

RoadPeace

Road death investigation: overlooked and underfunded

Amy Aeron-Thomas
November 2017

RoadPeace The national charity for road crash victims



Foreword

We are a modern and mobile society. We travel widely for work, education and enjoyment. Freedom of movement is a basic right, as should be safety of movement. But when the worst happens and someone is killed or suffers life changing injuries in a crash, the state should respond with a thorough investigation.



But how are we to know how that, after budget cuts and increasing workloads, the police are able to deliver thorough investigations. Where is the quality assurance? This is the key question posed by RoadPeace in this report. Supporting and advocating on behalf of bereaved families for over 25 years, RoadPeace has decades of experience of hearing questions and concerns about road death investigation.

I am a long standing campaigner for road traffic justice and I know the justice system does not treat road traffic crime as seriously as other types of crime. This includes less investigation being conducted in road deaths than other involuntary killings. When I was a London Assembly member and on the Police and Crime Committee, the average cost of a homicide investigation was over 12 times that of a road death. And that was in London, where best practice is supposed to be found. Almost five years on, there is reason to fear the situation has worsened. The MPS are unable to report the judicial outcomes of fatal collisions, including those involving hit and run. And London is reporting the lowest rate of breath-testing of car drivers in collisions in England, with fewer than one in four car drivers being breath tested after a casualty collision.

This report is a call to action – with a collaborative approach required. RoadPeace has highlighted the victims' perspectives but joint working is needed. I urge national government and individual police services and Police and Crime Commissioners to work together to ensure road deaths are investigated thoroughly, impartially and effectively. Transport authorities, committed to reducing road danger and increasing active travel, have a key role in getting proper priority from overstretched police. London, with its aim to eliminate road deaths by 2041, should lead the way. And of course, this effort should include the voices of victims and campaigners.

Jenny Jones
RoadPeace Patron
Baroness Jones of Moulsecoomb
Green Party
House of Lords

Contents

Foreword	i
1. Introduction	1
1.1 RoadPeace campaign	1
1.2 Aim of review	2
1.3 Structure of report	2
2. Background	4
2.1 Road crime not treated as real crime	4
2.2 Early efforts	5
2.3 HMIC review of road death investigation	7
3. Road death investigation baseline review	10
3.1 Resources	10
3.2 Training	12
3.3 National guidance	13
4. RoadPeace assessment	16
4.1 How thorough?	16
4.2 How impartial?	19
4.3 How effective?	20
4.4 How consistent?	25
5. Conclusions and calls	26
Appendix A: Number of FCIs, England and Wales (2016)	30
Appendix B: Road death investigation guidance structure comparison	31
Appendix C: MPS road death investigation policy monitoring report (2010)	32
References	33
Glossary	37

Dedication

This report is dedicated to the families of Jake Mitchell and Peter Price, who had very different experiences of road death investigation.

Jake was only 12 when he was hit whilst cycling and killed by a driver who had overtaken three cars and a tractor. Within a day, his parents Glen and Toni had been told by the police that it was 90% Jake's fault. The police prioritised collecting background information on Jake, including taking statements from people who had seen Jake cycling the day before the fatal crash. But the witnesses in the cars that were overtaken did not have statements taken for months.



The police did a reconstruction after the family requested a review of the CPS decision not to prosecute. This decision was overturned and the case went to court. It was stopped there by a judge who doubted the strength of a prosecution given the independent expert, i.e. collision investigator – had concluded the overtaking manoeuvre was safe to do.

It was not until the inquest – over two years after Jake's death, that his parents were able to hear all the evidence. An independent investigator, commissioned by the coroner, also concluded the overtaking manoeuvre could have been conducted safely. This was despite the lack of evidence as to where the overtaking manoeuvre started and the speed involved. The witnesses in the cars overtaken all reported commenting on the rashness or even stupidity of the overtaking manoeuvre. They had all been aware that there were children cycling on the road, but not the overtaking driver – not until it was too late. The inquest also identified that both investigators had included in their calculations time for overtaking the cars and tractor, but not the cyclists.

Contrary to the investigators, the coroner concluded that *"It seems to me that the decision to overtake was the wrong decision. I cannot accept for a minute that it was appropriate to pull out of this line of traffic and overtake them."* In addition to their son being killed in a easily avoidable crash, Glen and Toni suffered years of fighting to get the justice system to respond properly.

Peter Price was walking home one night in November 2014 when he was hit and killed by Omar Tariq, who continued a further third of a mile before stopping and calling the police. Witnesses had seen the vehicle speeding and the exact speed was provided by the vehicle's event data recorder. The data was analysed and established a pre crash speed of 61mph on the 40mph road, with speeds up to 93mph on the journey.

Tariq initially claimed his girlfriend was driving at the time of the crash. The police were able to prove that he had switched seats with her after the crash. The evidence was overwhelming but Tariq still took over a year to plead guilty to Causing Death by Dangerous Driving. The police effort did not stop with the investigation. They successfully appealed the lenient sentence given Tariq, with the prison sentence increased to four-and-a-half years.



In addition to the thorough investigation and assistance with getting a fair sentence, the police treatment of Peter's family was exemplary over the 16 months from the fatal crash to the end of the appeal. They kept the family informed, answered all questions and assisted with Victim Personal Statements. Their presence at the court hearings, including the appeal, gave great comfort to the family. The investigation team received a commendation after Peter's father wrote to the police about their outstanding work.

This report is intended to help avoid future investigations like Jake's and promote more like Peter's. When the worst has happened, families deserve the best from the police.

1. Introduction

Road deaths are violent deaths, with the police rightfully responsible for their investigation. Since 2001, it has been official police policy to approach road deaths as unlawful killings, until the contrary is proven (ACPO 2001, Police Scotland 2015, College of Policing 2017). Police Scotland state that all road deaths, regardless of the circumstances, are to be investigated to the highest standard (Police Scotland 2015).

As such, investigations should be thorough, impartial and effective. For investigations to be thorough, they require proper resourcing. And budget cuts have fallen hard on the police and disproportionately on roads policing.

Road deaths are not a priority for the police or the wider justice system. The Home Office and the Ministry of Justice (MoJ) do not classify culpable road deaths as homicide. Deaths caused by law breaking drivers, including dangerous or careless driving, are treated as second class deaths by the justice system (RoadPeace, 2016d).

1.1 RoadPeace Collision Investigation campaign

RoadPeace launched its campaign for quality assurance in collision investigation in summer 2016. At that time, causing death by driving prosecutions in England and Wales had fallen by 23% between 2010–2015, whilst fatal collisions had only dropped by 5%. And convictions for causing death by driving had decreased by 29% (RoadPeace, 2016c).

RoadPeace Collision Investigation campaign

Thorough collision investigation is the cornerstone of justice. Without it:

- ▶ Criminal culpability escapes detection
- ▶ Fair compensation is delayed, if not denied, to victims
- ▶ Prevention programmes are biased
- ▶ Victims suffer secondary victimisation, and
- ▶ the public lack confidence in the police, which deters many from walking and cycling.

Improved investigations have been a long standing priority for RoadPeace, with national standards a key call of our first Justice Campaign, launched in July 1998. Nor are we the only ones who have called for thorough, impartial and effective collision investigations (CTC 2013, MPS 2011). Thorough collision investigation was a priority for Cycling UK's (then CTC) Road Justice campaign, launched in 2013. It was also called for by British Cycling in their 2014 Time for Cycling manifesto.

Our response to the recent Justice for Cyclists inquiry by the All Party Parliamentary Cycling Group (APPCG) highlighted the need for improved investigations. This included best practice and minimum standards being defined nationally for both fatal and injury collisions, including checks for drink and drugs driving, mobile phones, and event data recorders (RoadPeace, 2017a). Our calls were supported by British Cycling, Cycling UK, London Cycling Campaign (LCC), and the Road Danger Reduction Forum (RDRF). The inquiry report endorsed our calls, stating that

*"The police must ensure that a **higher standard of investigation** is maintained in all cases where serious injury has resulted. This includes eyesight testing, mobile phone records, assessment of speed, drink and drug driving. We have received many examples of the police failing to investigate properly or even interview victims or witnesses. Too often weak investigations have undermined subsequent cases."* (APPCG, 2017)

1.2 Aim of review

This review highlights how road death investigation is resourced, consistency and standards maintained, and evaluated by the police. It also includes RoadPeace's assessment of how thorough, impartial, effective and consistent road death investigation is seen to be.

This review is intended to be constructive and help promote the development of a quality assurance system for road death investigation. Bereaved families should be able to trust that the death of their loved one is being investigated thoroughly, impartially and effectively.

It focuses on England and Wales, where over 85% of road deaths occur. It includes information on road death investigation in Scotland, where the police services have merged and where their road death investigation guidance differs from England and Wales. We need consistency in how road deaths are investigated in Britain. Examples of best practice are included in this review. Road death investigations can be outstanding.

This review is not a technical assessment of forensic collision investigation. It is based on RoadPeace's experience of supporting and advocating for bereaved families for over 25 years. It focuses on the issues regularly raised by families on the thoroughness, quality, and fairness of the investigation.

And whilst it discusses the impact on prevention, this review focuses on police investigations, not independent investigation programmes by research teams. Likewise it focuses on the collision investigation, rather than the Family Liaison Officer's communication with the bereaved family. These are both important areas in their own right and deserving of separate attention.

1.3 Structure of report

Background context is provided in the next chapter, including the lack of priority road deaths, even those involving criminal offences, receive from the justice system. It summarises the previous efforts made to improve and standardise collision investigation. It also discusses the first and only inspection of road death investigation conducted by Her Majesty's Inspectorate Constabulary (HMIC). We highlight the limitations of the inspection and the reasons why RoadPeace disagreed with its conclusions.

Chapter Three summarises the current situation in road death investigation, with a review of the key areas of resources, training, and national guidance, including how individual road death investigations are reviewed. This chapter presents information gathered from a Freedom of Information (FOI) RoadPeace made with all police services in 2016, and the main findings of the HMIC inspection.

Chapter Four contains RoadPeace's perspective of the extent to which road death investigation is:

- ▶ Thorough
- ▶ Impartial
- ▶ Effective
- ▶ Consistent

Thoroughness means full identification of criminal culpability, whilst impartial means avoiding biases in investigation. Effectiveness is evaluated in terms of:

- ▶ detecting offending
- ▶ ensuring fair and timely civil compensation
- ▶ mitigating suffering
- ▶ contributing to injury prevention, and
- ▶ instilling public confidence in police

Without national standards, consistency in investigation is difficult to achieve. As a mobile society, we need a national approach to ensure consistency wherever the crash occurs.

Chapter Five concludes a call for recognition of the lack of quality assurance in road death investigation and renewed commitment to ensuring thorough and fair road death investigations across the nation. Our recommendations are aimed at both national and local level actions, mindful of the ongoing austerity programme.

And we must include a warning. The focus in this report is on road death investigation but a much larger problem exists with injury investigations. Forensic collision investigation is conducted in only a tiny fraction of injury collisions – basically only those where life is threatened or independent living is no longer possible. The vast majority of injury collisions are investigated by police who do not have specialist investigation training. These investigations are desk based with prosecutions often dependent on circumstances – easy availability of witnesses or CCTV. The potential for injustice is huge. The House of Commons' Transport Committee has called on the police response to collisions to be researched.

The CPS is clear in stating that prosecutions depend on culpability, not consequences. Yet the thoroughness of investigation depends heavily on casualty consequences. This mismatching can only mean that law breaking drivers who pose risk of death and serious injury, but do not actually cause death or life threatening injury, are escaping detection. Justice is being denied and our roads are not being made safer.

2. Background

This chapter provides the context for this review, highlighting the long standing lack of priority given to road traffic crime and collision investigation. It covers the early efforts of Victim Support and RoadPeace and the development by the police of a Road Death Investigation Manual. The findings from a Fulbright scholarship research grant on collision investigation are then highlighted. It then summarises the first (and only) inspectorate review of road death investigation and why RoadPeace disagreed with its conclusions. The chapter concludes with highlighting police and crime plans that mention collision investigation.

2.1 Road crime is not treated as real crime

Road death investigation does not receive the same level of priority as homicide investigation. Causing death by driving charges do not qualify as homicide, according to the Home Office and Ministry of Justice (MoJ). Homicide, the most serious classification of crime, is restricted to murder, manslaughter and infanticide. Only a handful of road deaths are prosecuted as manslaughter each year. Instead of homicide, causing death by driving charges are classified under violent crime, a category which includes offences that pose risk but do not always cause injury.

