewed CPS staff, both from areas and Headquarters. In addition, we met or received comments from police officers, police staff dealing with witness care, other representatives of criminal justice agencies and organisations representing victims' families.

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

1.25 We were also greatly assisted by information provided by coroners, individually and through questionnaires through the Coroners' Society of England and Wales.

1.26 A list of the individuals we met or from whom we received comments is at Annex D.

1.27 Shirley Ford, nominated by Victim Support, joined the inspection as an unpaid volunteer lay inspector. She 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). She considered letters written by CPS staff to victims' families, examined files that had raised public interest considerations, and also visited some courts. This was a valuable contribution to the inspection process. The views and findings of the lay inspector have been included in the report as a whole, rather than separately reported. She gave her time on a purely voluntary basis, and the Chief Inspector is grateful for her effort and assistance.

Structure of the report

1.28 In order to present the findings in a coherent and logical way the report follows a generally chronological order through each stage. After dealing with the way the CPS approaches the handling of fatal road traffic cases it then covers charging, reviewing the evidence for the prosecution, case preparation and the trial. Important issues such as care of the victims' families and liaison with the criminal justice agencies and other organisations and bodies are covered throughout the report at points where they most sensibly fit within the chronology of events, as well as being considered in more detail towards the end of the report.

Acknowledgements

1.29 The Chief Inspector and the inspection team are grateful for the cooperation, support and assistance of all those with whom they came into contact throughout the inspection.

2 EXECUTIVE SUMMARY

2.1 This is the summary of HMCPSI's second thematic review of the decision-making, conduct and prosecution by the CPS of road traffic offences involving fatalities in England and Wales.

Background

2.2 HMCPSI published a thematic review of the advice, conduct and prosecution by the CPS of road traffic offences involving fatalities in November 2002. The review 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.

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

2.4 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.

2.5 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.

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

2.7 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

2.8 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.

2.9 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

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

2.11 We 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' and three Crown Court) were 'live' trials, identified in conjunction with the areas, which we observed at the relevant court centre. We also observed the conduct of 13 road traffic fatality cases in court (eight magistrates and five Crown Court).

2.12 We 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. We also received information from coroners, individually and through questionnaires through the Coroners' Society of England and Wales.

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

2.14 We were 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.

Findings

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

2.16 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 we 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.

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

2.18 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. We consider that the guidance should be expanded to provide further assistance on what constitutes dangerous driving.

2.19 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 victims' families, although there is still room for improvement.

2.20 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, develop links with coroners, and for greater engagement with community groups on a local level.

An effective prosecution

2.21 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.

2.22 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.

2.23 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

2.24 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 a discussion with the police, and frequently the prosecution expert, before the formal advice is given.

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

2.26 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 to 27 days. Although, prosecutors made their charging decisions promptly in 63.2% of cases, they took longer than 14 days in just over a quarter. The delay in 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 cases should proceed from that stage with the minimum delay, consistent with thorough and careful handling.

The quality of decision-making

2.27 In the main, the quality of decision-making in fatal road traffic cases is good and the presentation of advice to the police is of a high standard.

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

2.29 Inspectors identified a few instances in the sample of 111 cases 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 we consider would have benefited from expanded guidance.

2.30 There is still a need for the CPS to ensure consistency of decision-making and Chief Crown Prosecutor (CCPs) are now required to approve all charging decisions 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 we have made a recommendation designed to address this.

2.31 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

2.32 Fatal road traffic cases generally proceed expeditiously through the courts. Prosecutors keep cases under continuous review and undertake the necessary paperwork so that cases 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 instances in the sample where there was a delay of three-six months.

2.33 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 our thematic inspection Disclosure of unused material undertaken by the CPS, 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.

2.34 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.

2.35 Case management was generally good with the CPS case management system (CMS) being properly used and court and file endorsements 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 files are often not marked.

The case at court

2.36 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 (see paragraph 2.40), although there are some exceptions. More inexperienced members of CPS staff would benefit from some training to assist them in the discharge of their duties towards victims' families.

2.37 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.

2.38 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 the 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

2.39 Since the 2002 report the CPS has introduced victim and witness care arrangements through the No Witness No Justice (NWNJ) initiative and has also developed its direct communication with victims (DCV) scheme 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 (VFS), 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 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.

2.40 The ten point Prosecutors' Pledge, introduced by the then 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.

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

2.42 The overall quality of letters written to 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 them of sentences imposed upon defendants.

2.43 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 with the prosecutor to be offered. Such letters are not routinely being sent. There is also mixed awareness of the obligations under the VFS 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.

2.44 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.

2.45 The purpose of the victim personal statement (VPS) 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 VPS present on the file in half the cases within the sample.

Partnership working

2.46 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 we 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.

2.47 Work still needs to be undertaken in order 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 WCUs so that families are provided with timely and accurate information about the progress of cases.

2.48 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

2.49 We 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

2.50 We 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).

3 AN EFFECTIVE PROSECUTION

Champions and specialists

Background

3.1 The 2002 report found that CPS areas had different systems for allocating road traffic cases involving fatalities to prosecutors for advice, review and conduct. Although areas ensured they were given to lawyers of sufficient appropriate experience, their level differed. In most areas cases were handled by a senior lawyer, but in others by the unit head and even the CCP because they considered the sensitivity of such cases merited them being dealt with at the highest level. Thus the number of lawyers in each area dealing with cases varied, although nearly all had a system of referral to the CCP in certain circumstances, such as disagreement with the police on the level of charge.

3.2 Although the 2002 report concluded that the various approaches were not necessarily a cause for concern, it was considered that a system which ensured review and management of cases by trained specialists would reduce inconsistencies in decision-making. The report therefore recommended that areas should nominate one or more lawyers to handle road traffic cases involving fatalities and that they should receive appropriate specialist training.

3.3 Following the issue of the last report the CPS responded by preparing an action plan indicating whether the recommendations and suggestions were accepted and, if they were, setting out the proposals to address them with timescales for achievement. As part of this process areas were also requested to report on their position to inform the national action plan. Since the initial response, however, the action plan has not been updated nor has progress been monitored.

Area approaches to specialist prosecutors

3.4 The CPS responded to this recommendation by asking each area to nominate two specialists to attend one of two seminars. The seminars dealt with the recommendation and comments in the report relating to the use of specialists and were more of an awareness raising exercise than a training session. No national training was proposed or planned and no specific guidance or instructions were given in relation to training of specialists. It was left to areas to make individual arrangements if they considered it necessary.

3.5 Although areas now have nominated specialists there are still different approaches. Some have a single specialist or coordinator – in one this is the CCP. Others have a number of specialists (up to eight or so), sometimes dealing with cases area-wide and sometimes organised on a district basis. Some have an overall coordinator; others do not.

3.6 CPS London has its own unique system. In 2002 it established the London Traffic Prosecution Service (LTPS), based in Sidcup, to deal with all traffic summonses for London. The LTPS deals with all advice work and prosecutions in the magistrates' courts. If the Service advises prosecution of a case in the Crown Court it is handled by the local borough unit in CPS London. The area is proposing to move all traffic work, including Crown Court casework, to the LTPS in the next two years and has started the planning process.

3.7 Although area arrangements for, and the numbers of, specialists vary the deployment of them to provide advice to the police and review cases is very similar. These arrangements generally ensure that advice on charges is provided by specialists outside of charging centres.

3.8 There is, however, no consistent approach towards case handling by specialists after charge. In many instances they will retain conduct of the case in terms of review and case preparation, but that is not universal. In some, specialists may supervise the handling of cases by other prosecutors who are wishing to gain appropriate experience.

3.9 All nine advices to take no further action in our file sample were handled by a specialist. The decision to prosecute was made by a specialist in 78 out of 105 cases (74.3%). Overall, the case was handled after charge by a specialist in 59 out of 105 (56.2%).

Continuity of handling

3.10 It is important that cases involving road traffic fatalities be handled by the same prosecutor from the decision to prosecute until the proceedings are concluded. This should ensure continuity of approach and individual accountability. The charging prosecutor maintained responsibility in 59 out of 105 relevant cases (56.2%). In those where a different prosecutor was allocated after charge there was continuity of prosecutor thereafter in 32 out of 46 relevant cases (69.6%).

3.11 We consider that there ought to be continuity of handling by a specialist or a suitably experienced prosecutor working under the supervision of a specialist. This approach should be adopted so far as practicable even where managers are making the decision, although we recognise that there may be limitations.

3.12 It is less usual for the specialist to prosecute cases in the magistrates' courts. Intermediate hearings are likely to be dealt with by a non-specialist and many trials are prosecuted by agents.

GOOD PRACTICE

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

3.13 The introduction by the CPS of the optimum business model for trial preparation in the magistrates' courts should not detract from this principle. The model's approach is for a proactive case progression team to prepare summary trials, rather than an individual named prosecutor. However, the CPS still has a commitment to the principle of 'cradle to grave' handling of Crown Court casework and for serious or sensitive cases heard in the magistrates' courts. All fatal road traffic cases should, therefore, continue to be handled by one specialist throughout its progress from charge to completion.

RECOMMENDATION

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.

Coordinating the approach

3.14 The CPS has not appointed a national coordinator to oversee its approach to policy for handling road traffic cases involving fatalities. Few areas, if any, hold meetings for specialists to discuss relevant issues. This approach is in contrast to the CPS position in respect of other offences involving special considerations or sensitivities.

3.15 Although it was not specifically recommended in the 2002 report that there should be a national coordinator, or that areas should have a number of specialists with a single coordinator, we consider that there are compelling reasons for a greater degree of coordination and information sharing within areas and nationally than occurs at present. In particular, the implementation of the new offence of causing death by careless driving will require a consistent national approach in determining the circumstances, including the standard of driving, in which it should be charged. We understand that specific arrangements for achieving this have been put in place (see chapter 5) and these could usefully be built upon. A more rigorous approach has recently been adopted in relation to the standard of driving encompassed within the definition of dangerous and this approach should not be affected by the introduction of the new offence.

3.16 This is because road traffic cases involving fatalities have their own particular legal and evidential issues, in addition to the obvious sensitivities in such cases, to require a more systematic approach to their handling and monitoring and to the training of specialists.

3.17 As a first step, we consider that areas themselves should seek to coordinate their approach to fatal road traffic collision cases. Consideration should also be given to supplementing such arrangements by appointing an overall coordinator at area group level.

RECOMMENDATION

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.

Training for specialist prosecutors

3.18 There is still no nationally devised or approved training course for road traffic fatality specialists, although some areas have developed their own. CPS Headquarters Leadership and Learning Division, which is responsible for training, maintains a record of any courses referred to it by areas and will provide details of appropriate courses to areas who make enquiries. There has been some interest in courses dealing with road traffic cases involving fatalities, but such interest is not widespread.

3.19 The current approach in most areas appears to be that specialism 'goes with the territory'. Unit heads and other senior prosecutors are automatically considered capable of handling road traffic cases involving fatalities by virtue of their experience. Prosecutors' views on the need for training varied, although the majority view was that it would be of assistance in two principal respects. The first, understandably, related to newly appointed specialists but, secondly, many existing specialists considered that national training would help to establish a consistent approach towards the many issues and sensitivities inherent in such cases. We agree with this principle. The CPS has rightly issued national guidance to ensure consistency in decision-making. This should be reinforced by a national training plan.

RECOMMENDATION

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.

Legal guidance – the national approach

3.20 The 2002 report recommended that the Director of CPS Policy Division should issue revised guidance in relation to road traffic fatality cases and review the driving offences charging standard, particularly in relation to dangerous driving. This was prompted principally by inconsistent approaches to reviewing cases in determining the standard of driving and was partly a consequence of the lack of specialist prosecutors in some areas. It was considered that the existing charging standard on driving offences required clarification to avoid these inconsistencies.

3.21 The CPS established a working group chaired by a CCP to reconsider the charging standard. The standard was revised and incorporated within the legal guidance on driving offences, which was reissued at the end of 2004.

3.22 In January 2008 a further revision of the legal guidance – prosecuting cases of bad driving – was published and issued to all areas. This was updated in August 2008, when the new offences created by the Road Safety Act 2006 were introduced. The CPS has also separately published its policy for prosecuting cases of bad driving to explain to the public how its decisions are made. The policy's introduction section is at Annex B and the full document is available on the CPS website at www.cps.gov.uk.

3.23 The January 2008 legal guidance was issued with an accompanying minute and placed on the CPS internal electronic intranet. No specific instructions were given as to how it should be disseminated to appropriate staff. The majority of areas have simply passed on the guidance to specialists and other appropriate staff, although at least one saw the issue as an opportunity to deliver training in its application.

3.24 The legal guidance already contained some explanation of the offence of causing death by careless driving and how it might be used[1]. The updated guidance has provided further help in relation to the new sections and covers issues such as mode of trial. It remains the case that no specific training is planned in respect of the offence.