The National Police Chief Council (NPCC) Homicide Working group does not include culpable road deaths. As noted at the Parliamentary Advisory Council for Transport Safety (PACTS) conference on Collision Investigation in March 2017, the NPCC lead for Road Death Investigation is a voluntary part-time basis, unlike higher profile positions which are full time and paid.

This is part of a wider problem with roads policing not considered core work for the police. Roads policing is not included in any national policing plan or strategy. And within the NPCC's Roads Policing Strategy, there is no reference to collision investigation (NPCC, 2015).

This lack of prioritisation has severe repercussions on bereaved families. They do not qualify for a Homicide Caseworker and thus are denied additional support. And whilst the Homicide database collects much data on the victim and the offender, no such data is collected on victims of culpable road deaths. The government still does not collate or report the number of people killed by law breaking drivers. The DfT collects and publishes extensive data on road casualties, the MoJ publishes statistics on the number and gender of drivers prosecuted for causing death, but the total number of people killed or injured in crashes involving law breaking is not reported.

In response to concerns raised by British Cycling, Cycling UK, and RoadPeace about the failings of the justice system's response to fatal and serious injury crashes, the Department for Transport (DfT) established a Justice for Vulnerable Road User (VRU) Working Group. This included representatives from all key justice agencies: Police (ACPO), Home Office, CPS, MoJ, Sentencing Council, as well as British Cycling, CTC and RoadPeace. The group's Terms of Reference included addressing:

- ▶ How can incidents where vulnerable road users (specifically cyclists and pedestrians) particularly those involving fatalities or those more seriously injured be more effectively investigated by police and coroners and then prosecuted?
- ▶ What could be done to increase transparency and improve the quality of data on outcomes of cases from police, prosecutors and the courts?

The group has not met since summer 2014, after the Justice Minister announced a full review of driving offences, including their charging standards and sentences. This full review has not occurred nor appears likely in the next few years. RoadPeace and Cycling UK have continued to call for the re activation of the Justice for VRU Working Group as the need remains.

2.2 Early efforts

Specialist collision investigators were introduced in the late 1960s with the first collision investigation units formed in the early 1980s (Chambers, 2010).

In 1992 Victim Support convened a working group to review the experiences of families bereaved by fatal crashes, with representation from the Home Office, Association of Chief Police Officers (ACPO), Police Federation, as well as the Coroners' Society, RoadPeace and the Campaign Against Drink Driving. This working group met for two years before producing a report with 81 recommendations. As shown below, these recommendations included:

- ▮ standardised investigation procedures,
- ▮ senior officers in charge, and
- ▮ witness statements taken quickly and by specialist officers.

These calls remain relevant over two decades later.

Victim Support Working Party road death investigation recommendations

- 6.24 The working party recommends that the police service formulates and adopts a standardised procedure for the investigation of every road death, which would reflect the need for the support of bereaved families.
- 6.26 Not only the technical accident investigations, but the witness interviews should be carried out by specialist officers.
- 6.26 Every attempt should be made by the police to take witness statements at the earliest practicable time.
- 6.28 The collection of important evidence and investigation at the scene of the crash should take precedence over restoring traffic flow.
- 6.31 A police officer should be appointed in respect of each road death to be responsible for liaising with and informing the bereaved family of the progress of the case until it is concluded. Requests by witnesses to attend the victims' funeral should be passed to the family for a decision. A senior officer should co-ordinate the work of the officers involved.

(Victim Support, 1994)

RoadPeace provided the bulk of evidence for the working group, with over 150 case studies presented. RoadPeace went on to produce *Aftermath*, a guide for bereaved families explaining the legal procedures which follow a road death. In 1998, it launched an All Party Parliamentary Group Justice for Road Crash Victims and a Justice Campaign calling for national standards in crash investigations with proper training and funding. Priorities included the scene of road death or serious injury to be treated as a homicide or crime scene; drivers to be as fully investigated as victims (i.e. mandatory alcohol and drug tests), and interviews to be held without delay (RoadPeace, 1998). Essex Police provided information on their Service Delivery Standard. This had been endorsed by ACPO and included performance indicators on the level of public appreciation or dissatisfaction, monitoring of each road death, and an annual review of procedures.

In 1999, Sergeant Mark Bird of Essex Police reported his findings from a review of road death investigation training in all 43 police services. At that time, only 16 police services offered any form of training in road death investigation, ranging from 75 minutes to five days. Over half (27) did not offer any quantifiable training (Jenkins, 1999).

That same year, ACPO's Road Policing Committee approved the development of a Road Death Investigation Manual (RDIM). This was subsequently launched in December 2001, with its aims including:

- ▶ To standardise and improve the way in which the police service investigates death on the road;
 - ▶ To ensure the manual reflects the need to investigate road death to serve justice and provide support for victims, fairly, impartially, and without prejudice regardless of race, gender, ethnic origin or religion.
- (Forman and Greuter, 2001)

In 2007, the RDIM was updated and produced by the Professional Practice Unit of the National Policing Improvement Agency (NPIA). This drew on guidance on other areas of policing, particularly the ACPO (2005) Core Investigative Doctrine and the ACPO (2006) Murder Investigation Manual. The purpose of the 2007 RDIM was said to assist the police service to:

1. Conduct a thorough investigation to establish the circumstances that have led to a road death, and to discharge their responsibilities to the coroner.
 2. Provide an explanation of what happened to the family and friends of the deceased.
 3. Allow the outcome of investigations *"to be used to learn lessons which may assist in the prevention of further deaths and serious injuries on the road"*.
- (NPIA, 2007)

RDIM consultation

In 2012 ACPO held the first public consultation on the RDIM. RoadPeace coordinated a response on behalf of CTC, London Cycling Campaign, Living Streets, 20s Plenty for Us, British Cycling, and See Me Save Me. Our response warned that the RDIM was only advisory and that minimum standards were needed for national consistency. The RDIM should define best practice standards, with police services able to be benchmarked against which performance could then be assessed.

We urged the training of Senior Investigating Officers (SIO) and collision investigators to be a priority, so that old assumptions could be challenged as new evidence emerges, such as walking speeds and speed perceptions. We called for training programmes to tackle victim blaming, with collision investigators encouraged to do cycle training.

The need for greater transparency and accountability was also stressed, with police forces requested to monitor and report the legal outcome of collision investigations. Calls included surveying bereaved families as to their level of satisfaction with the police, with complaints collated, and lessons learned, including from reviews and acquittals.

Assistant Chief Constable Sean White of Cleveland Police, the NPCC lead on Road Death Investigation, reported that the revised guidance *"will strengthen the previous road death investigation guidance" and ensure that "feedback from every collision where a life is lost or somebody is seriously injured is fed into local casualty reduction activities to prevent further tragedies."* (White, 2013). Information provided to bereaved families about the collision was also to be improved. Hopes were high.

And hopes were dashed with the revised guidance published by the College of Policing (CoP) in October 2013. It was much shorter and as discussed in this review, appeared to weaken guidance rather than strengthen it.

Collision investigation research

In 2005 Simon Labbett, from Sussex Police, was awarded a Fulbright fellowship to research the application, training, and management of road death investigation in the United States. He subsequently published several papers on the evolution of collision investigation and presented his findings at RoadPeace's 2010 conference *Improving the Post Crash Response in London*.

Labbett Collision investigation recommendations

1. Undertake a fundamental review of training content and training for need analysis with prioritisation and identification of essential core elements.
2. Link training needs to investigation requirements and provide a process of evaluation.
3. Consider the need and justification for regional training centres, consider the requirement to establish a national training manual.
4. Adopt a tiered approach to investigator training to achieve minimum standards for levels of competence providing appropriate certification at each level.
5. Pool data from high level investigations to supplement scientific research beyond that available from STATS19.
6. Establish a process for creating and developing standards
7. Create a national collision investigation group to provide national coordination and external moderation. To provide support for individual police organisations irrespective of the level of individual investment and enables a consistent resource for the SIO and SCI.
8. Embed development with ongoing scientific support. It is likely that this will be better sourced external to the police service however requires national coordination.
9. Create ability to develop outputs of road death investigations, identify shortfalls to prevent reoccurrence and to monitor progress.

(Labbett, 2006)

2.3 HMIC review of road death investigation

In February 2015, a joint inspection of the investigation and prosecution of fatal road traffic incidents was published (HMCPSP and HMIC, 2015). Despite the HMIC operating for over 150 years, during which time over 500,000 people had been killed on Britain's roads, this was its first evaluation of road death investigation. By comparison, road death prosecution had been inspected twice before by Her Majesty's Crown Prosecution Service Inspectorate (HMCPSP) (2002 and 2008).

The Joint inspection stated its recommendations were aimed at *"reassuring both victims' families and the public that a road death investigation is not treated as in any way less important than any other homicide"* (HMCPSP and HMIC, 2015). Yet as noted above, culpable road deaths do not qualify as homicide, and their investigations do not receive the same priority as other homicide investigations.

A thematic review, it inspected road death investigation in just six police areas:

- ▮ Devon and Cornwall
- ▮ Hampshire
- ▮ Lancashire
- ▮ Durham
- ▮ Kent
- ▮ Metropolitan Police

The inspection methodology included:

- ▮ interviewing staff (over 100); College of Policing (CoP) and Roads Policing Learning Project,
- ▮ surveying bereaved families (36), and
- ▮ reviewing case files (72).

In each police area, the inspectorate team selected 10 files involving a criminal prosecution and another two files where the CPS had decided not to prosecute. The finalised files covered from early 2012 to late 2013 (thus almost all occurred before the CoP guidance was published). The files were reviewed by a set of 46 questions. These covered the crash circumstances, prosecution considerations, and communication with the bereaved family. Yet, despite this being a review of road death investigation, it did not include any questions on investigation. For instance, the questions did not ask about how well evidence was preserved at scene, or when the road death investigation was reviewed and by whom, i.e. senior investigator or peer.

The review was hindered in its ability to assess investigation due to the lack of documentation in the files. It stated *“Inspectors had intended to examine policy and strategy documents completed contemporaneously by SIOS in specific cases, but in most selected for examination on-site these documents had been detached from the evidential material itself, so they were not readily available for viewing”* (HMCPSP and HMIC, 2015). The first recommendation was thus *“Police disclosure officers must ensure that all disclosure schedules prepared include policy and strategy logs”* (HMCPSP and HMIC, 2015)

In addition to the 12 case files from each police area, a further two case files in each police area were selected where the police had decided not to prosecute. These were checked to see if the police had made the right decision. Despite appeals from RoadPeace, the joint inspectorate review did not call for all charging decisions in road deaths to be made by the CPS.

Despite the lack of information in the investigation case files, the inspection concluded that *“the investigation by police staff of fatal road traffic incidents was professional and thorough... standards of investigation and evidence gathering were satisfactory”*, with recommendations focused on *“improving and standardising the training of all road death investigation officers and especially senior investigating officers and family liaison officers”* (HMCPSP and HMIC 2015).

RoadPeace disagreed, arguing the inspection was limited, un-representative and superficial (RoadPeace, 2015). As it was a joint inspection, it focused on cases that had involved a criminal prosecution. Yet the majority of fatal collisions do not result in a prosecution, with RoadPeace estimating that only one in four (surviving) drivers in a fatal crash will face prosecution (RoadPeace 2016a).

Key issues with police investigation, such as budgets, were glossed over. Assessing the impact of budget cuts on the police was identified as a key objective of the joint inspectorate review (HMIC and HMCPSP, 2015). But on budget cuts, the review only reported finding *“little evidence that this had negatively impacted on the investigation of road deaths”* and that they had been told that this would continue to be closely monitored by the police. The joint inspection team recommended that:

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

(HMCPSP and HMIC, 2015)

No information was provided on how *“appropriate, necessary, or effective”* was to be defined or how the implementation of these recommendations was to be monitored or when. This was surprising, given the report criticised the CPS for the lack of progress made with implementing previous HMCPSP recommendations.

Over two years later, the HMIC has yet to report on any follow up monitoring, including the roll out of the good practice the joint inspection found. Good practice was identified in three of the police services inspected: Hampshire, Lancashire and Kent. No good practice was reported from Devon and Cornwall, Durham or the Metropolitan Police.

The joint inspectorate also mentioned DfT's Justice for VRU Working Group as an example of collaboration and working with community stakeholders.