1 This offence, which is now section 2B of the Road Traffic Act 1988 (as amended), came into force on 18 August 2008.

4 TIMELY ACCESS TO PRE-CHARGE ADVICE AND DECISIONS

The provision of advice and pre-charge decision-making

4.1 The statutory charging arrangements provide for duty prosecutors to give pre-charge advice and make decisions on whether or not to charge in serious cases. This is usually done face-to-face at charging centres, but may be dealt with over the telephone. If the need for urgent advice arises outside office hours prosecutors from CPS Direct (CPSD) are available to make decisions.

4.2 The introduction of statutory charging does not appear to have changed the approach by areas to pre-charge decision-making in fatal road traffic cases. In practice, as in 2002, most of these cases are still dealt with by the police submitting a formal request for advice and a decision about whether to prosecute to a CPS office. This means that pre-charge decisions are generally made in the form of written advices rather than face-to-face in charging centres.

4.3 There are advantages to pre-charge decisions in fatal road traffic cases being dealt with by way of formal advice – it enables prosecutors to devote the time required to consider these sensitive cases and to make considered decisions. The charging initiative was intended to facilitate the pooling of expertise by police investigators and prosecutors at an early stage in the investigation of cases, and the provision of formal advice can result in no face-to-face or telephone contact. This can still be achieved and we found that areas have not lost sight of the need for early consultation and case building and generally there is a discussion with the police, and frequently the prosecution expert, before the formal advice is given. This early consultation was considered to be mutually beneficial as it helped the police to structure their investigation, whilst at the same time giving the prosecutor a good knowledge of the circumstances and issues in the case.

Early consultation

4.4 We were pleased to note that the CPS responds well to requests for early advice. Police and prosecutors continue to liaise at an early stage and this consultation is not limited to complex and serious cases. In North Yorkshire there is a formal policy of consultation within 72 hours of the collision, which provides a steer on evidence gathering and directs the way the case is investigated. In other areas there is no specific policy but senior investigating officers may have an early conference with prosecutors (sometimes within days of the incident) to start a dialogue and to establish the direction the case is likely to go.

4.5 In CPS London formal advice surgeries, with designated appointments, are held once a month for face-to-face advice to be given in ongoing investigations. These not only assist the police in investigating lines of enquiry in individual cases, but also enable them to develop an understanding of what is evidence is required in order to provide cases with the best chance of a conviction.

4.6 We were told in some areas that there is generally a conference with the prosecution expert before a charging decision is made, but files did not always show this. This may be an issue of poor recording and prosecutors should ensure that they record all conferences and meetings with the police, including what was discussed and any decisions made or advice given. This will enable anyone reading a file to understand the way the case is being presented and the reasons for this.

GOOD PRACTICE

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.

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

Arrangements for urgent advice

4.7 As stated in the introduction over half the cases in the file sample were careless driving and triable in the magistrates' courts only. Proceedings for magistrates' courts' cases (that is, summary only offences) with a few exceptions have to be commenced within six months of the date of the commission of the offence (the statutory time limit). If cases are submitted by the police where this time limit is due to expire shortly specialists will consider cases urgently.

4.8 Areas generally have special arrangements with the police for urgent advice, for instance when the suspect is in custody. If the need arises during office hours specialists will consider the case.

4.9 Outside office hours prosecutors from CPSD are available to make decisions. In one area the police prefer not to refer cases to CPSD because they consider it to be desirable for fatal road traffic cases to be considered by a prosecutor with knowledge of the scene of the collision (we consider the importance of this in chapter 5). In some areas the police have senior prosecutors' telephone numbers and are able to contact them if a decision is required outside office hours. We were given examples of prosecutors providing advice out of office hours and saw cases where they had done so.

Timeliness of pre-charge decision-making

4.10 It is important that files are submitted by the police in sufficient time to enable prosecutors to make the pre-charge decision promptly and, if summary only proceedings are appropriate, before the expiry of the statutory time limit. Equally it is important that prosecutors provide timely advice so that the case can be dealt with expeditiously, including the need for the police to commence proceedings within the time limit.

4.11 In London the CPS have agreed a protocol with the Metropolitan Police which sets out timescales for the submission by the police of the full investigative file (within four months of the collision) and the provision by the CPS of advice (28 days). In other areas there is a general protocol with the police for timeliness of pre-charge advice in all cases.

GOOD PRACTICE

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.

4.12 In many instances there is delay in the progress of a case from the police to the CPS. Because of the nature and complexity of fatal road traffic cases, the police will inevitably require some time to investigate and submit files to the CPS for a charging decision. In addition the police usually submit formal advice files, which require time to prepare.

4.13 Whilst we are not able to evaluate fully the causes, it did seem that the overall process took longer than it should have done in a significant number of cases. There were examples in the file sample where submission to the CPS was five months after the collision and one file was submitted 11 days before the expiry of the statutory time limit. Just under a third of the coroners who provided us with information were concerned about the timeliness of decision-making, although they appeared not to be aware that there are issues about when the CPS actually receive the papers (we discuss this further in chapter 9).

4.14 The 2002 report recommended that prosecutors provide advice in road traffic fatality cases within the CPS time guidelines (14 days) in all but the most substantial cases.

4.15 It was not always possible to determine exactly when the file was received from the police and inspectors therefore used the earliest date that they could identify as being the date of receipt by the CPS. In some instances this meant that calculations were made on the premise that the case was received on the day the decision was made, even though in reality it is likely that sufficient evidence to enable a decision to be made would have been received earlier.

4.16 The pre-charge decision made by the prosecutor was timely in 72 out of 114 cases (63.2%). Even allowing for the favourable calculation of the date of receipt of the papers set out in the preceding paragraph, it took over 15 days for the prosecutor to make the charging decision in 62.8% cases, with 29.1% cases taking over 41 days. In 2002 the average time between receipt of a file and the decision being made was 21.4 days for all advice requests. In this inspection, timeliness has deteriorated so that the average time is now 27.0 days.

4.17 Given that charging decisions have to be approved by the CCP (see following chapter), it is not unreasonable for the CPS to take slightly longer than the standard 14 days to reach their decisions. We consider that the charging decision (including CCP approval) can be made within 21 days in all but the most substantial cases.

RECOMMENDATION

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).

Case building

4.18 Most files submitted by the police are well prepared, often with all the evidence being included, so it is rare that there is a need to request further evidence or information. This means that there is not always a need for case building at that stage. Prosecutors are, however, proactive in building cases where necessary – appropriate steps were taken in 70 out of 79 relevant files (88.6%).

5 THE QUALITY OF DECISION-MAKING

Background

5.1 Prosecutors take decisions in accordance with the principles set out in the Code for Crown Prosecutors. HMCPSI considers whether the decision taken was one that was properly open to a reasonable prosecutor having regard to the principles set out in the Code and relevant guidance. A statement that HMCPSI considers that a decision was not in accordance with the Code therefore means it was considered to be wrong in principle. On some occasions, therefore, while a decision not to prosecute or to select a less serious level of charge may not fall outside the Code, it would be equally proper to take a more robust approach.

Charges and outcomes in the file sample

5.2 Before dealing with our specific findings in relation to decision-making, we set out in the following table the charges selected and the eventual outcome of those cases which resulted in proceedings from the file sample and the cases we observed in court:

Crown Court cases

Charge	Total	Guilty plea	Guilty plea to lesser offence	Conviction	Conviction (alternative offence)	Acquitted	No evidence offered/ withdrawn
Manslaughter	1	0	1	0	0	0	0
Death by dangerous driving	37	20	3	8	3	3	0
Death by careless driving with excess alcohol	7	7	0	0	0	0	0
Other charges	2	2	0	0	0	0	0
Crown Court total	**47**	**29**	**4**	**8**	**3**	**3**	**0**

Magistrates' courts' cases

Charge	Total	Guilty plea	Guilty plea to alternative offence	Conviction	Conviction (alternative offence)	Acquitted	No evidence offered/ withdrawn
Careless driving	53	31	1	15	0	5	1
Other charges	7	5	0	1	0	0	1
Magistrates' courts' total	**60**	**36**	**1**	**16**	**0**	**5**	**2**

5.3 The table shows a high rate of successful cases. Including guilty pleas, 97 cases resulted in a conviction (90.7%). The conviction rate after trial was 77.1%. There were ten unsuccessful cases (9.3%); two were discontinued while eight resulted in an acquittal after trial.

5.4 These figures show that, on the face of it, there is a high success rate for cases involving road traffic fatalities. However this includes cases where there was a guilty plea to or conviction after trial on an alternative, lesser, charge: there were six cases in the sample where the conviction was for a lesser offence. If they were excluded the conviction rate would reduce to 85.0%. The figures also do not take into account the underlying issue of a lack of robustness in the selection of the charge – we comment on this further below.

The quality of pre-charge advice and decisions

The decision not to prosecute

5.5 We examined the quality of the decision to take no further action in nine cases. In all nine it was made on evidential grounds. The decisions were not unreasonable but we considered that there were a few cases which could equally have been properly brought before the court as careless driving offences. We consider this further below.

The decision to prosecute

5.6 We examined the quality of the decision to prosecute in 105 cases. This decision was in accordance with the Code in all but one. However there were a few cases where, although we would not go so far as to describe the decisions as wrong, the evidence could have justified a more serious level of charge. We comment further on this in the following section.

5.7 One case (a construction and use offence that relates to the condition of the vehicle) was not in accordance with the evidential stage of the Code. There was insufficient evidence to provide a realistic prospect of conviction and the case should not have been prosecuted. Ultimately, no evidence was offered on the day of the trial.

5.8 All public interest decisions were in accordance with the Code.

Selection of the appropriate charge

5.9 We have set out in the introduction the large range of offences that could lead to a road traffic fatality and the fact that, although wide ranging, the charges available still fall into two distinct categories: those where the fatality is reflected in the charge itself and those where it is not. The CPS has provided guidance, updated in August 2008, to help prosecutors determine the appropriate charge.

5.10 The potential charges available that do not reflect the death in the statement of the offence are varied. Dangerous driving is probably the most serious and it is triable either way, but the majority of other offences most commonly appropriate are purely summary offences, such as careless driving and excess speed.

5.11 There were mixed views in the evidence from criminal justice practitioners about the appropriateness of the level of the charge selected. Some considered that prosecutors had a tendency to select a lesser charge than the circumstances indicated and that might be perceived by the public as justice being seen to be done. Others considered that prosecutors overcharged when a death was involved. There were no cases in the file sample where we considered that the prosecutor had selected too high a level of charge.

5.12 We identified a few cases in the file sample in which prosecutors finally selected a charge of driving without due care and attention, but in which the evidence could have justified a charge of causing death by dangerous driving. These were all at the lower end of the scale of causing death by dangerous driving; the driving provided a significant risk of danger rather than a substantial one, or entailed a single bad mistake or error so that it was dangerous even if only for a short time.

5.13 We query whether the CPS guidance in listing a number of examples typical of what they are likely to regard as dangerous driving (including racing or competitive driving and disregard of traffic lights and other road signs which, on an objective analysis, would appear to be deliberate), may take the attention away from the earlier examples in the text which illustrate that a single mistake or error (such as driving across a junction controlled by a give way sign and failing to see a car on the major road) also constitutes death by dangerous driving. Such instances fall within the Level 3 of the offence guidelines issued by the Sentencing Guidelines Council which are termed as "driving that created a significant risk of danger and is likely to be characterised by:

- driving above the speed limit/at a speed that is inappropriate for the prevailing conditions; or
- driving when knowingly deprived of adequate sleep or rest or knowing that the vehicle has a dangerous defect or is poorly maintained or is dangerously loaded; or
- a brief but obvious danger arising from a seriously dangerous manoeuvre; or
- driving whilst avoidably distracted; or
- failing to have proper regard to vulnerable road users."

5.14 We consider that this part of the Sentencing Guidelines Council Offence Guidelines merit inclusion in the CPS guidance on dangerous driving so that it is readily accessible to prosecutors when decision-making.

RECOMMENDATION

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.

5.15 We considered that some cases which could have justified causing death by dangerous driving charges were serious single mistakes or errors. In some we concluded that prosecutors were reluctant to give full weight to the comments of witnesses about the speed or manner of driving being dangerous for the conditions. A jury will have to reach a view on these issues, but the accounts of members of the public are often valuable.

5.16 Issues of what would in the civil law be regarded as contributory negligence are difficult to weigh in the balance. These included a car parked on the hard shoulder of a motorway for the driver to rest that was hit by a lorry and pedestrians crossing the road when they should have seen an oncoming vehicle.

5.17 We noted variance of views between prosecutors on the same case. In one extreme example that variance ranged from considering the appropriate course of action was to charge death by dangerous driving to taking no further action (the case in the end being successfully prosecuted as careless driving). The infinite variations of individual cases and the strength of positive admissible evidence as to what took place will always provide difficulties. The CPS guidance as to the involvement of CCPs is designed to provide consistency between individual cases.

5.18 In the event, we do not assess the decision-making as falling outside the Code, and decisions were not perverse in the legal sense. Nevertheless the range of bad driving that is not deliberate but still can constitute causing death by dangerous driving appears slightly wider than has been applied to a few individual cases. We appreciate that in future the impact will be less severe as these cases will, at the very least, merit prosecution as causing death by careless driving. We envisage that they would merit trial in the Crown Court, with the judge having a suitably wide range of sentencing powers.

Acceptance of pleas

5.19 A plea was accepted to a lesser offence in only one case. The defendant had taken a car without the owner's consent and he pleaded guilty to aggravated vehicle taking, as a result of which the causing death by dangerous driving charge was dropped. This was fully justified and the plea was accepted at the earliest appropriate opportunity.

5.20 In another case a plea was accepted to one of two linked charges and the decision was made in a timely way. The defendant pleaded guilty to failing to stop after an accident and no evidence was offered on the charge of careless driving. The defendant was given a suspended prison sentence. The decision to accept the plea raises some interesting questions. It means that the standard of the defendant's driving was not reflected in the charge but, on the other hand, the defendant could not have been given a suspended prison sentence for the offence of careless driving as the maximum penalty is a fine. On balance, inspectors thought that it was an appropriate decision. The situation is unlikely to arise again: now that the new provisions have been brought in the defendant would probably have been charged with causing death by careless driving, which attracts a higher penalty than failing to stop.

5.21 We received evidence from one member of the judiciary of a disinclination to accept a plea to a charge of causing death by careless driving when under the influence of drink or drugs when this would be an appropriate course. These offences carry the same maximum penalty so the choice of charge does not inhibit the court's sentencing powers and the courts have made it clear that for sentencing purposes the two offences are to be regarded on an equal basis. The 2008 Sentencing Guidelines give a greater range of sentences for the charge of causing death by careless driving under the influence of drink or drugs dependent on the amount of alcohol or drugs consumed. CPS guidance, however, makes it clear that if the driving is such that it merits a charge of causing death by dangerous driving then this is the offence that should be pursued.

5.22 Although we saw no examples of refusal to accept an appropriate plea, the issue of acceptance of pleas is potentially of greater significance now that the offence of causing death by careless driving has been introduced. CPS Policy Directorate has issued further guidance now that the new offences have been introduced, including the issue of when it is appropriate to accept a plea. We discuss the need for CCP approval of decisions to accept a plea to a lesser offence below.

The quality of decisions to discontinue

5.23 We examined two cases where the prosecutor decided to discontinue the case. The decision was made on evidential grounds in both and was in accordance with the Code. One case was inappropriately charged and we have referred to it in paragraph 5.7. The second was discontinued after the prosecution expert met and discussed the case with the defence expert and the joint conclusion was that it was not possible to ascertain how the collision had occurred.

Consistency of decision-making

5.24 Concern relating to the level of charge that had been selected was an issue at the time of the last inspection and led to a recommendation that CCPs and unit heads monitor the quality of review decisions. The CPS issued guidance to CCPs in 2006 requiring them to quality control all prosecution decisions in road traffic fatality cases and, for a limited period, to submit all decisions to charge careless driving to the Director of Public Prosecutions' (DPP) Principal Legal Advisor. Decisions to charge careless driving no longer have to be referred to CPS Headquarters, but the requirement for CCPs to quality control all decisions was reiterated in 2007. Despite this, decisions were referred to the CCP in only five of the eight areas included in the inspection.

5.25 The revised guidance, issued in August 2008, now requires charging decisions in all fatal road traffic collisions to be approved by a CCP. The guidance also requires CCPs to approve mode of trial decisions for offences of causing death by careless driving and causing death by driving while unlicensed, disqualified or uninsured, and to approve all decisions to accept a plea to a lesser offence.

5.26 It was not always clear in the files we examined whether the unit head or the CCP had been consulted. Nor was it always clear in those cases where there had been consultation whether the papers themselves had been considered, or if reliance had been placed simply on a reading of the form used to make the charging decision (the MG3). In some files reference to referral or consultation was incorporated in the MG3. In others, there was a separate note showing that consultation had taken place. If a case is referred the evidential file should be considered. The referral and decision should be recorded on the file and the second prosecutor should be identified.

5.27 As the CCP will have been involved in approving all decisions to prosecute, including the selection of the level of charge, there may be an issue as to the appropriate handling if a victim's family question the level of charge. However, this is a point of general application and HMCPSI will consider it in relation to a current piece of work being undertaken on the CPS's handling of complaints.

General trends

5.28 We considered the question of whether or not the file sample revealed any general trends or issues, or any strengths and weaknesses, in order to determine if there are any lessons to be learnt.

Evidential decisions

5.29 It was difficult to see any general issues arising in the evidential decisions made by prosecutors. The use of mobile phones while driving did not feature as an issue and there were only one or two cases where a driver's tiredness may have been a contributing factor.

5.30 We found some striking similarities when we considered the facts of the cases. The majority in the sample fell into three main categories – drivers losing control of their vehicles, collisions occurring at junctions, and pedestrians being hit by vehicles.

5.31 There were 25 cases involving drivers who had left the road or lost control of their vehicles for no apparent reason. In some instances speed may have been a factor, but in others there appeared to be no major factors to say why this had occurred. In nine the defendant was charged with careless driving; in eight with causing death by careless driving after consuming alcohol or drugs; and in the remaining eight with causing death by dangerous driving.

5.32 Sixteen cases involved pedestrians as the victim. Twelve were charged as careless driving, three as causing death by dangerous driving, and the last as causing death by careless driving while under the influence of alcohol or drugs.

5.33 The third category of case was collisions occurring at junctions. There were 21 of these with 13 charged as careless driving and eight as dangerous driving.

5.34 None of the details in these cases were exactly the same but the fact that each of the three sets of circumstances gave rise to charges both of causing death by dangerous driving and careless driving raises the question of how the correct level of charge is determined. In some cases very similar facts gave rise to different charges. This reinforces our findings that there is not always consistency in decision-making in relation to the level of charge selected. We consider further in paragraphs 5.57-5.60 the need for areas to analyse case outcomes and the level of charges selected.

Public interest decisions

5.35 As we stated in the introduction there is 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. There were no cases in our sample where the prosecutor had decided that the public interest did not require a prosecution. As we have already commented we considered that all public interest decisions to proceed were in accordance with the Code.

5.36 There were cases in the sample, however, where the victim's family did not wish the driver to be prosecuted, or where they were anxious for the driver not to be sentenced to a term of imprisonment. In the main this was where the victim was related to the driver or where the victim and defendant had been friends. There was also a case in the sample where there was no prior relationship between the victim and the defendant where the family did not want a prosecution (see below).

5.37 In the past the CPS adopted a different approach in cases where the victim was in a close personal or family relationship with the driver: known as 'nearest and dearest' cases. The new policy states that the public interest will normally demand that a prosecution takes place in cases of causing death by dangerous driving or causing death by careless driving when under the influence of drink or drugs. However, the guidance requires prosecutors to consider the degree of culpability on the part of the driver in the new offences of causing death by careless driving and causing death by driving while uninsured, disqualified or unlicensed.

5.38 We considered that the relevant cases in our sample were ones where the public interest required a prosecution. However, it was not always clear that the prosecutor had considered the view expressed by the victim's family. In some instances, the view was expressed in the victim personal statement (we explain this in detail in chapter 8) and it would appear that this may not necessarily be taken as requiring a review of the decision to prosecute. Care needs to be taken to ensure that victims' families' views are always taken into account when determining whether or not to proceed with a prosecution.

5.39 Another set of circumstances which produces difficult public interest considerations is where a driver is over 70 years old and their health has declined to the extent that there are issues over their ability to drive. There were eight cases in our file sample where the defendant was over 70.

5.40 These cases raised issues such as whether prosecutors are considering the appropriate level of charge. For example, there was one case in the sample where it is likely that a younger driver would have been charged with causing death by dangerous driving rather than careless driving. The cases also raise the question of whether the defendant is safe to continue to drive. In one case the elderly driver turned across the path of another vehicle, killing the passenger in the oncoming car. The defendant offered to surrender his driving licence if the prosecution were willing to discontinue the case, and the victim's family expressed the view that they did not want a prosecution. The case proceeded and the defendant was fined but not disqualified from driving. Inspectors would have made the same decision but the ultimate public interest of the defendant not being allowed to continue to drive and perhaps put the public at risk was not necessarily achieved.

Review endorsements

5.41 Good recording of actions and decisions and of the reasons for them, both in and out of court, is essential. Recording reviews properly helps to focus the mind and thereby ensures a better, more effective, review and accountability for decisions. It also helps prosecutors provide reasons to victims' families when writing to them or in meetings to discuss the case (see chapter 8).

5.42 Review endorsements should now be recorded on CMS. The charging review and decision is generally recorded on the MG3, although it can be in a separate advice page or memo to the police. In either case a copy should be placed on the file.

5.43 The charging/initial review decision was properly recorded in 109 out of 114 cases (95.6%). The further review carried out at the time of preparing the case for summary or Crown Court trial was properly recorded in 58 out of 75 (77.3%), while continuing review decisions were properly recorded in 69 out of 77 (89.6%). The decision to discontinue was properly recorded in both relevant cases.

5.44 The presentation of the advice to the police continues in the main to be of a high standard. The majority of advices/MG3s were well reasoned and comprehensive, with a detailed consideration of the evidence and outlining the reasons for the decision. Others simply restated the CPS policy and guidance and/or did not consider all possible charges. The quality of advice is an aspect that CCPs will want to include in their quality assurance of charging decisions.

Visits to the scene of the collision

5.45 Prosecutors do not routinely visit the scene of the collision. In some areas they will be aware of the location and there may, therefore, be no benefit in visiting it. There were instances in the file sample of such visits taking place and some specialists told us that they will visit the scene if they consider it to be necessary. One unit head said that he would visit the site if he was not already familiar with it before he made the charging decision.

5.46 The importance of knowledge of the scene of the collision does not only apply to the prosecutor making the decision whether or not to charge. It can also be important for the advocate to visit the scene before the trial. We observed a case in the magistrates' courts where the collision had taken place at what was known to be a 'difficult' junction and the agent prosecutor was the only person in court not to know the location. Equally, it can be important for the jury to visit the scene and there was one case in our file sample where the prosecutor recommended that this take place.

5.47 It can be essential to be familiar with a location in order to appreciate what risks the manner of driving produced. Indeed the view was expressed by the police in one area that it is desirable for fatal road traffic cases to be considered by a prosecutor with knowledge of the scene of the collision. It is, therefore, important that prosecutors consider whether there is a need to visit the scene of the collision before reaching their decision whether or not to prosecute, or for the jury or advocate to do so.

Expert evidence

Cause of the victim's death

5.48 It is not usually necessary to establish the cause of the victim's death in magistrates' courts' cases as it is not an element of summary charges. It is, however, essential to show the cause in most Crown Court cases. Expert evidence to establish the cause of death was available in 72 out of 76 relevant cases (94.7%).

Standard of the defendant's driving

5.49 It is necessary in nearly every case to show how the defendant was driving. Expert evidence commenting upon how the collision occurred is usually provided by a police collision investigator, although the evidence itself does not prove the standard of the defendant's driving. However, the expert can usually provide an opinion upon issues such as the speed of the vehicle(s) and the point of impact, from which conclusions can be drawn. There was an expert's report commenting upon how the collision occurred in 106 out of 111 relevant cases (95.5%).

5.50 Some members of the judiciary considered that an experienced police officer is not always the best witness and were of the view that it might be sensible to use an independent expert where the defence are doing so. The police expert reports we saw were of good quality and there were no cases in our file sample where we considered that an independent expert should have been approached. Prosecutors should, however, be alert to the possibility that it might be necessary to obtain a report from a non-police expert.

5.51 As the expert's report showing the manner of driving is an integral part of the case it should be served on the defence and was in 93 out of 96 cases (96.9%). It is equally necessary that the prosecution are sent any experts' reports obtained by the defence and this was done in 22 out of 28 (78.6%). We saw good examples of prosecutors working to ensure that the best use was made of expert evidence, such as prosecution and defence experts agreeing non-contentious evidence, and meeting to consider the evidence and produce a joint statement. We also saw one case where the prosecutor's efforts in keeping the prosecution expert updated ensured that the late service of expert evidence by the defence did not delay the case.

5.52 We were pleased to see that prosecution experts on the manner of driving are generally included in conferences with counsel. Such conferences are considered to be very productive, with the evidence and issues being analysed and ways explored of overcoming any difficulties. Not only are they seen as helping to build and develop a strong case in the particular instant, but they are also seen as helping the police to develop overall expertise and knowledge in how to build strong cases in the future.