Good practice identified by Joint Inspection

1. Hampshire had a useful action plan for staff responding to a confirmed fatal or life threatening collision. It had the categories of fatal collisions and the type of SIO who would be appointed.
2. Lancashire had a good quality assurance and review process with a dedicated review officer (an experienced SIO who had undertaken review training) who reviewed every live investigation against a standard template document. This template was said to cover all aspects of the investigation. And the learning from these reviews was reported back to the SIO in a clear audit trail.
3. Lancashire had also produced clear guidance for police officers on the content and format of fatal collision files.
4. Kent Police met regularly with the CPS area prosecutor to review the outcome of cases. This included the effectiveness of the trial advocate.

(HMCPSI and HMIC, 2015)

Exclusion from HMIC PEEL

The HMIC has begun assessing police services under their Policing Effectiveness, Efficiency, and Legitimacy programme (PEEL). This covers the effectiveness of the police in investigating crime investigation, their cost-effectiveness and the level of confidence communities have in their police. RoadPeace, Cycling UK and others have called for the HMIC to include roads policing and collision investigation within PEEL (RoadPeace et al 2017).

Lack of inclusion in Police and Crime plans

Few police and crime plans include roads policing as a priority, and even fewer even mention collision investigation. Avon and Somerset Police are a notable exception, where the Bristol Road Justice group and RoadPeace South West local group have helped put it on the police agenda. In their recently revised Roads Policing Strategy, one of its three key objectives is: *"We will provide a proportionate but quality collision investigation and service to support victims"* (Avon and Somerset Police 2017). It has yet to state how investigations will be both proportionate and ensure quality, or how this will be monitored.

In London, the new police and crime plan acknowledges the *"too little transparency around collisions and criminal justice, which we will seek to address with the publication of a joint TfL/MPS annual report of road traffic enforcement in London, and working with the Crown Prosecution Service and the Courts Service to collate and publish information about fatal and serious injuries"* (MOPAC 2017).

Val Shawcross, current Deputy Mayor, was head of the London Assembly Transport Committee when it called for the police to report the outcomes of collision investigations as well as include driving offences in crime statistics (London Assembly, 2014). And in 2016, the London Assembly's Police and Crime Committee conducted a review of roads policing. RoadPeace coordinated a response on behalf of road danger reduction based organisations, which again called for increased transparency and accountability of the police in collision investigation. This included the collision investigation budget, staffing and the judicial outcomes. It should be possible to know how often a driver is prosecuted after a collision with a pedestrian or motorcyclist, etc. Reasons for No Further Action were also urged to be collated and monitored.

There were reasons for concerns. A TfL funded review of pedestrian deaths in London (2007–10) found a 35% conviction rate. But this varied with only 10% of child pedestrian deaths and 5% of elderly pedestrian deaths resulting in a conviction. The research also reported only 20 of the 49 fatal pedestrian crashes occurring at crossings and 8 of the 12 pedestrians killed on the pavement led to a conviction (Knowles et al, 2012).

3. Road death investigation baseline review

Road death investigation requires a wide range of specialist skills. The College of Policing (CoP) identifies nine core policing roles common to the investigation of all road death and serious injury collisions and a further eleven specialist roles for police and others that may be called on (CoP, 2017). The effectiveness of these teams will depend on the numbers available and how effectively they are deployed; their level of experience and training; and the guidance which defines the procedures to be followed and the standards that are set for the work.

3.1 Collision investigation – resources and deployment

Whilst police, like other public services, have been cut, there have been disproportional cuts to the roads policing teams. Traffic police numbers reported by the Home Office declined steadily from 2010 to 2014, with a cumulative drop of 23% (Home Office, 2017). In 2015, there was a notional increase due to changes in the way police functions were reported by the Metropolitan Police (Cycling UK, 2016). If these reporting changes in London are disregarded, the fall in traffic police numbers was 39% between 2010 and 2017.

RoadPeace had previously tried to collect information on road death investigation budgets. But the responses from police services had varied widely, with some police including training costs or related equipment costs. Others reported not having any set investigation budget but having to request funding when needed.

On the advice of the Institute of Traffic Accident Investigators (ITAI), the professional association of collision investigators, RoadPeace made a Freedom of Information (FOI) request asking the number of forensic collision investigators (FCI), i.e. specialist collision investigators, in each police area. The Home Office does not monitor the number of FCIs. It tracks over 65 different officer roles but specialist collision investigators are not one of them. As FCIs are also responsible for investigating other crashes, including life changing crashes, the number of non-fatal crashes investigated by FCIs was also queried.

The FOI responses showed how the structure and make up of these collision investigation units varied. Most notable is the move towards shared collision investigation units. A sharing of specialist resources has been encouraged by the government for some time.

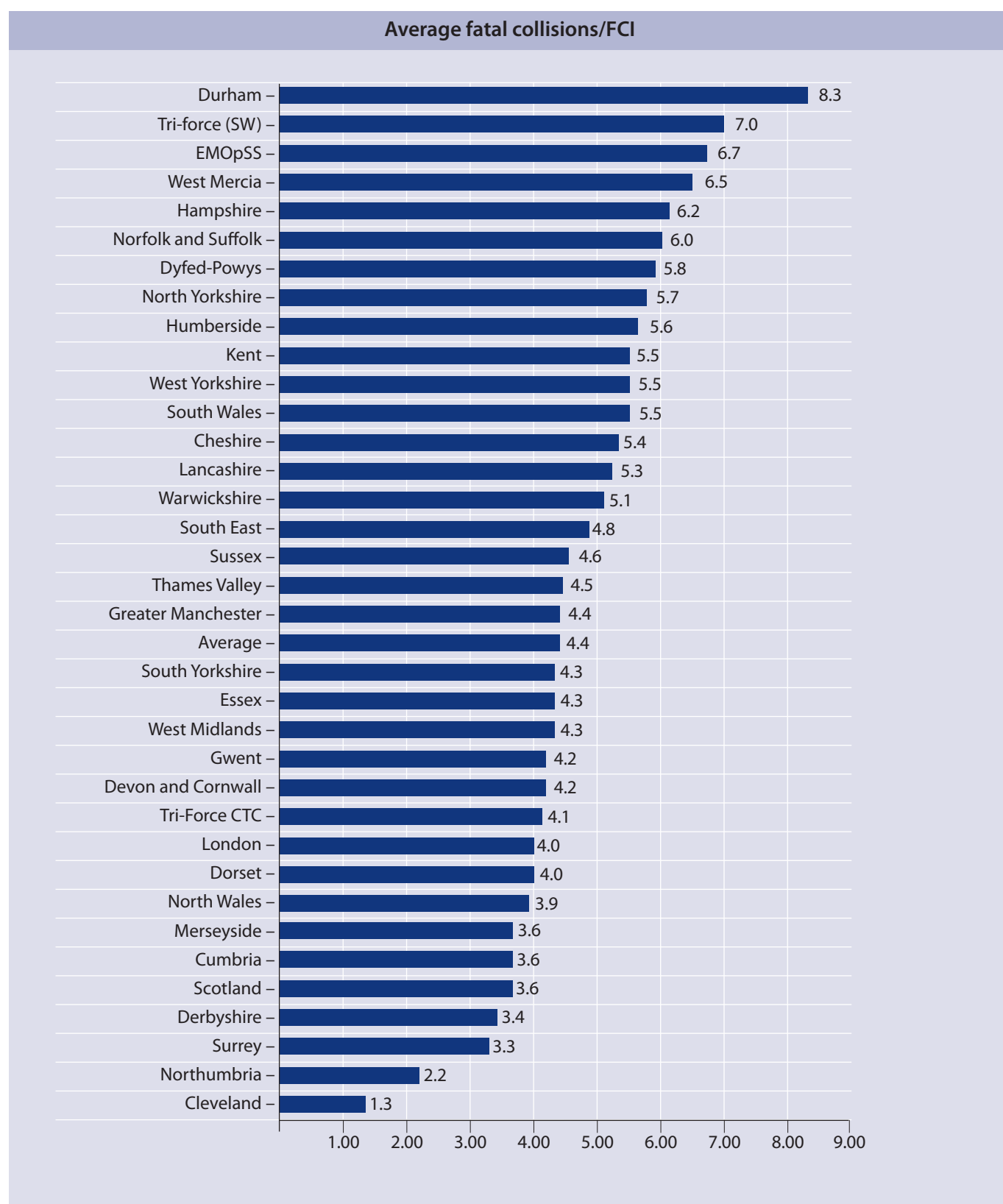
While these benefits are clear, particularly for services with small numbers of fatal collisions each year, there are downsides. Over half (23) police services reported having fewer than 10 FCIs with nine reporting five or under. Considering crashes can occur any time and on any day, FCIs will be under much pressure. A particular concern was the impact of unit mergers on response time due to the larger areas being covered. How this is being monitored or addressed is uncertain.

Roads Policing mergers		
Police district/area	Grouping	Forces
East Midlands	East Midlands Operational Support Service (EMOpSS)	Leicestershire, Lincolnshire, Northamptonshire, Nottinghamshire
West Midlands	West Midlands	West Midlands, Staffordshire
East of England	Tri-Force CTC	Bedfordshire, Cambridgeshire, Hertfordshire
	Norfolk and Suffolk	Norfolk, Suffolk
South East	Sussex and Surrey	Surrey, Sussex
London	London	City of London, Metropolitan Police
South West	Tri-force	Avon and Somerset, Gloucestershire, Wiltshire

The FOI response also revealed variation in staffing practice/terminology: for instance, Northumbria Constabulary reported not having FCIs but, instead, employs 13 police constables in the role of Constable Collision Investigators.

Road death investigation workload

The number of fatal collisions in each police area is reported as national statistics (DfT, 2016). The number of FCIs was reported in the police responses to RoadPeace's FOI (See Appendix A). The average number of fatal collisions per FCI in each unit was then calculated, over three years (2013–2015).



The national average number of fatal collisions each year per FCI was 4.4. The Tri-force area in the South West (7.0) reported investigating three times as many road deaths per FCI than did Northumbria (2.2). As shown above, for individual collision investigation units ranged from a low of 1.3 in Cleveland Police to 8.3 in neighbouring Durham Police. These two police services are now collaborating on collision investigation.

Average FCI workload, including non-fatal collision investigation

Most police services reported the number of non-fatal collisions investigated by FCI. Two points should be noted. Ten police services, including several larger police services, did not provide the number of non fatal collisions investigated by FCIs. This included the Metropolitan Police Service, Thames Valley Police, and Greater Manchester Police.

Second, amongst those police services which could report the number of non-fatal collisions being investigated by FCIs, there was much wider variation. This may be due to some police restricting their answers to those cases where the FCI produced an investigation report, whilst others reported those where FCI was involved in initial investigation.

Norfolk and Suffolk reported a low of 1.7 non-fatal collisions investigated per FCI whilst Cumbria had 2.7 non-fatal collisions investigated per FCI. At the other end were Lancashire Constabulary and North Wales Police reporting over 36 non-fatal collisions investigated per FCI. As stressed previously, these numbers may be misleading due to different interpretations of FCIs and collision investigation. What is clear is the difficulty in comparing resources allocated to serious collision investigation.

3.2 Training

In addition to the number of investigators, the level of specialist training will also influence their effectiveness. This section summarises the training related findings of the joint inspection, including the national investigation training programme developed by the police. It also highlights the current problems with the lack of monitoring and information on training programmes currently used by police.

Joint inspection training related findings

As noted previously, whilst this was the first time the HMIC had reviewed road death investigation, the HMCPSI had reviewed road death prosecution twice before and both times recommended specialist training programmes. So reviewing the *“availability and effectiveness of specific training for police and prosecutors”* was a key stated aim of the joint inspection (HMCPSI and HMIC, 2015).

With collision investigation training, it reported finding

- ▶ *“limited learning and training provision locally and gaps in national standards and accreditation*
- ▶ *more variation than seemed appropriate*
- ▶ *a range of courses available of uncertain quality and relevance”*

(HMCPSI and HMIC, 2015).

The Joint inspection acknowledged that training was already under review. The CoP had been working with ACPO since 2013 on developing a bespoke training package for police services on the investigation of road deaths.

Training dominated the Joint Inspection police related recommendations, *“our (police related) recommendations are aimed at improving and standardising the training of all road death investigation officers and especially senior investigating officers”* (HMCPSI and HMIC 2015). The specific recommendations for road death investigation training are shown overleaf.

Joint Inspection training related recommendations

1. The College of Policing should include road death investigation within the Professionalising the Investigation Process (PIP) levels of investigation and make the training programme accessible and relevant to all road death investigators.
2. The College of Policing should develop and promote:
 - ▶ an accreditation process for all road death investigators; and
 - ▶ national training standards for all road death investigation personnel.