5.53 Prosecution experts on the manner of driving are usually called to give oral evidence at trial. They were warned to attend court in 37 out of 41 cases (90.2%) and called to give oral evidence in five out of six (83.3%) we observed at court. It is not uncommon for the expert to be available to assist counsel during the whole of trial – by being in court throughout the case, or attending at the very least the first day and thereafter making themselves available on the telephone. This is a useful way of ensuring that the expert evidence is presented in the best possible way.

Unduly lenient sentences

5.54 There were seven cases in the file sample where the sentence passed was potentially unduly lenient. In five (71.4%), consideration was given to the possibility of referring the papers to the Attorney General's Office for a decision to be made whether or not to refer the case to the Court of Appeal for the sentence to be reviewed. There was no indication on the file to show that this had been considered in the remaining two cases.

5.55 In another case, not part of the file sample, careful handling meant that there was a referral of the case to the Court of Appeal.

5.56 There is now much clearer guidance on the appropriate level of sentence in fatal road traffic cases – most recently in the information issued by the Sentencing Guidelines Council in July 2008. It is important that prosecutors are aware of the guidelines and that systems are in place to ensure that all appropriate cases are considered and referred.

Performance management and monitoring

5.57 The approach to monitoring of fatal road traffic cases and learning lessons varied across the areas. In some there is no specific monitoring other than casework quality assurance (which includes all types of cases) and routine unsuccessful outcomes consideration. In others unsuccessful road traffic cases are analysed by the CCP and unit head and any lessons to be learnt are sent to reviewing lawyers and anyone who has had conduct of the case.

5.58 Areas do not routinely keep records of cases and outcomes. There is some limited record keeping - for example, of charging decisions - and in one a record is kept of outcomes, although no analysis is undertaken. It would appear that the police are also not maintaining records or routinely collating outcomes, although in London they use a 'tracker' which is available to the CPS. In another area, because of concerns about timeliness of decision-making, there is a proposal for a quarterly review of numbers and quality by a strategic group including the CCP and the Head of Road Policing.

5.59 Generally there are no inter-agency forums at which fatal road traffic cases are discussed and no joint analysis of outcomes or discussion to learn lessons. In Lancashire a meeting with the police was held at which the CCP restated CPS policy in such cases - this arose out of issues from a specific case.

5.60 There is a need at area level for collection of data and analysis of the level of charge and outcomes. This will be particularly important during the first year or so after the introduction of the new legislation. At the moment, even those areas who undertake some monitoring and analysis are working in isolation and there is a need for a national focus and forum in order to ensure consistency and learn lessons. The CPS has decided to introduce a similar national exercise to the one it undertook in 2006-07, when the DPP's Principal Legal Advisor considered all cases where prosecutors were proposing to charge careless driving or advise the police to

take no further action (although we note that limited use was made of the information collated from approximately 200 cases). Until the new offences have become established the Principal Legal Advisor will monitor the quality of decisions to charge either causing death by careless driving or causing death while driving unlawfully on a road. Areas now have to notify him of such cases by email and attach a copy of the MG3, where possible before the police are informed of the charging decision. There is an argument for saying that this should be extended to include all road traffic fatality cases, including those to be charged as causing death by dangerous driving or causing death by careless driving while under the influence of drink or drugs, but it is acknowledged that the numbers involved may make this too extensive an exercise.

RECOMMENDATION

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.

6 CASE PREPARATION

Case progression

6.1 It is important for all concerned, in particular the victims' families and defendants, that cases proceed expeditiously after the decision has been made to charge. Generally we found that cases progressed well after charge. Representatives of the other criminal justice agencies were satisfied that cases were usually ready for the first date of hearing and any subsequent hearings.

6.2 Overall post-charge progression was expeditious in 97 out of 105 cases (92.4%). Prosecutors are clearly aware of the distress that avoidable delay brings to victims' families. A number of files were seen where defence applications for adjournments were robustly challenged as they were deemed to be unnecessary.

6.3 There were some instances in the file sample of delay between the date of the decision to charge and the first date of hearing, with delays of three to six months. There were some instances of the service of the summons by the police being delayed until after the inquest had been held, which can lead to abuse of process arguments. Unless the decision to charge has been deferred, it is perfectly permissible to commence the proceedings.

6.4 Once the case was charged it was kept under continuous review in 76 out of 81 relevant cases (93.8%), thereby ensuring that decisions were able to be made promptly. The work required to prepare for summary or Crown Court trial was undertaken at the earliest opportunity in 63 out of 67 (94.0%).

Disclosure of unused material

6.5 Overall disclosure of unused material was handled appropriately. Initial disclosure was dealt with properly in 58 out of 68 cases (85.3%), while continuing disclosure was dealt with properly in 40 out of 44 (90.9%) and sensitive material in ten out of 14 (71.4%).

6.6 These results are better than the national averages in previous area inspection cycles and the assessments made in disclosure of unused material undertaken by the CPS, HMCPSI's thematic inspection published in 2008. Cases of this nature require careful handling and these findings show that prosecutors are handling them with some care.

6.7 Weaknesses, where they existed, were ones which have already been identified in thematic and area-based inspections, for example, not endorsing against each item on the schedules whether or not it is disclosable, or allowing the defence to inspect items that clearly do not fall to be disclosed under the disclosure regime. We did not identify any issues specific to the handling of this type of casework.

6.8 The main concern in relation to prosecutors' handling of disclosure was the limited use made of the disclosure record sheet (DRS) to record the actions taken in respect of disclosure on each file. A DRS had been used to provide a clear audit trail of decisions and actions in only 22 out of 65 cases (33.8%). If a record of action and reasons for those actions is not kept, it makes it difficult to ascertain exactly what has been disclosed, when and why.

Instructions to the advocate

The magistrates' courts

6.9 Generally files are allocated to prosecutors in good time to prepare for court. It is not always necessary to provide detailed instructions beyond the review records (if they are sufficiently detailed) for the advocate in the magistrates' courts. There were 19 cases in the file sample where we considered that instructions were necessary and they were provided in 17 (89.5%). Indeed, in some cases the instructions were very good.

6.10 In one case we observed a reviewing lawyer giving detailed guidance to a colleague prior to a hearing where he was not able to handle the case in court himself. Whilst issues such as the acceptance of a basis of plea rarely arose in the cases we observed at court, when they did the prosecutor was reliant upon the availability of the unit head, usually by telephone, for advice.

The Crown Court

6.11 Instructions to counsel were timely. They contained a case summary and dealt adequately with the issues in 26 out of 44 relevant cases (59.1%). Some simply comprised the police summary rather than any analysis of the issues raised by the case. Others were comprehensive, reflecting the seriousness of the case and the experience of the reviewing lawyer who had prepared them.

6.12 Where the charging lawyer had prepared a comprehensive advice note on the MG3, this was normally included in the papers for counsel and should be done in every case. Instructions on the acceptance of plea or a basis of plea in cases where they might be relevant were sometimes absent, but there was frequently close liaison between the reviewing lawyer and the advocate.

Case and file management

6.13 All fatal road traffic cases should be identified, flagged, reviewed and documents prepared on CMS from the initial advice to the conclusion of the case. The system was examined to ascertain whether CMS was being properly used in the cases in the sample.

6.14 We found that 104 out of 114 cases (91.2%) were flagged on CMS as involving a fatality. Some areas have in addition a road traffic fatality flag, which is a useful tracking and monitoring tool that can be used to track progress and assist in monitoring and collating outcomes (see preceding chapter). Information was completed on CMS adequately in 104 out of 114 cases (91.2%).

6.15 The 2002 report recommended that CCPs review the method of flagging fatal road traffic cases, to facilitate easier identification. The recommendation was designed to ensure that the appropriate care and attention was given to these sensitive cases. The information showing that a case has been flagged on CMS as a fatality is produced on a print out of case details which is attached to the front of the file cover. However, the print is small and not easily visible, and it is not sufficient to enable the file to be readily identified as a road traffic fatality case.

6.16 The file cover should also have some other indication that the case involves a fatality. This is usually done by writing the word "fatality" in marker pen in large letters across the front and those that were marked were easily identifiable. However, only 40 out of 110 files (36.4%) in the sample had the nature of the case clearly marked on the jacket. In most instances only the magistrates' courts' cover, which is then kept within the file in Crown Court cases, was marked (27 out of 59 files, 45.8%). The Crown Court jacket itself was rarely marked as a fatality case (nine out of 48, 18.8%).

File endorsements

6.17 It is important that court hearings are accurately and fully endorsed on the file jacket so that anyone picking up the case can see what has happened during its progress. The court endorsement provided a detailed accurate record of the hearing in 101 out of 104 cases (97.1%).

6.18 Endorsements in road traffic fatality cases are better than the generality of cases, but there is still room for improvement. A number of Crown Court files had results written on loose pieces of paper and were difficult to locate and interpret. The file jackets in magistrates' courts' cases were mainly legible and, on occasion, contained detailed notes of discussions held with family members. Instructions from the advocate to administrators and other CPS staff about matters arising from the hearing were generally clear and we found that actions were being completed expeditiously.

7 THE CASE AT COURT

Introduction

7.1 The relatively few numbers of road traffic cases which involve fatalities limited the opportunities to observe court hearings as part of the inspection. We observed five cases in the Crown Court and eight in the magistrates' courts. However, our own findings in this respect were supplemented by information from practitioners in other criminal justice agencies and from CPS lawyers and caseworkers, as well as from victims' families and organisations which provide them with support.

7.2 In 2006 the CPS issued guidance to areas on handling cases of bad driving. It states that the prosecution should be represented by an "appropriate advocate" and sets out the following principles for prosecuting cases in court:

- in the magistrates' courts the advocate should ideally be the reviewing lawyer at each hearing;
- fatal road traffic cases should not normally go to magistrates' courts' hearings prosecuted by an agent; and
- in the Crown Court the papers for the CPS higher court advocate (now called a crown advocate) or external advocate must include sufficient information for an explanation of the reasons of a charging decision to be provided to the bereaved family and/or the judge.

The prosecution in the magistrates' courts

Choice of advocate

7.3 It is less usual for the specialist to prosecute cases in the magistrates' courts. Intermediate hearings are likely to be dealt with by a non-specialist and many trials are prosecuted by agents. The 2002 report recommended that the CPS should review listing arrangements with the courts to ensure that road traffic cases involving a fatality were prosecuted by a CPS advocate. This still represents good practice and should be the normal procedure.

7.4 We were told by CPS interviewees that only experienced in-house prosecutors present these cases in the magistrates' courts. The file sample, our observations and responses from other court users all indicate that this is not an accurate picture. It is not the norm for the reviewing lawyer to prosecute the case at the magistrates' courts: this occurred in three of the seven cases we observed. The marked lack of a consistent approach to the continuity of prosecutor indicates a failure in some areas to give these cases the priority they require.

7.5 We observed five hearings in the magistrates' courts which were dealt with by in-house lawyers. A senior lawyer conducted a trial and was well prepared, providing good continuity for dealing with the victim's family. At other hearings the standard of in-house lawyers' advocacy in all the cases observed was good; their attendance was particularly timely and their interaction with families empathetic.

7.6 As stated above CPS guidance is that fatal road traffic cases should ideally be dealt with in the magistrates' courts by the reviewing lawyer. This means that associate prosecutors (formerly designated caseworkers) should not generally be handling these cases, even though their powers are such that they could cover certain hearings (although further training is required before they can exercise their extended powers). However associate prosecutors are routinely appearing in interim and sentencing hearings (we only observed one but there was other evidence of their use). Although there is no evidence that these cases are badly handled, hearings are often attended by victims' families and it is not uncommon for detailed explanations of the charging decision or sentencing provisions to be required. We are aware of one instance where an associate prosecutor spent a long time explaining the issues to a victim's family present at court. We understand that this was handled well, but it may have been more appropriate for the discussion to have been conducted by the reviewing lawyer who would have more knowledge of the case. In the one case we observed being handled by an associate prosecutor, there was no attempt to speak to the family despite the police family liaison officer indicating that this would have been of assistance. This was also a failure to comply with the Prosecutors' Pledge (see paragraph 7.26).

The use of agents

7.7 Of particular concern is the use of agents to deal with appearances, including trials. This practice goes against current guidance to areas and poses a risk to the quality of the prosecution. We observed two trials being prosecuted by agents. Their advocacy was not an issue, but the lack of time allowed to prepare for the trial was of concern. In one trial the case had been sent to counsel in one set of chambers to prosecute only for it to be returned and sent to counsel in a second. In the second case an agent prosecutor arrived at court with insufficient time to discuss issues with the victim's family, save for a brief word on the public concourse.

7.8 Conversely where the file is sent to an agent some days in advance of the hearing problems can occur when issues requiring last minute attention arise. In a number of cases in the magistrates' courts the defence expert evidence was served very late. Problems are less easily resolved where files have been sent to agents in advance and may need to wait until the day of trial.

The prosecution at the Crown Court

Choice of advocate

7.9 It is important to ensure that road traffic fatality cases are prosecuted by advocates of ability and experience appropriate to the type of case. In the Crown Court cases are prosecuted by experienced counsel or CPS crown advocates.

7.10 Two crown advocates were observed prosecuting interim and sentencing hearings. They were experienced and one was the original charging lawyer. This provided good continuity in the conduct of the case and the dealings with the victim's family. The crown advocates displayed a good knowledge of the facts and were able to explain technical issues. They were also familiar with sentencing provisions and guidelines. Feedback from other court users on their performance was mainly positive.

7.11 Our observations and interviews revealed that experienced counsel are instructed to prosecute trials and care is taken in their selection. They are usually selected by the specialist prosecutor or unit head and regularly deal with these types of cases. The two we observed were very good and were sympathetic to the needs of the witnesses and families, speaking appropriately to the relatives when required. No one commented adversely on the quality of counsel conducting trials and some were deemed to be exceptional.

Attendance at court by the reviewing lawyer

7.12 The reviewing lawyer is rarely present in the Crown Court though some do attend critical hearings. Where they do attend it provides a greater level of continuity, particularly in communications with family liaison officers and, therefore, with victims' families themselves. It also assists instances where the caseworker in the case is not at court.

Use of caseworkers

7.13 The approach to caseworker coverage at the Crown Court is variable. Some attend court in their own cases, others cover ones in which they have had no previous dealing. In some instances caseworkers provide a one-to-one coverage, in others they are also covering a full list of other cases.

7.14 Of the five Crown Court cases we observed there was one where no caseworker went into the court room, despite some (who were aware of the case being in the list) being available at the court centre. In the remaining four the caseworker at the court was covering their own case in only one instance. There was, however, one-to-one coverage in three of the four.

7.15 The attendance at the Crown Court of the caseworker in the case is as important as attendance by the reviewing lawyer as prosecutor in the magistrates' courts, providing a similar level of continuity and enhancing the care afforded to victims' families. Lack of continuity can reflect adversely on the CPS if their representative, through no fault of their own, displays a lack of knowledge about the case.

Advocacy monitoring

7.16 There is no specific monitoring of prosecutors dealing with road traffic fatality cases at court. Managers receive feedback on performance of individual in-house prosecutors from other court users and this forms part of the performance review process; however, this is unstructured. We have no doubt that the majority of in-house prosecutors in these cases are advocates of very good general ability and experience. However, such cases import special considerations already emphasised in this section and the report generally. These considerations apply equally to agent prosecutors, where they are used. CPS managers must satisfy themselves that all advocates dealing with road traffic fatality cases have the appropriate expertise.

Listing

7.17 In order to accommodate the needs of victims' families and witnesses at court some areas have established formal listing protocols with the courts. Others maintain more informal arrangements with both the magistrates' and Crown Court. In both situations the listing schedules are, in the main, working well. The CPS have established good communication between the criminal courts, police and Witness Service in ensuring that cases are dealt with appropriately.

7.18 All agencies endeavour to take into account the needs of the victims' families when listing cases. Road traffic fatalities are highlighted and, where necessary, given priority. In the magistrates' courts cases are normally only moved from one courtroom to another with the advance agreement of the prosecution, which ensures the prosecutor has proper preparation time. Such instances are rare in any event.

7.19 The CPS principles for prosecuting fatal road traffic cases at court should mean that they are always handled by a CPS prosecutor, rather than an agent. It should be the normal procedure.

Victims' families at court

Attendance of victims' families at court

7.20 The needs of victims and witnesses are rightly an important consideration for the criminal justice agencies. The systems for informing the courts that the family may be attending are generally working well, particularly for trial cases. Witness Service staff are notified and arrangements are made in good time. Remand hearings are more problematic. Although the availability of a proactive family liaison officer is an advantage, things can go wrong and inspectors received evidence of one case where a family had attended but were left waiting outside the courtroom for two hours, unaware that the case had already been completed. Where a number of agencies are involved in different aspects of witness care it is important that each is aware of its role and responsibilities. The nature of the case should of itself indicate to prosecutors and caseworkers the likelihood that victims' families will be in attendance.

7.21 It is also apparent that adjournments are occasionally agreed in advance without the families being told. This results in unnecessary attendance and distress particularly when attendance had required lengthy travelling or the taking of annual leave. Conversely, communications errors can occasionally mean that the family lose the opportunity to attend. We encountered one such case where that had happened and the remedial action taken was prompt and commendable. However, the importance of such cases to the family is such that any occurrence of this nature is a serious matter.

The facilities for victims' families at court

7.22 The facilities available at court have continued to improve, particularly in more modern court buildings which incorporate private rooms for witnesses in sensitive cases. However, this is not universal. There are still some court centres where it continues to be difficult for victims' families to remain separate from defendants' families. Whilst some prefer to remain on the general concourse, many do not. In many of the court sites visited the Witness Service was able to find private and comfortable rooms for family members if they wished to use them. This is much appreciated by the families and should be the norm.

7.23 Arrangements for seating victims' families in court are well considered ensuring, where possible, that where there is potential conflict with the defendant's family they are seated apart. In the cases we saw prosecution advocates were careful to liaise with the defence and the court to make appropriate arrangements. Importantly, this was done in the absence of the families to avoid upset that such discussions would naturally cause.

7.24 Families reported that they would like more advance information about the facilities that will be provided. For example practical issues such as car parking availability were often overlooked. They are, in the main, well supported by the family liaison officers at court.

The prosecutor's responsibilities at court

7.25 The Prosecutors' Pledge is a public policy statement issued by the CPS on the delivery of services to victims. It was last updated in January 2008. The Pledge sets out ten standards that the service expects its prosecutors to follow when dealing with victims at various stages of a prosecution. Some relate specifically to expectations at court hearings. In particular, one requires those working in the service to "promote and encourage two way communications between victim, and victims' families, and prosecutor at court". Prosecutors are expected to ensure that during the

course of the court hearing the victim is kept informed of the progress of the case and will promote two way communication to enable a victim or their family to pass to the prosecutor any information that may assist in the conduct of the prosecution or have a bearing on an assertion made by the defence. Wherever possible the prosecutor should explain the reason for any delay to any victim or family members and provide information about how long a delay is likely to be.

7.26 Additionally, the guidance in case handling referred to in paragraph 7.2 states that prosecuting advocates should introduce themselves to the victim's family if they attend court. After the hearing the advocate should explain what has happened and the next steps, if necessary by asking the court to adjourn for a short period for this to happen.

7.27 The overall picture is positive. Witness Service managers reported that, on the whole, CPS staff take their responsibilities to families very seriously despite having other tasks to perform. They are courteous and professional and usually arrive in good time to fulfil their obligations. Discussions take place at appropriate stages and care is taken to avoid distress. Where, exceptionally, the Witness Service has been unhappy with the way a family has been treated they have drawn this to the attention of CPS senior managers. Examples of failures in procedures concerned inexperienced members of staff who were uncomfortable or lacked the skills to speak to victims' families.

7.28 Some caseworkers in the Crown Court and prosecutors in the magistrates' courts felt that the training they had received did not equip them to fulfil the role they were expected to perform in victim and witness care in these sensitive cases. These meetings are more spontaneous than those we describe in the following chapter and cannot be planned to the same extent. Nevertheless, similar complex issues sometimes need to be addressed. It is unfair to all those involved, including the families, to expect inexperienced staff to perform this work without appropriate training. This should form part of the training we have recommended in chapter 3.

7.29 Inspectors found that CPS representatives were generally proactive in introducing themselves to the victim's family and providing explanations of events where required, particularly after the hearing. This was usually, but not always, done away from other members of the public.

7.30 In smaller courts advocates may be released by the magistrates, on request, to speak to the family following the disposal of the case. This is more problematic in busy remand courts where the flow of business is more constant.

7.31 However, this is not universal. In one case we saw the CPS representative made no attempt to introduce themselves to the family before the case, or to seek a few minutes on its conclusion to explain the outcome. The prosecutor preferred to rely upon the assistance of the family liaison officer. In another case counsel spent an extremely brief time with the victim's family and only did so after the conclusion of the proceedings. Although the police family liaison officer is there to liaise closely with the victim's family, not only does CPS policy require the prosecutor to engage with them, the need to do so is included in the standard instructions to counsel.

8 VICTIMS' FAMILIES AND WITNESSES

Background

8.1 Victim and witness care is central to the changes to the criminal justice system that have been introduced by the government in recent years. All local criminal justice boards are now responsible for the local delivery of the Justice for All government targets which include:

- to increase the percentage of public confidence in the fairness and effectiveness of their local criminal justice system; and
- to increase victim and witness satisfaction with the police and with the criminal justice system as a whole.

8.2 The CPS, together with its criminal justice partners, has demonstrated a high level of commitment to delivering these targets and has introduced a number of initiatives to improve the standards of care afforded to victims and witnesses in all cases, and victims' families in road traffic fatality cases. We set out the significant developments since the 2002 report below:

- *Prosecutors' Pledge*. In October 2005 the then Attorney General introduced the Prosecutors' Pledge. It sets out the level of service that victims, or in the case of fatalities their families, can expect to receive from prosecutors. The Pledge underpins the Attorney General's Guidelines on the acceptability of pleas and outlines the role that all prosecutors have to play in protecting victims' interests.

- *The Code of Practice for Victims of Crime*. The Victims' Code was issued under the Domestic Violence, Crime and Victims Act 2004 and came into force on 1 April 2006. It sets out the minimum level of service to be provided to all victims of criminal conduct in order to support them through the criminal justice process. Certain categories of victims, who fall within the definition in the Victims' Code of vulnerable or intimidated, should be provided with an enhanced level of service which refers to the timescales in which information is provided. The families of victims who have died as a result of criminal conduct are included within this definition and are eligible to be provided with an enhanced level of support.

- *No Witness No Justice*. The scheme was introduced in 2003-04 and is based on two main principles, a needs assessment approach for all witnesses (in cases where there is a not guilty plea) and the introduction of dedicated witness care units. The initiative sets out 14 minimum requirements to support witnesses through the criminal justice process, underpinned by a number of primary and secondary measures against which performance should be monitored by local criminal justice boards.

- *Witness care units*. Created under the NWNJ initiative; since the end of 2005 all areas have had dedicated WCUs, with a combination of police and CPS staff. They are responsible for assessing the needs of witnesses and provide information on the progress of the case directly to the victim or their family or via the family liaison officer where there has been a fatality, and notifying families of the outcome of each court hearing and the next hearing date within one working day.

- *CPS policy bulletin 2006*. In 2006 the CPS issued instructions that once a charging decision had been taken in a road traffic fatality case the reasons for the decision should be fully explained to the victim's family. Prosecutors were advised that this could initially be by telephone and/or letter, but that they should not to wait for the family to ask for a meeting: one should be offered at the time the decision was notified to the family.

- *Victim Focus scheme*. This came into force on 1 October 2007. Prosecutors will offer to meet the bereaved families of victims of homicide to explain the procedures in relation to the prosecution of the case.

- *CPS victim and witness strategy 2008-11*. The CPS strategy for 2008-11 aims to deliver excellent standards of victim and witness care to achieve the Justice for All targets. The strategy seeks to provide a coordinated service to victims and witnesses with other criminal justice partners, build on the initiatives described above, to ensure effective delivery of commitments and engage with victims and witnesses of crime at the earliest appropriate stage of the prosecution process. The strategy recognises that a more joined-up approach is required and contains a commitment to consolidating public policy and guidance to include the publication of an overarching public policy statement on victims and witnesses.

8.3 Currently all the CPS policy, practice and guidance in relation to these initiatives are contained in a number of separate documents. This can make it difficult for the public and staff to locate the information they require and it is not entirely clear whether more recent guidance supersedes that issued previously. This can lead to inconsistencies of approach between prosecutors and across areas.

RECOMMENDATION

The CPS should clarify and collate the guidance relating to its commitments to victims' families in road traffic fatality cases.

Communicating with victims' families

8.4 At the time of the 2002 report it was the responsibility of the police to inform victims' families and witnesses of the progress in the case, relying on information provided by the CPS. We commented that in a small number of cases families had not been kept up-to-date and as a result were critical of the CPS. The Service has worked hard with other agencies since then to improve the level of communication with victims' families.

8.5 One of the aims of the Victims' Code is to provide a joined-up multi-agency approach to victim care. It clarifies who is responsible for keeping victims or families informed of the progress in the case at each stage of the proceedings and sets out the appropriate timescales within which communication should take place. Each organisation has an obligation to pass to others with responsibility under the Victims' Code details of any vulnerable or intimidated victim.