(HMCPSI and HMIC, 2015)

The Professionalising the Investigation Process (PIP) training package, developed by the CoP and ACPO, was organised into four levels. At the time of the Joint inspection, the CoP road death investigation guidance called for PIP Level 2 requirement for any multiple party fatal crash. Fatal crashes involving the single (sole) driver/rider death required PIP Level 1 whilst likely homicide investigations required PIP Level 3.

Investigation training in 2017 – lack of transparency and monitoring

But whilst a national set of training standards were developed, training requirements are not nationally set. These remain local decisions with Chief Constables able to determine the relative level of priority and resources invested in training, and the training requirements for investigators. Adoption and implementation of the national training programme is not monitored, or at least not reported by the CoP.

In addition, police do not publish the training standards of their key investigation team officers (e.g. Senior Investigating Officer, Forensic Collision Investigator, Family Liaison Officer). Greater transparency around the training requirements of investigation team should lead to greater consistency between police services. It would also reassure victims that their loved one's death was being investigated to high standards.

3.3 National guidance

Without national standards agreed, there is heavy reliance on official guidance to promote consistency and quality assurance in road death investigation. This section compares the previous RDIM with the current CoP guidance. A comparison with Police Scotland's Road Death Investigation Manual is shown in Appendix B.

RDIM (2007)

SIO – status and training

Central to the investigation process was the SIO, who was to act as the lead investigator in all fatal collisions. This role was neither department nor rank specific, as the seniority and training (PIP) level of the officer appointed as the SIO was to be determined by the circumstances of the collision.

SIOs combined the roles of investigator and investigation manager. As investigators, it was stated that they *"must have"*:

- ▶ knowledge of road traffic legislation and other criminal law, for example, health and safety legislation;
- ▶ the principles of criminal investigation and supporting disciplines;
- ▶ decision-making ability.

As managers, SIOs were expected to identify and co-ordinate the resources/skills needed for the investigation. A key topic, SIOs were mentioned 243 times in the RDIM.

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

Source: NPIA (2007)

Policy file

One of the SIO's key roles was to maintain the policy file. This was to be used to record the initial investigation strategy and all subsequent decisions that affected it. This file was seen as the definitive record used, if necessary, when accounting for their decisions at:

- ▶ The magistrates' court or crown court;
- ▶ Coroner inquests;
- ▶ Other judicial proceedings;
- ▶ Reviews.

At the conclusion of the investigation, the policy files were to be retained and stored with the case papers. As reported previously, this key procedure was not being adhered to in the case files examined by the Joint inspection.

Coverage of main areas

While the RDIM covered a number of other roles (e.g. family liaison, post-mortem, coroner etc.), Sections 2 to 6 were much more specific to collision investigation:

- ▶ Key roles in fatal collision investigation (10 pages); Initial response (10 pages); Investigation stage (18 pages);
- ▶ Collision scene management strategy (5 pages); and
- ▶ Forensic collision investigation strategy (6 pages) – 49 pages in total.

The importance of training (in addition to experience) was repeatedly emphasised. In relation to the SIO, it stated:

"Experience, however, is relative and can be influenced by personal prejudices, beliefs or stereotypical images of certain groups and individuals. Furthermore, even the most experienced RP SIO will not have first-hand experience of all types of fatal collisions. Experience alone, therefore, is no longer a sufficient preparation for leading a fatal collision investigation." (RDIM, 2007)

College of Policing Guidance (2013 onwards)

As noted, in October 2013, the CoP replaced the RDIM with online guidance, *Investigating Road Deaths*. In 2017, this was updated and its title changed to *Investigation of fatal and serious injury road collisions*.

SIO – status and training

References to the SIO have been dropped in the latest CoP guidance and reference is now made to the Roads Policing Lead Investigator. This does not reflect a more general decision to change terminology within the police, as more recently published guidance on other areas of policing still refer to SIOs. The removal of SIOs from road death investigation guidance can be expected to lead to downgrading of this role and inconsistency between police services.

Policy file

The guidance includes advice on what both should and can be done. However, the scope for discretion by police is significant. There are only two policy decisions that are requested to be recorded within the policy file. These include the reasons not to use a

- ▶ Forensic collision investigator
- ▶ Forensic vehicle examiner.

The need to record policy decisions with investigating potential criminal offences, e.g. testing for drink/drug driving, mobile phone use or eyesight, are not mentioned.

Emphasis on training

Training (both pre-requisites and the need for further training) has been significantly de-emphasised. All references to the appropriate PIP level of lead investigators have been removed (by deleting the last column of RDIM Figure 3, e.g. Figure 2 above). PIP standards are expected to be reintroduced to road death investigations.

Road death investigation review

The Joint Inspection reported finding ... a lack of robust quality assurance by supervisors of investigations, especially while they were still ongoing. (HMCPSI and HMIC, 2015). All areas visited did have quality assurance checks but the *“effectiveness and frequency of these varied considerably”*. (HMCPSI and HMIC, 2015).

Good practice was identified in Lancashire where a dedicated review officer reviewed every live investigation against a standard template document. This was reported to cover all areas of the investigation and provide a clear audit trail. The review officer was an experienced SIO who had been trained in road death investigation review.

RoadPeace’s FOI asked how police services were evaluating their road death investigation procedures. Almost all responded that they were following the CoP guidance. And whilst road death investigation review was one of the key courses developed by the CoP, as seen below, their guidance is quite superficial on this topic.

Road death investigation review process

An appropriate review process should be developed and implemented. Throughout this process consideration should be given to:

- ▶ timing
- ▶ the reviewing officer and the focus of the review
- ▶ procedures
- ▶ reports and subsequent action
- ▶ disclosure

(CoP, 2017)

Furthermore, budget cuts are reported to have led to peer reviews being conducted, instead of having a dedicated and specially trained review officer. Peer reviews are likely to be less critical as they will be done by colleagues, with the role expected to be reversed. When the roles of reviewer and reviewed are likely to be regularly reversed, leniency is to be expected.

4. RoadPeace assessment

As police can decide unilaterally to end an investigation and not allow a prosecution to be considered, quality assurance of collision investigation is essential. The police are seen to function as “investigator, judge and jury” and there should be some way of ensuring their investigations are thorough and impartial.

“For justice to be done, it must be seen to be done”. Here we summarise how road death investigation is seen from the perspective of RoadPeace and bereaved families.

4.1 How thorough?

A thorough investigation should:

- ▶ check for all possible criminal offending, and
- ▶ clarify the crash circumstances and explain how and why it occurred

Road death investigation best practice

In 2003, five year old Sam Walker was killed by a hit and run driver whilst walking with his mother, sister and cousin on a quiet street in Manchester. The owner of the vehicle was arrested within a few hours but he claimed his car had been stolen. Unable to identify the hit and run driver, the case was closed after 73 days. It lay dormant for nine years before being assigned to Sgt Lee Westhead in late 2012.

Sgt Westhead traced and interviewed every person aged between 16 and 25 who lived on the estate at that time, as well as all those deemed a person of interest by the original investigation. Within a year he identified someone who knew who the driver was.

The CPS was reluctant to prosecute. But Sgt Westhead persisted. The driver was eventually prosecuted for Causing Death by Dangerous Driving with the car’s owner prosecuted for Perverting the Course of Justice. The car’s owner was convicted but the jury was unable to decide on the driver’s guilt. After another two week trial, the driver was convicted and sentenced to nine years in prison (Keeling, 2016). Sgt Westhead rightfully won the Police Federation Roads Policing 2016 Award for his dedication to securing justice.

John Radford, cyclist campaigner and regional CTC representative, was riding in July 2013 when he was challenged by a car driver. Witnesses saw an exchange of angry words but the subsequent collision was not seen by any independent witnesses. John suffered life changing injuries from which he never recovered, dying the following year. The car driver denied being in collision with John.

Initial paint checks came back negative but Detective Constable Paul Morrison, of West Yorkshire Police, refused to give up. He insisted on further tests which did find evidence that the driver’s vehicle had collided with John’s bike. Over two years after hitting John, the car driver finally pleaded guilty to Causing Death by Dangerous Driving.

John’s family and friends credited the conviction to Detective Constable Morrison’s determination and diligence, who was recommended for a commendation for his efforts (Shaw, 2015).

The best practice examples above highlight exceptional personal dedication. But all fatal crashes deserve thorough investigations. And based on national guidance, there is little reason to think that all criminal

culpability is identified. And without this information, what led to the crash occurrence may never be fully or accurately known. This can have lasting and devastating impact on bereaved families, who fear their loved one's death was accepted as the price to pay for a car dependent society.

Specific areas where RoadPeace believes investigation practice needs to be clarified and made consistent include:

Drink driving

There has been a long standing policy, dating back over 20 years, with police agreed to breath test all drivers in collisions attended, even if no injury was involved. Yet DfT reports wide ranging rates of breath tests conducted in England, with car drivers twice as likely to be breathalysed after a crash in North Wales than in London (DfT, 2016). Even in fatal crashes it is a problem. DfT has reported receiving alcohol levels in only 62% of driver fatalities in recent years (DfT 2017). And it is only drink driving where there is agreed national policy to check for impairment.

Drug driving

Guidance recommends testing for drug driving if officers have been Field Impairment Testing (FIT) trained. There is no police agreement with drug testing all drivers, or even the subset most likely to be impaired by drugs, e.g. drivers in night-time crashes.

The contrast with the testing of the deceased is worth noting. Toxicology tests are done on all road fatalities over the age of 16 (and can be done on younger victims, if the coroner chooses). This has long shocked families that their loved ones killed will be tested for drugs but not the driver involved. Almost 20 years ago, RoadPeace's first Justice Campaign called for drivers to be tested for drink/drugs to the same extent as the deceased were (RoadPeace, 1998).

Mobile phone use

In July 2014, then ACPO lead for Roads Policing, Gloucestershire Chief Constable Suzette Davenport advised police to check mobile phones at the roadside of all casualty crashes (Greenwood, 2014).

But there is still no instruction on checking mobile phones in the CoP guidance. The only reference to use of mobile phones is found in a section about the need to appoint a hospital liaison officer.

Investigation bad practice: mobile phones

"The days and weeks following the death of my mother who had been hit by a car whilst crossing the road were devastating. It was clear to the family from the circumstances of the collision that the driver had been distracted by something which took his attention away from driving or looking where he was going.

Our initial grief was not helped by the attitude of the police officers investigating the incident. We could not believe that, amongst other things, the police did not intend to check the drivers phone for usage prior to the collision. This decision was based on the fact that there was no supporting evidence from either CCTV or witnesses and that the process of phone analysis would be time consuming and costly. It was only through the families persistence that the police eventually agreed to analyse the phone records and it was discovered that the driver had received a number of calls around the time of the collision and this fact helped to bring about a charge of him causing the death of my mum through dangerous driving.

In my opinion when any family loses someone in a fatal collision it is potentially an unlawful killing and every road death should be treated as such until it is proved otherwise, every collision has the potential to be unlawful. I believe that it should be standard practice for the police service to check mobile phone use immediately. Every driver should be treated as a suspect and mobile phones are an important part of early evidence gathering. I strongly support more stringent guidelines when dealing with fatal collision investigation."

Amanda Bray, bereaved daughter

Eyesight

Guidance does not mention eyesight checks, or how soon they should be conducted or if they should be conducted in the same light conditions as the crash. Nor does it request the eyesight test to be recorded in the policy file, including reasons why it could not be conducted.

Investigation bad practice: eyesight checks

"Jail is not the justice we want" was the headline of the press release issued by Kate Cairns after a lorry driver was convicted of causing the death of a pedestrian. The same driver had collided with and killed Kate's sister Eilidh three years earlier. His eyesight was not checked for 14 weeks after Eilidh's death. It was found to be defective. The second death occurred when he was not wearing his glasses. *"For three years I have battled the whole way through an inadequate system which assumes the guilt on the cyclist, and which is rife with incompetence and complacency and which has failed us on all so many levels. There was no interest in carrying out a proper investigation nor in finding witnesses."*

The police report was riddled with assumptions, omissions and conclusions contrary to evidence... Nora Guttman did not have to die. Lopes did not have to lose his freedom, if the professionals had done their jobs. All I wanted was the truth so that other deaths could be avoided and other families did not have to suffer.