8.6 All communication with victims' families prior to the first appearance at court (with some exceptions, see below) is the responsibility of the police and this is invariably undertaken by the police family liaison officer (required under the Victims' Code for cases where a victim has died as a result of criminal conduct). The Victims' Code is clear that, following the first appearance at court, responsibility for keeping the family informed of the outcome of the court hearing and the next hearing date is that of the WCUs, but in practice this is usually undertaken by the family liaison officer. In cases where family members are also witnesses in the case, usually both the WCU and family liaison officer will communicate with them. This can work well where the liaison officer has established a relationship with the family, having been appointed very soon after the collision, and we saw many examples of excellent care of families.

8.7 It is essential that, where information passes between the liaison officer and CPS concerning the family, the WCU is also kept informed. Some WCU managers have concerns that from time to time they are inadvertently left out of the communication chain, sometimes with embarrassing consequences for the witness care officer, for example, when the prosecutor has failed to notify them that a case has been discontinued. We comment further on the need for liaison with WCUs in chapter 9.

Direct communication with victims

8.8 The direct communication with victims initiative (DCV) was introduced in 2001 and at the time of the 2002 inspection it was too soon to form judgements as to its success.

8.9 Under DCV the CPS should write to victims where a charge is dropped or substantially altered to explain the decision and in certain categories of cases the prosecutor will also offer a meeting. In cases involving a death, such as road traffic fatalities, the scheme extends to victims' families.

8.10 We have commented in chapter 5 about the small number of adverse outcomes in our file sample. There were only two cases where the charge was dropped and one where it was reduced. Letters were sent in the two that were dropped but not in the one where the charge was reduced. Only one of the letters offered the family a meeting.

8.11 In order to assist CPS staff in identifying cases which fall within the DCV scheme a 'flag' should be set on CMS when the file is registered to show that the case is one that comes into the category of having a victim. Where a case involves a vulnerable and intimidated victim an additional flag is required and both should be set in road traffic fatality cases. When the file label is then generated it will include a record of the flagging. Most areas also mark the front of the file jacket manually to indicate that DCV applies.

8.12 HMCPSI conducted an audit of DCV in September 2007. The report noted inconsistencies in flagging cases involving vulnerable and intimidated witnesses. The audit findings are reflected in those in this inspection: 46 out of 113 cases (40.7%) were flagged as having a victim and ten out of 113 (8.8%) as having a vulnerable or intimidated victim. There was also a general lack of awareness on the part of managers that the vulnerable and intimidated victim flag was necessary in road traffic fatality cases. There is a clear risk that where cases are not correctly flagged the need for a DCV letter may be overlooked or timescales for sending letters will not be complied with.

8.13 Following the audit the CPS victim and witness strategy 2008-11 has included a commitment to improve performance in delivery of DCV and to review and update the processes of the initiative, in particular to take into account the impact of the CPS taking the decision on charging.

Letters written to victims' families outside the DCV scheme

8.14 There appears to be confusion as to when letters to families should be sent. The Victims' Code extended the DCV initiative to those cases where the prosecutor has decided there is insufficient information to bring any proceedings for a criminal offence at the pre-charge stage and has not had a face-to-face or telephone discussion with the officer in the case about the decision (that is, where the advice has been provided in writing). The family must also be offered a meeting to explain the decision. The CPS policy bulletin that was issued in 2006, however, required a letter to be sent (and a meeting to be offered) once a charging decision was made, regardless of whether the decision was to charge or take no further action and regardless of how the advice was given.

8.15 It is clear that such letters are not routinely being sent. There were nine cases where the prosecutor had advised no further action at the pre-charge decision stage and a letter was sent to the victim's family by the prosecutor in only two (22.2%). This maybe because prosecutors are now applying the guidance to the CPS policy on prosecuting cases of bad driving which makes no mention of the 2006 policy.

8.16 The way the current guidance is expressed could give the impression that there has been a reduction in the commitment made by the CPS to victims' families. There is a need for clarity to emphasise the need for letters explaining decisions and offering meetings to be sent in every case at the charging decision stage.

RECOMMENDATION

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.

Quality of letters written to victims' families

8.17 The overall quality of the letters written to families was good and they were of a much higher standard than those found in other inspections, for example in domestic violence cases and in the DCV audit. We were impressed with the thought and care that had gone into many. They were sympathetically written, with many including personal and humane comments and not drawing too much on standard paragraphs.

8.18 There were, nevertheless, a few letters in the sample that were bland, lacked appropriate sensitivity and relied heavily on the use of standard paragraphs. The better letters tended to include certain elements, which were set out in a logical order that was easily understood. These would include:

- introduction of writer of letter;
- purpose of letter;
- expression of sympathy; and
- setting out what the decision was at an early stage.

8.19 In at least one area a well written letter to a victim's family has been circulated as an example of how such letters should be drafted. Any such circulation could usefully include a checklist of points to include.

GOOD PRACTICE
The circulation of good examples of letters written to victims' families.

Timeliness of letters

8.20 In our file sample communication with families was timely in 32 out of 36 relevant cases (88.9%).

8.21 However, we saw letters sent to families notifying them of the sentence a significant time after the court hearing. This not only appears to be unprofessional but it can potentially cause distress.

Meetings with victims' families: frequency and evaluation

8.22 Prior to the introduction of the DCV initiative the CPS was committed to offering meetings to victims' families under the Victims' Charter. In 2002 there had been an increase in the number of meetings being held as a result of the DCV initiative. It was anticipated that this would continue and that staff would be able to build up experience in handling meetings, provided proper evaluation took place to assess good points or aspect to improve. We made a recommendation in the 2002 report to reflect this. However, meetings have not been evaluated, perhaps because of the small number of cases that are discontinued or where pleas are accepted to lesser offences.

8.23 Meetings are not always offered and, when they are, the offer is not always taken up by the family. In our file sample meetings were offered in only three out of 12 cases (25.0%) in which no further action was advised, or where the case was discontinued or charges reduced. A meeting took place in only one case. Meetings took place in a further four cases, two of which were at the instigation of the family who were unhappy with the way the case had been handled. The CPS victim and witness strategy 2008-11 includes piloting and evaluating meetings with victims' families in cases of homicide, which includes causing death by dangerous driving and causing death by careless driving whilst unfit through drink or drugs. It will also include the two new offences created by the Road Safety Act 2006: causing death by careless driving and causing death while driving unlawfully on a road. We consider that all meetings with families in fatal road traffic cases should be evaluated, whatever the charge, and including cases where the decision was to take no further action.

8.24 The CPS DCV guidance states that although meetings will usually be conducted by the reviewing lawyer in the case, explanations of decisions in cases involving a death should be dealt with by staff at level E and above with the relevant experience/training. In some areas prosecutors below level E are conducting meetings with families. DCV training (which is now part of the induction process for all lawyers) used to include a role play scenario of a meeting with a family in a road traffic fatality case, but no longer does so. Many prosecutors attended the training some time ago and, as they are not regularly conducting meetings, some further training would be beneficial. This should form part of the training we have recommended in chapter 3.

Meetings with victims' families: format

8.25 In the 2002 report we recommended that meetings should be arranged in accordance with the advice set out in the guide to DCV. The guidance sets out the appropriate steps to follow and contains a helpful annex with a checklist and tips. When meetings do take place they are almost always attended by the family liaison officer, and prosecutors have demonstrated a willingness to be flexible concerning the location of the meeting, provided it complies with the DCV guidance.

8.26 A full note, recording what was said at the meeting, should be made and retained on the file. This is not always being done. If the meeting was held before the conclusion of the proceedings, the prosecutor should notify the defence that it took place. In the four cases where meetings were held during the proceedings there was no note on the file to indicate that they had taken place and the defence was notified in only one of the four. In some instances the prosecutor wrote a letter to the victim's family after the meeting to confirm what had been discussed. We consider this to be good practice.

GOOD PRACTICE

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

Timing of meetings

8.27 In the 2002 report we commented that the timing of meetings is of great importance to victims' families and that road traffic cases involving a fatality were ones in which an exception could be made and a meeting held before the conclusion of the case, especially as the families are often not also witnesses. We suggested that where a decision is made not to hold an early meeting, area managers would wish to satisfy themselves that proper reasons can be given as to why the meeting could not be held earlier. Since then the CPS has set out further guidance on the timing of meetings in the policy bulletin issued in 2006 which states:

- it may be desirable to hold an early meeting with the bereaved, before the charging decision is made to explain the law, processes and procedure and to enable the bereaved to put a 'face to a name';
- it is essential that once a charging decision is taken the reasons for a decision are fully explained to the bereaved. This may initially be by telephone and/or a letter. Prosecutors should not then wait for the bereaved family to request a meeting: a meeting to explain the decision should be offered at the same time the decision is notified.

8.28 The CPS guidance on DCV, which was updated in January 2008, also now states prosecutors should note that where a death has occurred and the victim's family has requested a meeting, this should not be delayed until the conclusion of the case unless there are exceptional and justifiable reasons for doing so. The CPS guidance on the Victim Focus scheme (see below) states that ideally the meeting held under the scheme will take place after the case has been served upon the defence and before the plea and case management hearing in the Crown Court.

The Victim Focus scheme

8.29 The Victim Focus scheme (VFS) came into force on 1 October 2007 and was amended in August 2008 to take account of the new charges created by the Road Safety Act 2006. Under the scheme the CPS will offer to meet victims' families in homicide cases, usually after charge. The definition of homicide extends to the offences of causing death by dangerous driving, causing death by careless driving whilst unfit through drink of drugs, causing death by careless driving, causing death by driving unlawfully on a road, and aggravated vehicle taking where a death is caused. The purpose of the meeting is to deal with any questions and concerns the family may have, outline the court process, progress in the case, explain the role of the CPS, the legal basis on which the case is proceeding and the victim personal statement scheme (see below).

8.30 CPS guidance, which sets out the procedures for prosecutors to follow, has been disseminated to areas and is available on the CPS internal intranet. The introduction of the VFS is likely to increase the number of meetings held with victims' families, but no central training has been delivered or is planned. This should form part of the training we have recommended in chapter 7.

8.31 Awareness of the obligations under the scheme by those prosecutors and caseworkers we interviewed was mixed. This was supported by our file reading: the VFS applied to 25 cases in the sample and there was compliance with the scheme in only 14 (56.0%).

The victim personal statement

8.32 The victim personal statement (VPS) scheme was introduced in 2001 to enable close family members to make a statement setting out the impact of the events on them. The VPS is usually made by parents, guardians, spouses, civil partners, partners and children of the deceased. At the time of the 2002 report concerns were raised with us that not all victims' families were being made aware of the opportunity to make a statement and they were not always informed how it would be used in court. We made two recommendations to reflect these concerns.

8.33 This is now covered in the VFS booklet for families of victims of homicide, which sets out the procedure for making a VPS and how it will be used and the CPS guidance on the scheme for prosecutors.

8.34 Although generally there was a good awareness of the VPS, prosecutors were not always proactive in requesting one from the police where it had not been provided and, in some cases where the statement had been made soon after the collision, an updated one had not been requested from the police. A VPS was present in 20 out of 63 magistrates' courts' cases (31.7%) and 33 out of 48 Crown Court cases (68.8%), which represents 47.7% overall.

9 PARTNERSHIP WORKING

Liaison with the police

9.1 In the light of the highly sensitive nature of cases involving road traffic fatalities and the impact of decisions made both by prosecutors and the police on victims' families, accused drivers and the public at large, it is generally recognised that clear and robust working practices are a vital ingredient of effective prosecutions. Strengthening this relationship is key to improving the quality of investigations, charging decisions and the service offered to families.

9.2 There were many examples of well-established links between the police and the CPS, particularly at operational or command unit level, with CPS assistant/district crown prosecutors speaking regularly to police managers of road death investigation units or their equivalent. We were especially impressed with the extent of liaison in CPS London where a dedicated unit had been set up to deal solely with road traffic prosecutions (although this may not be practicable or even appropriate in the rest of the country).

9.3 Nevertheless, in many areas police managers expressed clear concerns that stronger guidelines were necessary so that both agencies could concentrate their resources in a way that allowed a greater focus on cases involving road traffic fatalities. We heard from several practitioners that all or some of the following issues could lead to frustration and a lack of clarity in their dealings with their counterparts in the other agency:

- timeliness of initial file submission by the police;
- minimum standards for file content and quality by the police;
- timeliness of the CPS charging decision;
- method and timing of communication of decisions to victims' families (whether or not the Victim Focus scheme applies); and
- timing of the approach to families to obtain a victim personal statement.

9.4 Those issues also arose during the course of the inspection and we have commented upon them in earlier chapters.

9.5 So that cases can be properly managed through the criminal justice system, the vast majority of these issues could be usefully amalgamated into one area service level agreement or protocol clearly setting out what each organisation expects from the other.

RECOMMENDATION

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.