Fatigue

Guidance does not address detection of fatigue. Fatigue used to be considered a mitigating factor, but is now rightfully recognised as a condition that drivers (and their employers) have a duty to avoid. Drivers with 4–5 hour of sleep have been reported to have the same crash risk as a driver above the drink drive limit (0.08) (National Safety Council, 2017). The recent London Assembly report on bus safety highlighted the problem of tired drivers (London Assembly, 2017).

Speed

Guidance does not cover such technical aspects as to how vehicle speeds are to be calculated. In 2008, the Home Office Minister and ACPO Road Death Investigation lead promised to produce a technical collision investigation manual which would cover such issues. This was after a long campaign by RoadPeace members whose son had been seriously injured by a speeding motorcyclist. The police had calculated the motorcycle's speed using the formula of a car and had thus under-estimated the motorcyclist's speed. And the TRL On The Spot Study collision investigation research report published in 2010 highlighted the problem of police under-estimating vehicle speed (Cuerden, 2010). Yet no such technical manual was ever produced by ACPO.

Witnesses

Whilst CoP guidance has little to say about witnesses, Police Scotland (and the ACPO RDIM), views them as a key source of evidence.

"The success of any fatal collision investigation usually depends on the accuracy and detail of the material obtained from witnesses."

(Police Scotland 2015)

Guidance does not address how quickly witnesses are to be interviewed. At the RoadPeace 2010 conference on *Improving the Post Crash Response in London*, the case for collecting witness statements at scene, through the Self-Administered Interview (SAI), was made (Hope, 2010). This is standard practice in some European countries, including the Netherlands and Norway. The SAI is still being considered, with a recent grant application for a pilot in Wales.

Road death investigation bad practice

Diana Walker (76) was hit by a cyclist in May 2016 and died the following day. Specialist collision investigators did not attend the scene, and the death was reported to have been dealt with by neighbourhood officers. The cyclist involved was not interviewed until three months after the crash.

Diana's family conducted its own investigation after the police refused to release the identity of the cyclist. After the inquest, the assistant coroner wrote to the Chief Constable of Wiltshire Police stating that *"Both the family and myself are very concerned the Serious Collision Investigation team do not attend collisions involving cyclists and pedestrians"*.

Wiltshire Police responded that they had *"reviewed and made amendments to the standard operating procedures for the call out of the Collision Investigation Unit in all cases of serious pedal cycle incidents"*.

(BBC, 2017)

Event data recorder (EDR)

Guidance does not cover how to check for presence of an EDR. Police can contact TRL to see if the vehicle involved is equipped with an EDR. This is a free service but it is not mentioned in the guidance.

4.2 How impartial?

Unconscious bias occurs with everyone. It is not restricted to collision investigation. It has received much more attention in respect to sexual and domestic violence.

The Parliamentary Office of Science and Technology's briefing on *Unintentional Bias in Forensic Investigation* highlighted three key types of cognitive bias:

- ▶ Contextual bias – where irrelevant information influences reasoning
- ▶ Confirmation bias – where evidence is interpreted to align with pre-existing beliefs
- ▶ Expected Frequency bias – where results are expected to occur, based on past experience

An example of contextual bias could be where a lack of driving licence is presumed to mean the victim had little road sense. Confirmation bias can occur, for example, when investigators presume cyclists wobbled or came up the inside of a lorry. With expected frequency bias, police may approach a single vehicle fatal collision with a readiness to blame the victim, rather than eliminate the chance of a more complicated reason.

"I have investigated over 100 fatal crashes. In only about five was a driver prosecuted."

(Collision investigator)

The cycling community is a vocal and leading campaigner for thorough collision investigation. Whilst cycling is becoming more common, it is still only a regular activity for a small minority of people. Some police, reflecting the communities they represent, still perceive cycling as a high risk activity – *"an accident waiting to happen"*.

Many FCIs began their career at a time when cycling was discouraged and perceived as a high risk activity. They were trained and worked for years during which drivers responsible for fatal crashes were only prosecuted for a summary offence. Bereaved families report being told by the police that the driver involved was a *"good egg"*, and how *"the driver did not wake up that morning intending to kill anyone"*.

Road death investigation bad practice: victim blaming

Cycling along Regent Street on an early February evening in 2014, Michael (Mick) Mason, was hit and critically injured by a car driver, Gail Purcell. CCTV showed both his lights working with Regent Street well lit. He was hit from behind by Purcell who claimed *"I just didn't see him"*. The police decided No Further Action without even referring the case to the CPS. The family appealed and the police tried to justify their actions on the grounds that Mick was wearing dark clothing, not using a cycle helmet and Regent Street was very busy at the time, with Mick's bike lights easily lost amongst the other lights.

Thanks to crowdfunding, a private prosecution was possible. Witnesses which the police had rejected reported Purcell driving relatively fast. She was also said to have continued up Regent Street after the crash with a witness testifying that he had run up the street to the car which was stopped at the lights and made it pull over.

Whilst the trial ended in an acquittal, the judge rejected the defence lawyer's request to dismiss the case. (Dollimore 2017)

Much evidence was collected by the City of London after Ying Tao was killed by a 32 tonne left turning lorry. They were able to prove that she could have been seen in three of the lorry driver's mirrors. They also found that the lorry had indicated it was turning left only 1.4 seconds before pulling off. And the audible warning system and one of the two side sensors were broken.

The problem came with their interpretation of the evidence. City Police Collision investigator gave evidence at the coroner's court that the lorry driver's *"failure to spot Ms Tao as he turned left was not a careless act"*. The investigator blamed Ms Tao, saying she was in the wrong gear, had put herself in an unsafe position (by using the bike lane) and had been too slow to move off when the lights changed. He defended the lorry driver stating that *"it's a very busy junction with lots going on and lots vying for Mr Williams' attention. I can understand how Ms Tao would have been missed in that situation"*.

(Lydall 2016)

4.3 How effective?

Evaluating the effectiveness of collision investigation is difficult. The traditional measure of effectiveness with police investigation is Offences Brought to Justice. As not all collisions involve criminal offences, it is not in itself an appropriate indicator of collision investigation effectiveness. Nor is it always possible to secure convictions, as can be seen with such crimes as sexual violence and domestic abuse.

Deliver criminal justice with offenders detected?

As previously discussed, there is reason to doubt that all offending is being detected. Police are not required to check for mobile phone use, drug driving, or defective eyesight. And as highlighted earlier, there is concern that alcohol impairment may be being missed, with alcohol readings missing in more than a third of drivers killed.

According to the CPS Code for Prosecutors, which is also used by the police, the decision not to prosecute can be due to the lack of evidence or because it is not believed to be in the public interest. RoadPeace, LCC and Cycling UK have called for the reasons for no prosecution to be collated and monitored. It should be possible to know how often the investigation was unable to identify culpability as opposed to cases where driver innocence was proven or it was not in the public interest to prosecute.

Facilitate civil justice?

Police investigation is often criticised for focusing exclusively on criminal justice, and not thinking of the wider areas of civil justice or prevention. Its key role in ensuring fair and timely civil compensation is regularly overlooked, even

though there is a lower standard of proof with civil liability. And bereaved families are often left with much greater need for financial compensation than for criminal convictions or custodial sentences for offenders.

The NPCC have recently acknowledged this need, stating that: *“National practice dealing with requests for police/CPS disclosure of information in relation to road traffic collisions (RTC’s) to civil litigators has varied across the country. This inconsistency of approach frequently leads to delays in respect of relevant and important information being released to those involved in civil claims which in turn severely impacts upon victims of road traffic collisions.”*

(NPCC, 2016)

NPCC disclosure timeframes	
What	When
Basic information (date and time of the collision; names and addresses of those involved; description and ownership of vehicles involved; names of insurers in cases involving personal injury; copies of certain statements; name of defendant in any forthcoming criminal proceedings and the date and place of hearing)	No later than 4 weeks post crash
Other documents (Police Collision Report, Forensic Collision Investigators Report with photographs, plans, CCTV footage and note book entries of reporting officers)	Within 4 months and no later than 6 months post crash
Police witness statements	Within 6 months and no later than 9 months post crash or within 4 weeks of verdict

Source: NPCC, 2016

Developed in association with the CPS, police disclosure (release of investigation information) time frames were proposed. But as with training standards, these time frames are advisory and are not being monitored, so their adherence and effectiveness is unknown.

Mitigate suffering of bereaved families?

In a recent review of *What Works with Supporting Victims*, the importance of how victims are treated was stressed. This included being kept properly informed.

“The quality of service that victims get from criminal justice professionals and associated agencies is often a more important factor in victim satisfaction than the final outcome of their case.”

“Lack of information can leave victims feeling uncertain and isolated causing further harm and distress.”

(Wedlock and Tapley, 2016)

Information is a basic need of victims. Yet little written information is provided to bereaved families about road death investigation. Bereaved families in England and Wales receive a guide funded by the Ministry of Justice and produced by Brake, a road safety charity. This is expected to be given to families within one to two days of the fatality. It has chapters on criminal prosecution and civil compensation but not on road death investigation. Its section on road death investigation is limited to a few paragraphs. Families are not told an investigation team will be involved or that they can ask the police for a site visit where preliminary information about the crash can be shared.

RoadPeace’s Road Death Investigation Guide for Bereaved Families was based on the RDIM. It seeks to explain the likely investigation procedures and help manage expectations of bereaved families.

Families are expected to get their information on the investigation into their loved one’s death from their FLO. But with lack of national training and updated guidance, this will inevitably result in variation. National FLO guidance has not been updated since 2008. Families frequently report contact drops off after the first week with substantial delays in receiving follow-up information. Families often have to chase FLOs, who are often out of contact due to night shifts, leave or training.

The West Midlands Police introduced a dedicated Roads Policing FLO Unit in 2015, with full time FLOs assigned. This was intended to both improve the service delivered to bereaved families and also reduce the demands on police officers. Previously, FLO responsibilities were additional to other work, as is the standard practice in other police services.

How satisfied?

There is no standard procedure for collecting feedback from bereaved families. Exit interviews with families were included in the previous RDIM but are not mentioned in CoP guidance. Some police do ask families for feedback. The West Midlands Police, with their dedicated FLO Unit, have prioritised receiving feedback and have developed a questionnaire for bereaved families.

In London, the MPS used to have a road death investigation monitoring policy which reviewed

- ▶ key checkpoint compliance, including submission dates to CPS, and
- ▶ level of service feedback from coroners, CPS and bereaved families.

See Appendix C for more information on this policy but it is no longer in use.

The Joint Inspection surveyed bereaved families as to their level of satisfaction with the police and the CPS. On investigation, the survey asked families:

- ▶ Overall, how would you assess the service you received during the police investigation?
- ▶ Were you given regular updates about the investigation?
- ▶ Were you given an opportunity to speak to the investigators?
- ▶ Do you feel that your questions were answered in a satisfactory way?

(HMIC and HMCPSI, 2015)

In comparison, victim satisfaction surveys used to be routinely conducted with victims of domestic burglary, violent crime, racist incidents and vehicle crime. Vehicle crime meant theft or damage to or from the vehicle, not conducted by the driver of a vehicle. These surveys asked about the victim's satisfaction with their whole experience, initial contact, police actions and follow-up and treatment.

RoadPeace has led calls for the use of level of satisfaction surveys to be extended to road crash victims, starting with bereaved families. We raised this gap with the Victims' Commissioner at the start of 2017. She has recently published the findings of her review into level of satisfaction monitoring. Of the 20 police services who responded, only two mentioned crash victims. (Victims' Commissioner, 2017)

Good practice: Independent Police Complaint's Commission (IPCC) Family Listening Day

At the request of the IPCC, the charity INQUEST organised a family listening day. Families of those who had died in custody attended, as did several IPCC staff. Families who were not able to attend were able to send in written submissions. The day was to:

- ▶ Provide a platform for investigators to listen to the experiences of families
- ▶ Help IPCC to assess its achievements in addressing key areas identified by previous review
- ▶ Identify positive and negative experiences of families so that operations staff can learn, and feedback from families can assist with training

Sessions covered the key areas of: initial contact, investigations, reporting, relationships and communication.

(IPCC/Inquest, 2013)

Second post mortem

Whilst RoadPeace has highlighted many areas needing more investigation, it is worth mentioning where investigation procedure is believed to be unjustifiable and a cause of much suffering to bereaved families.

Second post mortems are reported to be the right of the defence. RoadPeace believes their cost to bereaved families greatly outweighs any benefits they bring to suspect drivers. It is extremely rare for second post mortems to identify a different cause of death than the first post mortem. Families can understand why court cases can take a long time to be heard. But they cannot understand why the person suspected of causing the death of their loved one has the power to delay the release of the body of the deceased.

Collision reporting and investigation

Most collisions are due to human error. Collision reporting occurs shortly after a crash, before any thorough investigation has taken place. This means that the contributory factor data reported to DfT is based on early assumptions and best guesses. But contributory factor data is unreliable with police often not able to check or reluctant to voice suspicions. DfT guidance states that police should be willing to testify in court on contributory factors.

Under the Safe Systems approach, which the government has adopted, the transport system is designed to ensure that human fallibility does not result in death or serious injury, Road users are expected to comply with traffic laws. But they are also expected to be fallible. So how often crashes occur due to non-compliance as opposed to system failure should be monitored by road safety practitioners and policy makers.

Yet there is no data linkage between collision and court conviction data, thus it is not possible to know which collisions resulted in a criminal prosecution. Nor is this data collected in the DfT's Road Accident In Depth Studies (RAIDS) research programme or Highway England's road death review programme.

The Parliamentary Advisory Council for Transport Safety (PACTS) has led calls for a National Collision Investigation Branch, similar to those operating for air and rail accident investigation (PACTS, 2017). Whilst RoadPeace has been a long standing supporter, we have also argued for investment in police collision investigation. The vast majority of collision investigation is done by the police, and only by the police. This will not change. For instance, Highways England's road death reviews are based on police investigations. Investment should thus prioritise upskilling police investigation, and not be restricted to investigating a small sample of collisions in-depth.

Road death investigation should contribute more to risk reduction. Coroners have a public health duty to reduce the risk of re-occurrence of road deaths by making Preventing Future Death (PFD) reports. But these are rarely done (some 35 a year from over 1,200 road death inquests) and are believed to depend largely on the police evidence. This is more reason for investing in police investigation.

Contribute to road traffic injury prevention?

Despite the wide range of circumstances, what unites RoadPeace members is their desire for others to be spared. This is true for deaths involving criminal prosecutions as well as inquests where the deceased was the only one involved. Families want to see lessons learned and risks reduced. It is the chance they have of seeing something positive come out of their loved one's death.

Good practice: Wales Fatal Review Board

The Welsh government is adopting the practice initiated in Sweden whereby multi-disciplinary working groups review each fatal crash to determine what could have prevented the death, if not the fatal crash. Wales's Fatal Review Board will include the lead Collision Review officers from all four Welsh police services.

(Grey, 2017)

Inspire confidence in police?

Public confidence in the Criminal Justice System (CJS) is a core aim of the government. It is believed to be a prerequisite for securing cooperation from victims and witnesses.

Confidence in police is hindered by their joint role as investigator and prosecutor. Police have the authority to decide no prosecution without needing this to be checked by the CPS. This situation is then further aggravated by the lack of transparency on how often they make the decision not to prosecute and the reasons. Families may be able to appeal this decision but this varies by police service. There is not a national system amongst the police services in England and Wales, as there is with the CPS.

As noted previously, RoadPeace, Cycling UK and LCC have called for police (and CPS) to report reasons for No Further Action including if it was due to lack of evidence, proof of driver's innocence, or not in public interest to prosecute. But this has yet to happen and lack of transparency remains a key obstacle. Nor is there any current monitoring of points of conflict, including charging decision, appeals, charges downgraded by the CPS, judge or juries; and acquittals.

Few police services are transparent about the outcomes of their road death investigations. Each police service was asked if they reported prosecution outcomes. Eight police services reported they did with seven reporting the data for the latest year. This included Merseyside, Nottinghamshire, South Wales, Staffordshire, Warwickshire, West Mercia and West Yorkshire. Data linkage between collisions and court outcomes was a key call of DfT's Justice VRU WG.

Levels of confidence in the effectiveness and the fairness of the CJS are included in the Crime Survey for England and Wales. But victims of road traffic crime are not included under this survey. It asks about incidence of drink driving, but not if respondents have been affected by a drink driver or any other law breaking by drivers.

Recognition of best practice

Whilst cases of bad practice may be covered in the media, best practice is rarely publicised. This would help reassure families, remind others what is possible, and rightfully reward the work of committed collision investigators.

Recognising best practice in London: the Livia Award

The Livia Award for Professionalism and Service to Justice is an annual, independent and public award established in 1999 by Livia's family following her death which was caused by a dangerous driver who mounted the pavement where she was walking. The award began as an expression of appreciation and gratitude for the dedicated way the Metropolitan Police Service fatal crash investigation team handled Livia's case, and family trauma, to ensure that the appropriate charge would be brought that would lead to a successful prosecution. While the driver was convicted of death by dangerous driving, the court's sentence was a fine of £2,000, ten points and a five-year ban.

The award continues to highlight the exemplary work of the outstanding in serious road crash investigation and FLO work in the MPS Roads and Transport Policing Command. It encourages best practice and the will to serve in the interests of justice for victims and their families.

(Galli-Atkinson, 2017)

4.4 How consistent?

As highlighted throughout this report, road death investigation in Britain is not consistent. There is no national standard for investigating road deaths. National guidance varies between England and Wales with that in Scotland.

Investigation procedures vary by police services, e.g. impairment tests, assignment of SIOs, collection of witness statements, etc. Timing of road death investigation reviews is a key example of inconsistency. Whilst training on road death investigation review was part of ACPO's recent training programme, it did not include identifying standard review deadlines. So this has varied by police service. Thames Valley Police and Hampshire Constabulary reported reviewing road death investigations 21 and 90 days after the crash, but also note that a review can be conducted at any time by the SIO. In North Yorkshire, fatal cases are reviewed after 48 hours, 7 days and 3 months.

And it cannot be forgotten that there is much less priority and much greater inconsistency in injury collision investigation. There is believed to be only one policy adopted by the police that applies to injury collision investigation. This is the 1996 ACPO agreement to breath-test all drivers in road crashes attended by police. But as shown in the table below, practice varies widely by region. What is consistent is the decrease in breath-testing after a car crash.

Car drivers in reported casualty collisions, % breath tested by region, England							
						change since	
Introduction	2012	2013	2014	2015	2016	2012	2015
North East	55%	54%	53%	53%	50%	-11%	-5%
North West	58%	62%	62%	62%	58%	0%	-6%
Yorkshire and the Humber	50%	49%	51%	50%	46%	-7%	-8%
East Midlands	56%	55%	52%	53%	50%	-11%	-5%
West Midlands	52%	49%	46%	42%	40%	-30%	-6%
East of England	62%	60%	58%	56%	56%	-11%	0%
London	33%	33%	30%	27%	23%	-41%	-15%
South East	60%	59%	58%	56%	57%	-6%	1%
South West	61%	59%	57%	56%	56%	-9%	0%
England	53%	53%	51%	49%	47%	-13%	-4%

Source: DfT (2017c), RAS51020

5. Conclusions and calls

Road death investigation is fundamental to bringing justice to our roads. The vast majority of road crime goes undetected and unpunished (RoadPeace, 2017d). So, it is essential that when a road death is caused by a driver's criminal disregard for the safety of others, that this is identified and prosecuted. This means investigators need to be properly trained and resourced, so they can systematically identify factors that may have contributed to the collision – checking phones, speed, CCTV cameras, interviewing witnesses etc.

The cuts in police budgets and numbers have fallen disproportionately on traffic police and collision investigation has suffered. Many of the advances in guidance and training that had occurred in the first decade of this century have been reversed. ACPO had invested in the 2007 Road Death Investigation Manual and professionalising SIOs. But, in England and Wales, current guidance is briefer and less specific and makes no reference to this specialist function. (Scotland has maintained both the RDIM and its use of SIOs.) In addition, some of the efficiencies achieved by merging collision investigation units between forces may have been offset by the delays in arriving at the scene.

This situation led to this review. This is the first time a national review of road death investigation has been conducted. That it was undertaken by RoadPeace, the national road victims charity, shows just how overlooked road death investigation is. Quality assurance with the police investigation of fatal crashes was sought. RoadPeace clarified what it expected from quality assurance with road deaths being investigated thoroughly, impartially, effectively and consistently. Acknowledging the reality that police budgets face further threats and police have other priorities, our recommendations are low/no cost and aimed at closing the gap in how road deaths are investigated, compared to other involuntary killings.

Quality assurance

1. National oversight group

Road death investigation is too important and too fragmented to be so overlooked. If standards are to be improved, coordination is needed between the many different organisations involved. This includes the NPCC, CoP, Police Scotland, Home Office, HMIC, Forensic Science Regulator, Police Federation, Metropolitan Police Service, Coroners Society and DfT, and key stakeholders, including victim organisations.

The need for multi-disciplinary working groups has been recognised with other crimes: Homicide Working Group, National oversight group on Domestic Abuse, Rape Monitoring Group, Inter-ministerial Group on Violence against Women and Girls, Custody Death Panel, etc.

Key issues to be considered include:

- ▮ Variation in guidance across the nation
- ▮ Impact of budget cuts and mergers, including on response time and evidence collection
- ▮ CoP introduction of Roads Policing lead investigations vs SIOs
- ▮ Implementation of recommendations from Joint Inspection
- ▮ Road death investigation review practice

In addition, there should be a stakeholder's panel to encourage wider participation and contribution, including from personal injury solicitors and insurance companies.

RoadPeace call: A multi-disciplinary National Oversight Group on road death investigation should be established to ensure that road deaths are investigated to the highest standard, including being approached as unlawful killings, as police guidance has called for since 2001.

2. National guidance and best practice

Over 9,000 people have died on our roads since the last consultation on road death investigation. The guidance that resulted was summary and failed to promote consistency and thoroughness. Police cuts and new risks have added to the obstacles in getting high standards in road death investigation.

What is needed is clearer guidance on what evidence should be collected and when, according to best practice. What steps are taken both at the scene and after will always be best determined by the officer in charge. However, for reasons of consistency and transparency, police should have to record the reasons why recommended steps are not taken. This includes such key impairment tests as drink driving, drug driving, mobile phone use, eyesight. Guidance should also clarify when witnesses are to be interviewed and reconstructions conducted. It should allow the police to be held accountable for high quality investigations.

RoadPeace call: National guidance should be revised, with best practice investigation standards defined, and police expected to document reasons why standards were not met. Development of a case file template should promote consistency.

3. HMIC assessment

Protection of life is the key police role. Yet over 500,000 people died in crashes before the HMIC inspected road death investigation. And even then it was a partial inspection as well as unrepresentative and superficial.

HMIC continues to overlook collision investigation. Its PEEL programme evaluates police services on their effectiveness and efficiency at investigating and preventing crime, but not road traffic crime.

Police services should report on how they have implemented the recommendations or good practice identified in the 2015 Joint Inspection review, as well as how they currently manage to deliver high standard road death investigations.

RoadPeace call: HMIC should treat road crime as real crime and include collision investigation and roads policing in its annual assessments. HMIC should also conduct a performance inspection of road death investigation amongst all police services.

4. DfT and prevention

With road deaths no longer decreasing, there is growing interest in learning from collision investigation. In addition to collision reporting, DfT has invested in collision investigation research, and is now being urged to go further and establish a Road Collision investigation Branch. Any independent collision investigation branch or programme should include investing in police collision investigation, as it will remain the main source of information for injury prevention.

And there is more that DfT could do, including promoting event data recorders and dash cams through government procurement powers. As part of its Cycling and Walking Strategy, it should re-establish the Justice VRU WG and address the concerns around victim blaming by collision investigators.

RoadPeace call: DfT should seek to promote higher standards in collision investigation, as its road safety programme depends on police investigations.

5. London

With its concentration of road deaths and greater investigation resources, London should be able to ensure best practice in road death investigation. And TfL is promoting more thorough investigations, especially with lorries and buses. But like all police services, the MPS' budget has been cut (and faces further cuts). TfL funds the MP's Roads Policing Transport Command but not collision investigation which is financed by the MPS.

Mayor Sadiq Khan has adopted a Vision Zero approach with road deaths and serious injuries to be eliminated from London's streets by 2041. London also is committed to increasing walking and cycling. All these require thorough and impartial collision investigations by the police. The Livia Award is to be commended for highlighting excellence in investigation. What is missing is a systematic assessment of collision investigation to show that high standards are being consistently met.

RoadPeace call: London should help define and demonstrate best practice in road death investigation. This should include increased transparency with reporting judicial outcomes, training first responders in scene management, surveying victims on level of satisfaction, and tackling unconscious bias.