9.6 We found relatively few examples of strategic liaison between CPS and the police where longer term trends, policy developments and contact with community groups or other interested bodies could be raised and a common 'prosecution team' approach formulated. Where cases attract major media attention amid a time of legislative change, this level of joint work is necessary.

RECOMMENDATION

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.

Liaison with HM coroners

9.7 Whenever a road traffic collision involves a death the coroner must hold an inquest into the circumstances. The law and procedures are governed largely by the Coroners Act 1988 and rules made under the Act. If there is to be a prosecution as well legal guidelines are in force relating to the timing of proceedings to avoid the defendant in the criminal proceedings being in 'double jeopardy' and to prevent potential conflict between the criminal courts and the coroner's court. Section 16 of the Act (amended by the Road Safety Act 2006) obliges the coroner to adjourn any inquest until after the conclusion of criminal proceedings for offences including manslaughter, causing death by dangerous or careless driving or causing death by careless driving while under the influence of drink or drugs, unless there is a reason not to adjourn. In practice the court or police make the coroner aware of any proceedings and coroners are generally alert to the need not to proceed with the inquest until the CPS have made a decision whether to charge and, if so, for what offence.

9.8 In cases where the fact of death is not encompassed within the offence the coroner will usually proceed with the inquest. In practice this applies principally to offences of careless driving but may include offences of failing to stop after an accident and failing to report an accident and others. Established case law *Re Beresford ([1952] 36 Cr App R 1)* approved in *DPP v Smith ([2000] RTR 36)* makes it clear that it is good practice not to proceed with summary proceedings in the magistrates' courts until the inquest is concluded.

9.9 The 2002 report commented that prosecutors did not always ensure that summary proceedings were adjourned until the conclusion of the inquest. The CPS had issued guidance to all relevant staff in June 2002 and recommended that areas should reinforce this by ensuring that prosecutors dealing with cases in the summary courts should be made aware of this. The guidance was also included in the that previously issued nationally on driving offences. It was not referred to in the legal guidance issued in January 2008, but has now been restated in the revised information issued in August 2008.

9.10 The position may have improved overall, but coroners still noted incidences of cases being dealt with before the inquest verdict; in some areas in numbers that should give rise to continued concern.

9.11 Prosecutors told us that the date of the inquest was usually provided by the police when the file was submitted for advice. Specialist prosecutors told us they were clearly aware of the guidance in *DPP v Smith* and that, as far as they were aware, those prosecuting cases in the magistrates' courts would also be aware of the position. Our discussions, however, revealed that a few senior area lawyers were not aware of the guidance.

9.12 In no area was it routine or standard practice specifically to refer to the date of the inquest, or provide a note to the prosecutor requesting that an adjournment be sought in appropriate cases.

9.13 Despite the assertion that details of the inquest were usually provided with the police case report, we found that the information was often not included and no query was raised by the reviewing lawyer. The date of the inquest was clearly noted on the file in only 13 out of 103 relevant cases (12.6%). In most of the magistrates' courts' cases examined there was no indication that the prosecutor had any knowledge of the date of the inquest.

9.14 The 2002 report noted that it was unusual for CPS prosecutors to attend inquests or receive a report from the police about the issues raised at the inquest. Attendance at inquests is still rare, although prosecutors recalled instances where they or colleagues had attended inquests in the past. In one case this was done specifically to form an assessment of the way the evidence was presented in court: it was regarded as immensely valuable to the prosecutor in the subsequent decision.

9.15 The recently issued CPS guidance on cases of bad driving suggests that lawyers might attend inquests "where it is considered beneficial to do so". We would not seek to be any more prescriptive than that but would view attendance at inquests in appropriate circumstances as just one aspect of increased contact and liaison between coroners and the CPS.

9.16 If CPS prosecutors were to notify coroners of decisions to charge or to take no further action in cases involving a fatality, then coroners could arrange their business to take account of the decision. From the responses provided by coroners across the country and from the comments made by local prosecutors and police officers, there is a clear view held by many coroners that there is a lack of both understanding and appreciation of their role within the investigation of a death both as a result of a road traffic fatality and in other circumstances. Several coroners have expressed a desire for more effective communication with the CPS at a local level and it is apparent that where in one or two CPS areas CCPs have forged close working relationships with coroners. Benefits have flowed from them including contributions to training programmes and a greater understanding of the role of the CPS.

9.17 It is a commonly held view of coroners that delays in holding inquests in cases involving road traffic fatalities are frequently the result of poor timeliness on the part of prosecutors. The file sample has shown that the CPS charging decision has been taken in a reasonably timely fashion in 63.2% of cases, but that the police have expended a substantial proportion of the six months statutory time limit before delivering a file to the prosecutor. The CPS is currently failing to take the opportunity to ensure that coroners are informed accurately of the case history.

9.18 There is no reason why the CPS cannot communicate directly with the coroner to ascertain the date of the inquest or on any other matter connected with the case. However, such direct communication was rarely found on files within our sample. The 2002 report commented that closer liaison between coroners and the CPS would be advantageous for both. We believe it is likely to contribute to more timely proceedings in both the criminal courts and the coroner's court with consequent benefits for the families of victims in road traffic collision cases.

9.19 There is, therefore, a clear need for CCPs to engage with coroners who represent jurisdictions within the CPS area. As a minimum, areas need to:

- identify a single point of contact to act as a first line of communication with the coroner's office; and
- ensure coroners are notified of all CPS charging decisions in cases involving road traffic fatalities and decisions to take no further action in such cases.

RECOMMENDATION

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.

9.20 If CCPs adopt the recommendation above in relation to a strategy group involving police representatives, then it is highly appropriate that coroners be invited to attend such meetings.

Liaison with witness care units

9.21 As we stated in chapter 8, areas need to develop and maintain close and effective working relationships with witness care units. Effective trial management and high standards of victim and witness care rely upon the achievement of such partnership working.

9.22 WCU managers told us that they did not distinguish between cases involving road traffic fatalities and other cases where victims had been killed or seriously injured. They considered that their staff had the necessary skills and knowledge to deal with such sensitive cases, and were aware that in road traffic fatalities the police would appoint a dedicated family liaison officer to look after victims' families and keep them informed of all significant developments in criminal proceedings.

9.23 There is a potential blurring of the two roles of witness care officer and family liaison officer which could impair effective liaison with CPS staff in a particular case and thus lower the standard of care offered to a victim or witness. In order to eliminate this possibility one area we visited had successfully brokered an agreement for early liaison between the police and WCU where it is determined which officer is to play the leading role in communicating with the victim's family.

9.24 We spoke to several WCU managers about their relationships with their local CPS areas and a majority expressed their satisfaction with the current arrangements. However, in a few they told us that they found it difficult to secure informed and timely responses to requests for information. In one case the standard of CPS communications was described as "appalling". However, this comment was not confined to cases involving road traffic fatalities.

9.25 The overall impression gained from the file sample and conversations with staff in all three organisations was that the family liaison officer was pivotal to well-informed and timely communications to victims' families. Once a case had been listed in court for the first time, CPS staff need to maintain effective links with both the family liaison officer and witness care officer. The following aspects of the progress of a case are of great significance:

- notification of hearing dates;
- preferred methods of communication;
- explanations of legal decisions or other developments in the case; and
- when and how a victim personal statement can be made.

9.26 We were given examples of Crown Court hearings that had been changed where the new information had not been notified to victims' families in good time, or at all. Nevertheless there were several instances of protocols negotiated with local courts restricting the alteration of hearings in these cases and we were told that these were normally respected.

Engagement with community groups representing victims' families

9.27 Since the publication of the 2002 report there have been developments in the policy and legislative landscape relating to road traffic fatality cases which have ushered in a new atmosphere among the public at large – not solely victims' families – that in turn have brought the decisions and conduct of the CPS in these very sensitive cases into even sharper focus.

9.28 At the same time, in common with its criminal justice partners the CPS has publicly rededicated itself to providing a better service to victims and witnesses generally and an enhanced service to victims' families.

9.29 In the course of the 2002 review inspectors met organisations representing victims' families and it is clear that at national level, and to a much lesser extent at local level, contacts have been established with a number of groups with a high public profile in this field. The CPS consulted with these groups, for example, RoadPeace and the Royal Society for the Prevention of Accidents (RoSPA) during the formulation of its new policy for prosecuting bad driving published in late 2007.

9.30 At a national level contributions by CPS Policy Directorate to the RoadPeace annual conference, and at a local level in London and the north west the piloting of programmes and attendance at group meetings, are acknowledged and welcomed. At the same time some areas have sent representatives to conferences or workshops, or invited community group members to meetings as a means of sharing information and concerns.

9.31 There is, however, greater scope for establishing contact at a local level with community groups and to promote thereby a wider appreciation of the role of the CPS in the criminal justice process and a more positive image of the CPS as a modern and professional organisation.

ANNEX A: NEW OFFENCES OF CAUSING DEATH BY CARELESS OR INCONSIDERATE DRIVING AND CAUSING DEATH BY DRIVING WHILST UNLICENSED, DISQUALIFIED OR UNINSURED

The offences

The Road Safety Act 2006 (RSA) created two new offences: at section 20, the offence of causing death by careless or inconsiderate driving; and, at section 21, causing death by driving whilst unlicensed, disqualified or uninsured. They came into force on 18 August 2008 for offences committed on or after that date.

The maximum penalties for the offences are five years' and two years' imprisonment, respectively. Each carries a minimum disqualification of 12 months. They are offences capable of being tried in either the Crown Court or the magistrates' courts.

Causing death by careless or inconsiderate driving

Section 21 RSA creates a new section 2B of the Road Traffic Act 1988 (RTA): "A person who causes the death of another person by driving a mechanically propelled vehicle on a road or other public place without due care and attention, or without reasonable consideration for other persons using the road or place, is guilty of an offence".

The maximum penalty for the offence is five years' imprisonment with a mandatory minimum disqualification of 12 months.

Causing death whilst unlicensed, disqualified or uninsured

Section 21 RSA creates new section 3ZB RTA as follows: "A person is guilty of an offence under this section if he causes the death of another person by driving a motor vehicle on a road and, at the time when he is driving, the circumstances are such that he is committing an offence under –

a section 87(1) of this Act (driving otherwise than in accordance with a licence);
b section 103(1)(b) of this Act (driving while disqualified); or
c section 143 of this Act (using motor vehicle while uninsured or unsecured against third party risks)."

It is an offence triable either way with a maximum sentence of two years' imprisonment and a minimum disqualification of 12 months.

ANNEX B: CPS POLICY ON PROSECUTING CASES OF BAD DRIVING

Introduction

1.1 This document explains the way in which we, the Crown Prosecution Service, deal with cases involving bad driving. It supplements and is subordinate to the Code for Crown Prosecutors.

1.2 Bad driving resulting in death or injury has devastating consequences for victims and their families and friends, and it is important that justice is seen to be done in cases where this has happened.

1.3 The CPS is committed to ensuring that in such cases our prosecutors reach the correct charging decisions, so that the right person is prosecuted for the right offence in the right court.

1.4 For this to be achieved these decisions must be in line with current law, but also, where it is just and lawful to do so, they should reflect changing public attitudes to bad driving and the desire of victims, or their families, friends and the public, to see that justice is done in these cases.

1.5 In 2002 HMCPSI undertook a review of the way in which the CPS was handling road traffic cases involving fatalities. That review found that in the vast majority of cases under review the correct charge was chosen by the CPS[2].

1.6 In 2006 the Director of Public Prosecutions (DPP) acknowledged that, notwithstanding the findings of the HMCPSI report, there were occasions where victims or their families and friends did not agree with the decisions made by the CPS or found them hard to accept or understand.

1.7 Following a public consultation carried out by the Home Office in 2005, Parliament passed the Road Safety Act 2006, which will introduce new offences of causing death by careless driving and causing death while driving unlawfully on a road[3].

1.8 The DPP decided that the time was right for the CPS to review its prosecution policies and procedures for dealing with cases of bad driving, and that this review should be informed by a wide public consultation, which was launched in December 2006[4].

1.9 The purpose of the consultation was to open up the CPS practices and procedures and to explain how CPS prosecutors reach their decisions in these cases, because the CPS wants the public to have confidence in the decisions that we make.

1.10 There were 139 responses to the consultation, showing how deeply people care about the consequences of bad driving and how its consequences, especially where a loved one has been killed or seriously injured, cause unimaginable distress.

1.11 The issues raised by the consultation attracted a wide range of views, all of which have been taken fully into account in the preparation of this policy. The content of the policy, however, is the responsibility of the CPS alone.

---

2 A report on the thematic review of the advice, conduct and prosecution by the Crown Prosecution Service of road traffic offences involving fatalities in England and Wales – available from the HMCPSI website (www.hmcpsi.gov.uk).

3 Sections 20 and 21 of the Road Safety Act 2006. These sections are not in force at the time of writing.

4 Prosecuting bad driving – a consultation on CPS policy and practice.

1.12 The CPS is not the only agency that deals with cases involving bad driving. The police, the criminal courts, magistrates and judges all have roles to play in promoting greater confidence in the criminal justice system. We shall work with our partner agencies to ensure that justice is done in these cases.

The policy can be found in full on the CPS website: www.cps.gov.uk.

ANNEX C: IMPLEMENTATION OF RECOMMENDATIONS AND SUGGESTIONS FROM 2002 REPORT

Recommendations	Position in 2008
CCPs review the method of "flagging" fatal road traffic offences cases, to facilitate easier identification.	Limited progress. Files are not always marked clearly, with areas relying on flagging on CMS.
CCPs nominate one or more lawyers with suitable experience to specialise in road traffic fatality and other serious road traffic cases to be available for consultation; such lawyers should receive appropriate specialist training.	Substantial progress. Specialists have been nominated and are available for consultation. There is, however, no national specialist training available.
CCPs ensure that prosecutors are aware of the guidance given in relation to the timing of inquests in cases involving summary criminal proceedings and take steps to ensure that summary proceedings involving road traffic fatality cases are not dealt with until the relevant inquest has been held.	Substantial progress. Guidance in relation to inquests has been disseminated and has been reinforced in the guidance issued in August 2008. A few senior prosecutors remained unaware of the issues.
Prosecutors provide advice in road traffic fatality cases within the CPS time guidelines wherever practicable (in all but the most substantial cases).	Limited progress. Some advice continues to be provided late and a new recommendation has been made.
Prosecutors ensure that where further information is needed from the police before advice can be given, any such requests are made as soon as practicable and in any event within 14 days of the receipt of the original request for advice.	Achieved. Papers submitted by the police are generally well prepared and generate limited requests for further information.
Unit heads review the effectiveness of the systems used to monitor the timeliness of advice to ensure that requests are dealt with in a timely manner.	Limited progress. See above.
The Director, Policy records all road traffic fatality cases that are prosecuted for an offence of manslaughter and that such records are properly analysed so that any lessons can be learned.	No progress. The CPS decided not to implement this recommendation as they were not maintaining offence-based statistics.

Recommendations	Position in 2008
CCP and unit heads monitor the quality of review decisions in all road traffic fatality cases, to ensure that: • all relevant issues in the case are properly considered; • cases proceed on the correct level of charge; and • any training needs on the part of prosecutors are identified and addressed.	Substantial progress. CCPs have been required to quality assure charging decisions since 2006, although not all are doing so. Guidance issued in August 2008 requires CCPs to approve all decisions on charging, mode of trial (where appropriate) and those to accept a plea to a lesser offence. Concerns remain over the level of charge and, as stated above, there is no national training available.
The Director, Policy issues revised guidance in relation to road traffic fatality cases and reviews the driving offences charging standard, particularly in relation to dangerous driving, and if amendment is appropriate enters into negotiation with ACPO to agree necessary amendments.	Achieved. The charging standard and legal guidance were revised at the end of 2004. New guidance was issued in January 2008 and revised that August following the introduction of the new offences.
CCPs ensure that prosecutors are in possession of road traffic fatality files in sufficient time to enable them to prepare the case for presentation in court properly.	Substantial progress. Prosecutors are generally in possession of files in good time (but issues remain where agents are instructed in the magistrates' courts – see below).
CCPs ensure that where agents are instructed to prosecute road traffic offences involving fatalities in the magistrates' courts, files (or copies of papers) are sent to the agents sufficiently in advance of the hearing to facilitate effective case preparation.	Limited progress. Areas endeavour to provide agents with papers in good time but this is not always achieved.
Prosecutors and caseworkers introduce themselves to witnesses and victims' relatives at court and provide appropriate and useful information, in fulfilment of the commitment of the CPS.	Substantial progress. Generally, prosecutors and caseworkers do introduce themselves to victims' families, although there remain instances of limited or no contact being made.
CCPs and CPS staff at all levels should regularly take steps to: • identify staff who deal with victims' relatives and witnesses in sensitive cases such as road traffic involving fatalities; • evaluate whether those staff are properly equipped with the skills and experience required to deal with their duties; and • ensure that appropriate training or any other assistance is provided.	Limited progress. Staff who deal with victims' families in formal meetings are experienced and generally have the skills - although updated training is required. Staff who deal with victims' families at court have not been provided with appropriate training.

Recommendations	Position in 2008
CCPs ensure that systems are in place to ensure that the quality of letters informing victims and relatives of decisions to discontinue cases or to alter substantially the charge are supervised, to encompass typographical and factual errors, as well as the overall content of the letter.	Substantial progress. DCV letters are generally sent by experienced prosecutors and the quality overall is very good.
CCPs ensure that in all road traffic fatality cases appropriate victims' relatives are informed that they may meet the reviewing prosecutor to receive an explanation of the reasons for a decision to discontinue the case, or to alter substantially the charge, in accordance with the CPS's statement on the treatment of victims and witnesses.	Limited progress. Victims' families are not always informed that they may meet the reviewing prosecutor.
All staff arranging meetings with victims' relatives should ensure that: • arrangements for the meetings are in accordance with advice set out in the guide to DCV; • CPS staff make all efforts to explain the decision(s) made, and the reasons for them, in as helpful and informative a manner as possible; and • the meetings are properly evaluated to consider whether any improvements can be made for the benefit of future meetings.	Substantial progress. Meetings with victims' families are arranged in accordance with the DCV guide, but they are not evaluated.
Prosecutors ensure that victims' relatives are informed about how their victim personal statement will be used in court and, where appropriate, are given an explanation as to why a particular course has been adopted.	Substantial progress. There is generally a good awareness of the VPS, although prosecutors do not always request one where it has not been provided, or an updated one where appropriate.

Suggestions	Position in 2008
CCPs review their systems for monitoring the progress and listing of road traffic cases involving fatalities, to ensure that they can arrange for cases to be listed in courtrooms where CPS advocates are prosecuting.	Achieved. Agreements with the courts, both formal and informal, appear to be working well.
Prosecutors and caseworkers ensure that discussions about road traffic fatality cases, whether with other prosecutors, caseworkers or defence advocates, are undertaken in circumstances which do not undermine the expectations of professionalism of members of the CPS and those instructed to appear on behalf of the CPS.	Achieved. Discussions generally undertaken in an appropriate and professional manner.
CCPs ensure that letters informing victims' relatives of decisions to discontinue cases or to alter substantially the charge are issued within the CPS time guidelines.	Achieved. Letters to victims' families are generally timely.
Prosecutors and caseworkers dealing with road traffic fatality cases confirm with the police that the victims' relatives have been made aware of the opportunity to make a VPS.	Limited progress. Prosecutors and caseworkers are not always confirming with the police that victims' families are aware of the opportunity of making a statement. However, although a VPS was present in only just over half the cases in the file sample, one is generally available at an appropriate stage in the proceedings.

ANNEX D: REPRESENTATIVES OF CRIMINAL JUSTICE AGENCIES, OTHER ORGANISATIONS AND SPECIAL INTEREST GROUPS AND MEMBERS OF THE PUBLIC WHO ASSISTED WITH THE INSPECTION

HM coroners
Dr P Knapman
Mr A Rebello, Hon Secretary, the Coroners' Society of England and Wales
Written comments were also received from 39 HM coroners across the country.

Crown Court
His Honour Judge Ashurst, Honorary Recorder of York Crown Court
His Honour Judge Collier QC, Honorary Recorder of Leeds Crown Court
His Honour Judge Brown
His Honour Judge Diehl QC
His Honour Judge Gullick
His Honour Judge McKinnon
Mr S Jones, Court Manager
Mr C Kreffer, Lead Court Manager
Mr D Manning, Head of Operations
Mr S Tozer, Crown Court Manager

Magistrates' courts
Mr H Charles, JP, Bench Chairman of Northallerton Bench
Rev Dr W Dolman, JP, Bench Chairman of Croydon Magistrates' Court
Mr F Higgins, JP, Chairman Eastern Sussex Bench
Mr D Bathurst, Divisional Legal Manager, Chichester Magistrates' Court
Mr J Bryer, Deputy Justices' Clerk, HM Courts Service (London)
Mrs J Burke, Deputy Justices' Clerk, HM Courts Service (Cumbria and Lancashire)
Mr K Burman, Deputy Justices' Clerk, HM Courts Service (Greenwich Magistrates' Court)
Mr M Dodds, Clerk to the Justices, HM Courts Service (Kent)
Mr P Edwards, Divisional Legal Manager, Eastern LJA, Sussex
Mr E Hall, Senior Legal Team Manager, Bexley Magistrates' Court
Mr R Hook, Deputy Justices' Clerk, HM Courts Service (Kent)
Mrs K McNally, Divisional Legal Manager, Northern LJA, Sussex
Miss K Nickless, Acting Deputy Area Legal Manager, Telford Magistrates' Court
Ms K Rana, Legal Team Manager, Kingston-upon-Thames Magistrates' Court
Mr A Roveri, Deputy Justices' Clerk, HM Courts Service (Devon)

Police
Chief Superintendent T Swarbrick, Head of Operations Unit, Devon & Cornwall Constabulary
Superintendent S Barry, Road Policing Department, Sussex Police
Superintendent I John, Road Policing, Dyfed Powys Police
Chief Inspector C Booty, Head of Roads Policy, Devon & Cornwall Constabulary
Chief Inspector K Botting, Traffic Criminal Justice Operational Command Unit, Metropolitan Police
Inspector M Armstrong, Road Policing Department, Sussex Police
Inspector D Brown, North Yorkshire Police
Inspector P Cottam, Lancashire Constabulary

Inspector P Sellwood, Tactical Operations, Kent Police
Inspector S Turner, Road Policing, West Mercia Constabulary
Detective Sergeant M Hine, Central Traffic Unit, Metropolitan Police
Police Sergeant T Jones, Sussex Police
Police Sergeant A Judson, Sussex Police
Police Sergeant B McCartney, Road Policing Department, Sussex Police
Police Sergeant I Milnes, Lancashire Constabulary
Police Sergeant J Settle, North Yorkshire Police
Police Sergeant A Thompson, Tactical Operations, Kent Police
Police Sergeant G Walker, Tactical Operations, Kent Police
Police Sergeant D Willey, North Yorkshire Police
Family Liaison Officer R Kruk, Metropolitan Police
Police Constable H Donovan, Road Policing, Sussex Police
Police Constable L Ellis, Collision Investigation Unit, West Mercia Constabulary
Police Constable G Gibson, North Yorkshire Police
Traffic Constable A Rathbone, North Yorkshire Police
Police Constable A Short, Road Policing Unit, Sussex Police
Mr R Lynn, Head of Special Casework, Traffic Criminal Justice Operational Command Unit, Metropolitan Police
Mr N Rowley, Principal Investigating Officer, Serious Collisions Investigation Unit, Devon & Cornwall Constabulary
Miss J Smith, Criminal Justice Support Manager, Kent Police
Mr D Vidgeon, Senior Criminal Justice Unit Manager, Traffic Criminal Justice Operational Command Unit, Metropolitan Police

Witness care unit managers (police)
Mrs S Janman, Victim and Witness Manager, Chichester
Mr B Tapley, Witness Care Unit Manager, Exeter
Mrs S Turner, Criminal Justice Unit Manager, Maidstone

Counsel
Mr S Shay

Victim Support and Witness Service
Mrs F Amos, Senior Manager, Sussex
Mrs J Baker, Senior Witness Service Manager, Victim Support Cornwall
Mrs L Bramley, Witness Service Manager, Kent
Mr J Gardner, Regional Manager, Victim Support, London Region
Mr P Gilbert, Area Manager, Dyfed Powys
Mr K Robotham, Witness Service Manager, West Mercia
Mr S Scott, Witness Service Manager, Sussex
Miss A Thomas, Witness Service Manager, London
Mrs A Westoby, Senior Witness Service Manager, Lancashire

Special interest representatives/organisations
Ms A Aeron-Thomas, RoadPeace
Mr K Clinton, The Royal Society for the Prevention of Accidents

Victims' families
We were also assisted by members of victims' families in cases we observed at court.

HMCPSI Publication No. CP001:871

If you ask us, we can provide a synopsis or complete version of this booklet in Braille, large print or in languages other than English.

For information or for more copies of this booklet, please contact our Publications Team on 020 7210 1197, or go to our website: www.hmcpsi.gov.uk

HM Crown Prosecution Service Inspectorate
London Office:
26 – 28 Old Queen Street
London SW1H 9HP
Tel. 020 7210 1197
Fax. 020 7210 1195

York Office:
United House, Piccadilly
York, North Yorkshire, YO1 9PQ
Tel. 01904 54 5490
Fax. 01904 54 5492

Website:
www.hmcpsi.gov.uk

© Crown copyright 2008