Transparency and accountability

6. Transparency and open justice

This report has highlighted the lack of information currently available about road death investigation, including inputs (budget, staffing), outputs (number of fatal and injury crashes investigated) as well as outcomes (prosecutions, quality assurance).

If we are to be able to hold police to account for thorough investigations, greater transparency is key. It should be possible to know how police services resource road death investigation. This should be public knowledge and help manage expectations. It would also allow comparison between other work areas and allow local communities the chance to lobby for more resources.

RoadPeace call: Police should report their investigation staffing and budgets, as well as their standard operating procedures on road death investigation. Investigation outcomes should also be published with reasons given when prosecution was not thought justifiable. The Home Office should include FCIs in their workforce monitoring report.

7. Annual review and stakeholder engagement

Essex Police reported annual reviewing its road death investigation programme almost 25 years ago. This should be standard practice in all police services. They should report to the community how they have maintained high standards in collision investigation. Annual reviews should include collating the lessons from complaints, appeals and adverse case reports produced after an acquittal.

It is victims, RoadPeace and cycling groups, especially Cycling UK, who have led the calls for improved investigations by police. They should be encouraged to work with police in ensuring road death investigations are impartial and effective.

RoadPeace call: Police services should annually review their road death investigation effectiveness, and work with the local community, including victims and campaigners, to improve collision investigation.

8. Awards

Excellence in investigation deserves recognition as the Livia Award does in London. Bad practice will be covered in the media. Police should take action to ensure examples of outstanding road death investigation are reported.

This would help reassure bereaved families that best practice was happening and remind others, including senior police and policy makers, what efforts road death investigation can involve.

RoadPeace call: Police services and districts are encouraged to establish annual awards programmes for FCIs.

Treatment of victims

9. Improved information

In the next year, over 1700 people are expected to die on Britain's roads. Their families will be dependent on the police for information and for justice, with (any) offending detected.

Road death investigation deserves to be much better explained to bereaved families. At a time when families are still in shock and grieving, this information should be written down, rather than left to part time and overstretched FLOs to deliver.

RoadPeace call: Guides for bereaved families should explain the local road death investigation procedures, including how they will be kept informed. A checklist should be developed for families to use.

10. Learning from victims

Police services should want feedback from victims. They should be confident enough to face criticism and welcome opportunities for improvement. It is telling that so few police services ask bereaved families about their experience.

Better engagement has been achieved with victims of other crimes. This includes Level of Satisfaction surveys and Family Listening Days. Both these are reported to contribute to the improvement of training and practice.

RoadPeace call: Police should survey bereaved families of their level of satisfaction survey with the police investigation. Annual Family Listening Days should be introduced.

Funding

11. New sources needed

Thorough investigations require resources. Whilst the Health and Safety Executive is able to claim for its investigations, police cannot do this. And although police and PCCs are starting to lobby for increased precepts, any additional funding can be expected to go on other priorities.

Road use related revenue should be sought. This could include increasing the MIB levy on insurance premiums, charging the cost of impairment tests on offenders, increasing traffic fines, or obtaining the proceeds from vehicle confiscation.

RoadPeace call: Additional sources of funding for collision investigation should be explored. Costs should be borne by motor vehicle owners, and offenders, as they pose the risk.

Appendix A: Forensic Collision Investigators, England and Wales (2016)

	Number		Number
North West		East of England	
Cheshire	6	Essex	9
Cumbria	7	Norfolk and Suffolk	10
Greater Manchester	10	<i>Tri-Force CTC</i>	18
Lancashire	7	– Bedfordshire	(18)
Merseyside	7	– Cambridgeshire	(0)
		– Hertfordshire	(0)
North East		London	32
Cleveland	6	– Metropolitan	(32)
Durham	3	– City of London	(0)
Northumbria	13		
Yorkshire and The Humber		South East	
Humberside	4	Hampshire	7
North Yorkshire	5	Kent	9
South Yorkshire	7	Surrey	8
West Yorkshire	9	Sussex	9
		Thames Valley	14
West Midlands		South West	
Staffordshire	0	Devon and Cornwall	10
Warwickshire	5	Dorset	6
West Mercia	6	<i>Tri-force</i>	15
West Midlands	13	– Avon and Somerset	(15)
		– Gloucestershire	(0)
		– Wiltshire	(0)
East Midlands		Wales	
EMOpSS	21	Dyfed-Powys	5
– Leicestershire	(8)	Gwent	4
– Lincolnshire	(6)	North Wales	6
– Northamptonshire	(0)	South Wales	5
– Nottinghamshire	(7)		
Derbyshire	8		
Total			304

Notes: (1) Response to RoadPeace FOI request.

(2) No.s in brackets, subtotals within regional units as reported.

(3) Cleveland and Durham are merged but reported separately

Appendix B: Road death investigation guidance structure comparison

Road Death Investigation Manual (ACPO, 2007)	Road Death Investigation Manual (ACPO, 2007)	Road Death Investigation Manual (ACPO, 2007)
Introduction	Road deaths and life changing injuries	Overview
Part 1 Resources Key roles in fatal collision investigation		Key Roles in Fatal Collision Investigation
Part 2 Key Investigative Principles Initial response	Initial response	Initial response
Investigation stage	Investigation stage	Investigation stage
Part 3 Key components of Fatal collision investigation Collision Scene Management Strategy	Collision scene management	Developing an Investigative Strategy
Forensic collision investigation strategy	Forensic collision investigation strategy	Implementing an Investigative Strategy
Intelligence strategy	Road policing intelligence strategy	Collision Scene Management Strategy
Witness management strategy	Disaster victim identification	Forensic Collision Investigation Strategy
Suspect Management Strategy		Intelligence Strategy
Family Liaison Strategy	<i>Link to other section</i>	Witness Management Strategy
Communication and Community Strategy	<i>Link to other section</i>	Suspect Management Strategy
The Role of HM Coroner		Family Liaison Strategy
Post-Mortem and Pathologist		Communication and Community Strategy
Other Agencies and Resources		Post Mortem and Pathologist
		Other Agencies and Resources
		Support Agencies

Appendix C: MPS road death investigation policy monitoring report (2010)

The MPS Traffic Operational Command Unit Monthly Management Report included the following case investigation checkpoints:

- ▶ Inspector's 14 day case review – Target 90%
- ▶ Number of fatal collision reports completed within 4 months of death – Target 70%
- ▶ Number of fatal collision reports completed within 5 months of death – Target 90%
- ▶ Number of cases where FLO or SIO contact made within 24 hours of assuming responsibility for the investigation – Target 90%

In addition, Coroners and CPS were asked to complete quality of service feedback forms asking:

- ▶ Did the submitted case papers contain all the relevant information?
- ▶ Were you kept fully apprised of the progress of the investigation?
- ▶ Did you find the CIU staff to be very helpful when responding to requests for information?
- ▶ Was the overall service provided by the CIU of a good standard?

Target: The overall service provided by the CIU is of a good standard. (Very satisfied or satisfied 100% of the time)

And quality of service feedback forms were also given to relatives of those killed in road collisions, asking:

- ▶ Did your family liaison officer explain their role in the investigation to you?
- ▶ Were you supplied with the Brake Care booklet early in the investigation?
- ▶ Were you able to make contact with your family liaison officer in a reasonable time – if not was a reason given?
- ▶ What was good about the service you received from your family liaison officer?
- ▶ What was not so good about the service you received from your family liaison officer?
- ▶ How do you feel that the service provided by a family liaison officer could be improved?

Target: The overall service provided was of a good standard (Very satisfied or satisfied 90% of the time)

Source: MPS (2010), Road Death Investigation Policy Monitoring Report 2010

References

- ACPO (2001), *Road Death Investigation Manual*, <http://library.college.police.uk/docs/acpo/ACPO-Road-Death-Investigation-Manual-2001.pdf>
- Aeron-Thomas (2013), “*Ending the discrimination against road crash victims*”, in Priti Patel’s Rebalancing the Scales – Prioritising Victims of Crime in the Criminal Justice System, <http://paladinservice.co.uk/wp-content/uploads/2013/10/Priti-Patel-MP-2013-Rebalancing-the-Scales-prioritising-victims-in-the-Criminal-Justice-System.pdf>
- APPCG (2013), *Get Britain Cycling: Report from the Inquiry*, https://allpartycycling.files.wordpress.com/2013/04/get-britain-cycling_goodwin-report.pdf
- APPCG (2017), *Cycling and the Justice System*, <https://allpartycycling.files.wordpress.com/2017/05/appcg-justice-report-2017.pdf>
- Avon and Somerset Police (2017), *Roads Policing Strategy*, BBC (2017), *Diana Walker death: Police probes to follow fatal cycle crash*, 26 August 2017, <http://www.bbc.co.uk/news/uk-england-wiltshire-41047810>
- Brake (2017), *Information and advice for bereaved families and friends following death on the road in England and Wales*, http://www.brake.org.uk/assets/docs/Help_for_victims/EWProcedures1718complete.pdf
- British Cycling (2014), *Time to Choose Cycling*, <https://www.britishcycling.org.uk/campaigning/article/cam20140207-British-Cycling-launches-10-point-plan-to-transform-Britain-into-a-true-cycling-nation-0>
- Caswell C (2013), *Roads policing training review ‘will establish best practice’*, Police Oracle, 11 July 2013, http://www.policeoracle.com/news/Roads+Policing/2013/Jul/11/Roads-policing-training-review-will-establish-best-practice-_67891.html
- Chambers N (2010), *Investigating fatal collisions*, RoadPeace conference Improving Post Crash Response in London, 22 September 2010
- College of Policing (2017), *Investigating Road Deaths and Serious Injuries*, <https://www.app.college.police.uk/app-content/road-policing-2/investigating-road-deaths/>
- CTC (2013), *The Role of the Police*, http://www.roadjustice.org.uk/sites/roadjustice.org.uk/files/CTC%20Road%20Justice%20-%20the%20role%20of%20the%20police_0.pdf
- Cycling UK (2016), *Traffic police and other enforcement agencies*, <https://www.cyclinguk.org/campaigning/views-and-briefings/traffic-police-and-other-enforcement-agencies>
- DfT (2017), *Estimates for reported road accidents involving illegal alcohol levels: 2015* (Second prov), https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/588591/illegal-alcohol-levels-second-provisional-2015.pdf
- DfT (2017b), *Reported road casualties Great Britain Annual Report 2016*, RAS60003 Total value of prevention of reported accidents by severity2 and cost element <https://www.gov.uk/government/statistical-data-sets/ras60-average-value-of-preventing-road-accidents>
- DfT (2017c), *Car drivers in reported injury road crashes, Percent breath tested, England* <https://www.gov.uk/government/publications/reported-road-casualties-great-britain-annual-report-2016>
- Dollimore (2017), *The Michael Mason case – why, what happened and where now?*, <https://www.cyclinguk.org/blog/duncandollimore/mason-verdict>
- FORS (2017), *Collision Management Toolkit*, <https://www.fors-online.org.uk/cms/wp-content/uploads/2016/09/Collision-Management-Toolkit.pdf>
- Galli-Atkinson (2017), *The Livia Award*, <http://clamourandcampaign.com/policeawards.htm>
- Greater London Authority (2017) *Mayor’s Transport Strategy Draft for public consultation*, https://consultations.tfl.gov.uk/policy/mayors-transport-strategy/user_uploads/pub16_001_mts_online-2.pdf
- Greenwood C (2014), *Police to check mobiles in every car crash: Crackdown on calls and texting at the wheel in bid to cut deaths by distracted driver*, <http://www.dailymail.co.uk/news/article-2706182/Police-check-mobiles-EVERY-car-crash-Crackdown-calls-texting-wheel-bid-cut-deaths-distracted-drivers.html>
- Grey C (2017), personal email 03/08/2017
- Home Office (2005), *Review of Road Traffic Offences involving Bad Driving Consultation*

- Home Office (2017), *Police Workforce: England and Wales 31 March 2017*: data tables, <https://www.gov.uk/government/statistics/police-workforce-england-and-wales-31-march-2017>
- HMCSI and HMIC (2015), *Joint inspection of the Investigation and Prosecution of Fatal Road Traffic Incidents*, <http://www.justiceinspectorates.gov.uk/hmicfrs/wp-content/uploads/the-investigation-and-prosecution-of-fatal-road-traffic-incidents.pdf>
- IPCC/Inquest (2013), *Report on the INQUEST/IPCC Family Event March 2013*, https://www.ipcc.gov.uk/sites/default/files/Documents/deaths_review/INQUEST%20family%20listening%20day.pdf
- Keeling N (2016), *The remarkable story of the detective who never gave up his hunt for the hit-and-run killer of a five-year-old boy*, Manchester Evening News, 18 April 2016
- Labbett S (2006), *Collision investigations within the UK Police Service: Evolving the role of the specialist investigator*.
- Lincolnshire Police (2017), webpage about EMOPSS
- London Assembly (2014), *Feet First*, https://www.london.gov.uk/sites/default/files/gla_migrate_files_destination/FEET%20FIRST%20PEDESTRIAN%20REPORT%200104%20FINAL_0.pdf
- London Assembly (2016), *London Assembly Roads Policing effectiveness inquiry*, 21 January 2016
- London Assembly (2017), *Driven to distraction – Making London's buses safer*, https://www.london.gov.uk/sites/default/files/final_driven-to-distraction-17-07-17.pdf
- Lydall R (2016), *Moment cyclist Ying Tao is hit by lorry at Bank, as grieving husband calls for driver to face prosecution*, Evening Standard, 29 July 2016
- McCarthy M and A Barrow (2016), *Towards Zero: Study on fatal collision son the SRN during 2014*, TRL,
- MIB (2017), *Annual report and accounts 2016*, <https://www.mib.org.uk/media/379062/mib-annual-report-2016-issue-low-res.pdf>
- MoJ (2015), *Analytical Summary 2015 – Public confidence in the Criminal Justice System – findings from the Crime Survey for England and Wales (2013/14)*, July 2015
- MPS (2010), *Road Death Investigation Policy Monitoring Report 2010*
- MPS (2011), *Road Death and Life Threatening/Changing Serious Personal Injury (SPI) Collision Investigation Policy*
- Mulraney S (2001), *Call for ranks above OC to investigate road deaths*, Police Review 15 June 2001
- National Audit Office (2015), *Financial sustainability of police forces in England and Wales*, <https://www.nao.org.uk/wp-content/uploads/2015/06/Financial-sustainability-of-police-forces.pdf>
- NPCC (2015), *Roads Policing 5 Year Strategy*, http://library.college.police.uk/docs/NPCC/Policing_the_Roads_in_Partnership_2015.pdf
- NPCC (2015), *National Policing Guidelines on Charging for Police Services*, <http://www.npcc.police.uk/documents/finance/2015/NPCC%20Guidelines%20on%20Charging%20for%20Police%20Services.pdf>
- NPCC (2016), *National Policing Guidance Road Policing: Policy when dealing with disclosure of information held by the police to third parties in road traffic collisions*
- NPIA (2007), *Road Death Investigation Manual*, <http://www.npcc.police.uk/documents/FoI%20publication/Disclosure%20Logs/Uniformed%20Operations%20FOI/2012/041%2012%20Att%2001%20of%202%20Publications%20of%20Fatal%20Accidents.pdf>
- National Safety Council (2017), *Undercounted is Underinvested: How incomplete crash reports impact efforts to save lives*, <http://www.nsc.org/DistractedDrivingDocuments/Crash%20Report/Undercounted-is-Underinvested.pdf>
- Office of national Statistics (2017), *Focus on violent crime and sexual offences, England and Wales: year ending Mar 2016*, Homicide chapter, <https://www.ons.gov.uk/peoplepopulationandcommunity/crimeandjustice/compendium/focusonviolentcrimeandsexualoffences/yearendingmarch2016/homicide>
- Parliamentary Office of Science and Technology (2015), *POSTbrief 15 Unintentional Bias in Forensic Investigation*, October 2015, <http://researchbriefings.parliament.uk/ResearchBriefing/Summary/POST-PB-0015#fullreport>
- Police Scotland (2015), *Road Death Investigation Manual*, <http://www.scotland.police.uk/assets/pdf/340047/341626/road-death-investigation-manual?view=Standard>

- Richards DC, Cookson RE, and Cuerden RW (2010), *Linking accidents in national statistics to in depth accident data*, <https://trl.co.uk/reports/PPR513?reportid=6626>
- RoadPeace (1998), *RoadPeace Campaign for Justice for Road Traffic Victims*, <http://www.roadpeace.org/wp-content/uploads/sites/19/2017/11/Justice-Campaign-Manifesto.pdf>
- RoadPeace (2008), *Not a Normal Death*, <http://www.roadpeace.org/wp-content/uploads/sites/19/2017/11/RoadPeace-Not-a-normal-death.pdf>
- RoadPeace (2012), *ACPO Road Death Investigation Manual Consultation response*, <http://www.roadpeace.org/wp-content/uploads/sites/19/2017/11/roadpeace-response-rdim-review.pdf>
- RoadPeace (2014), *Transport Safety Commission inquiry Who's Responsible – RoadPeace response*, <http://www.roadpeace.org/wp-content/uploads/sites/19/2017/11/roadpeace-response-transport-safety-commission-whos-responsible-enquiry.pdf>
- RoadPeace (2015), *Joint Inspection of the Investigation and Prosecution of Fatal Road Traffic Incidents: RoadPeace summary*
- RoadPeace (2016), *From fatal crash to conviction*
- RoadPeace (2016b), *Collision investigation campaign*, <http://www.roadpeace.org/wp-content/uploads/sites/19/2017/11/roadpeace-collision-investigation-campaign-leaflet.pdf>
- RoadPeace (2016c), *Road collisions and enforcement; England and Wales 2010-2015*, <http://www.roadpeace.org/wp-content/uploads/sites/19/2017/11/road-casualties-and-enforcement-e-w1.pdf>
- RoadPeace (2016d), *The discrimination of road crime victims in England and Wales: Dec 2016 update*
- RoadPeace, CTC et al (2016), *Joint response to London Assembly Police and Crime Committee review into road traffic crime from CTC, Living Streets, London Cycling Campaign, RoadPeace, Road Danger Reduction Forum, Sustrans, and 20's Plenty for Us*, <http://www.roadpeace.org/wp-content/uploads/sites/19/2017/11/joint-response-to-london-assembly-police-and-crime-committee-re-road-traffic-crime.pdf>
- RoadPeace (2017a), *RoadPeace response to APPCG Justice for Cyclists inquiry*, <http://www.roadpeace.org/wp-content/uploads/sites/19/2017/11/roadpeace-response-appcg-cycling-justice-inquiry.pdf>
- RoadPeace, Cycling UK et al (2017b), *Joint response to HMIC work programme consultation*, <http://www.roadpeace.org/wp-content/uploads/sites/19/2017/11/joint-response-to-hmic-consultation.pdf>
- RoadPeace, Cycling UK et al (2017c), *Joint response to A Safer City for All Londoners Draft Police and Crime Plan for London, 2017–2021 consultation*, <http://www.roadpeace.org/wp-content/uploads/sites/19/2017/11/joint-response-london-police-and-crime-plan-consultation.pdf>
- RoadPeace (2017d), *Our Lawless Roads*, <http://www.roadpeace.org/wp-content/uploads/sites/19/2017/11/roadpeace-lawless-roads-report-2017.pdf>
- Rowley M (2013), letter to Jenny Jones, 22 April 2013
- Shaw M (2015), *Family of John Radford speak after Michael Gledhill admitted causing death by dangerous driving*, Examiner, 12 November 2015, <http://www.examiner.co.uk/news/west-yorkshire-news/family-john-radford-speak-after-10434516>
- TfL (2013), *Safe Streets for London*, <http://content.tfl.gov.uk/safe-streets-for-london.pdf>
- TfL (2017), *FfL response to GLA Transport Committee Report on Bus Safety*, https://www.london.gov.uk/sites/default/files/tfl_response_to_bus_safety_report.pdf
- Victim Support (1994), *Support for the families of road death victims*
- Victims' Commissioner (2017), *Are Victims Satisfied? The Victims' Commissioner's Scoping Review into the Measurement and Monitoring of Victims' Satisfaction with the Police*, https://s3-eu-west-2.amazonaws.com/victimcomm-prod-storage-clhgxgum05k1/uploads/2017/08/6-3475_VC_Victim-Satisfaction-Police-report-140817-final.pdf
- Wedlock E and J Tapley (2016), *What works in supporting victims of crime; A rapid assessment of evidence*, University of Portsmouth and Victims Commissioner, <http://victimcommissioner.org.uk/app/uploads/2014/10/What-works-in-supporting-victims-of-crime.pdf>
- White S (2012), *Letter re Review of Road Death Investigation Manual*, 5 April 2012
- White S (2013), Letter to K Cairns, 20 August 2013

Glossary

ACPO	Association of Chief Police Officers
CJS	Criminal Justice System
CPS	Crown Prosecution Service
CoP	College of Policing
CTC	Cyclist Touring Club (now Cycling UK)
DfT	Department for Transport
EMOpSS	East Midlands Operational Support Services
FCI	Forensic Collision Investigator
FIT	Field Impairment Testing
FLO	Family Liaison Officer
HMCPSP	Her Majesty's Crown Prosecution Service Inspectorate
HMIC	Her Majesty's Inspectorate of Constabulary
IPCC	Independent Police Complaints Commission
LCC	London Cycling Campaign
MoJ	Ministry of Justice
MPS	Metropolitan Police Service
NIMI	Notice of Investigating Major Incident
NPCC	National Police Council of Chief Constables
NPIA	National Police Improvement Agency
PACTS	Parliamentary Advisory Council for Transport Safety
PEEL	Police Effectiveness, Efficiency and Legitimacy
PIP	Professionalising the Investigation Process
RAIDS	Road Accident In Depth Studies
RDIM	Road Death Investigation Manual
RDRF	Road Danger Reduction Forum
RPLO	Road Policing Lead Officer
SCI	Senior Collision Investigator
SIO	Senior Investigating Officer
TfL	Transport for London
VRU	Vulnerable road user

This review has highlighted the critical role the police have in delivering justice and safer roads after a fatal collision. It has identified many opportunities for improvement. And RoadPeace will continue to campaign for these improvements. But we end with a reminder of the difference a good police response makes to bereaved families.

All That We Can Hope For

In the dark of the night comes a knock at the door,
Two officers to report that you are no more;
A devastating impact, a sudden collision –
This feels overwhelming, impossible to envision.
These officers talk with compassion and care,
Adding a gentle cloak to the information they share.
And their kindness is all that we can ask for.

Weeks turn into months, but then charges are pressed,
And we see first-hand how much these officers invest,
In an investigation that gets it right –
Their job is simply to bring the truth to light.
Our FLO is in touch and keeps us updated,
Always aware of the pain that has been created.
And her help is all that we can wish for.

These officers stand with us as we go to court,
A source of some comfort as justice is sought –
But mouths drop open as the sentence is passed,
Even the SIO can be heard to gasp.
Three short years for taking a life –
For such reckless driving, it cuts like a knife.
And this is not what the police have worked for.

Our family is exhausted and ready to give up;
Angry and frustrated at the way the judge summed it up.
Our loved one has been taken forever,
There will be no 'getting over' this, not now, not ever.
So, the police talk cautiously to us of an appeal –
They say "take a few days and see how you feel".
And they convince us there is more to fight for.

Seeking advice, the police are told there is no chance,
Yet they refuse to back down, they take a firm stance –
Determination pays off, an appeal is granted,
A tiny seed of hope is carefully planted.
They meet us in London, we hear the details again,
And as the prison term is increased it eases some pain.
And this is more than we dared to pray for.

This has been a nightmare – will it ever truly end?
Our grief will not disappear – let's not pretend;
But as a family, we can say from our hearts –
These police were superb right from the start.
We have been treated with respect and dignity,
And an understanding that our lives have changed infinitely.
These officers have given us all that we had left to hope for –
And perhaps even, a little bit more.

Lucy Harrison, RoadPeace West Midlands Local Group Coordinator, on the third anniversary of her brother Peter's death by a dangerous driver who also fled the scene



This report was made possible thanks to funding from the Network for Social Change Charitable Trust.

About RoadPeace


RoadPeace, the national charity for road crash victims, has been helping the families cope with the aftermath of road death and injury since 1992. We provide emotional support and information to help the bereaved and injured understand the justice system. RoadPeace also campaigns for an improved post crash response by the justice system, including thorough investigations, effective inquests, appropriate prosecution and sentencing, fair compensation and better treatment of crash victims. This includes treating road traffic crime like other crime and ending the discrimination against road crash victims.

Office 020 7733 1603

Helpline 0845 4500 355

info@roadpeace.org

www.roadpeace.org

 [@roadpeace](https://twitter.com/roadpeace)

Registered charity no.1087192