‘Killed and Seriously Injured’ (KSI) pedal cycle collisions and the London criminal justice system 2007 to 2009

Acknowledgements

The analysis of case files and review of processes in this document has been undertaken by the Transport for London Community Safety, Enforcement and Policing Intelligence and Analysis Team, and the London Criminal Justice Partnership Performance Analysis Unit with guidance from the project steering group. Additionally, specific mention is made to Dr Sally Cunningham (University of Leicester School of Law) who provided advice during the initial stages of the review.

The authors would like to thank all those who contributed their data and expertise including:

City of London Police Roads Policing Unit
Crown Prosecution Service London Traffic Unit
London Criminal Justice Partnership
Metropolitan Police Service (Safer Transport Command Unit, Traffic Criminal Justice Unit and Traffic Operational Command Unit)
RoadPeace
TfL Better Routes and Places Directorate

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1 Executive Summary

Background

The substantial increase in cycling trips made in recent years has been accompanied by a comparatively small increase in cycle collisions resulting in casualties. The relative risk of cycling per trip is reducing. The Mayor's Cycle Safety Action Plan[1] aims to drive this positive trend forward and improve the perception and experience of cycling as a safe and attractive transport option. The Plan is supported by TfL, the Metropolitan and City of London Police Services and other partners. It includes the commitment to:

> *Work with the London Criminal Justice Board to review "Killed and Seriously Injured" (KSI) collisions with a view to strengthening criminal justice arrangements for dealing with such cases*

This priority is important for ensuring there are robust processes in place which will deliver better support to cyclists and their families affected by bad driving, and instil confidence that cases are investigated and prosecuted to the best of Criminal Justice Service (CJS) agencies abilities in a fair and effective manner.

Focus of the report

This research has been conducted in partnership with the City of London Police, the Crown Prosecution Service, the London Criminal Justice Partnership, the Metropolitan Police Service, and TfL.

A project steering group comprising representatives from the above agencies directed this review to cover:

- Each agency policies and processes concerning the management and handling of criminal cases involving cyclists that have resulted in a fatality or serious injury;
- A review of collision investigation and prosecution case files for KSI collisions between 2007 and 2009; and
- From this Identification of changes and improvements already made and opportunities to further strengthen criminal justice arrangements.

Limitations

As the stated priority concerns KSI collisions, other less serious (or slight injury collisions) were not addressed. Whilst KSI collisions involving a cycle average almost 450 per year between 2007 to 2009, slight injury collisions involving a cycle are far larger in magnitude averaging over 2,800 per year in the same period and have also increased year on year during the period.

[1] http://www.london.gov.uk/who-runs-london/mayor/publications/transport-and-streets/cycle-safety-action-plan

2007 – 2009 was chosen to allow an end to end review of collisions through the criminal justice system. Statistics relating to fatal and serious personal injury collisions for 2010 have been included in sections five and six, however the detailed assessment of cases has only been conducted for a selection of files between 2007 – 2009.

The large volume of fatal and serious personal injury case files precluded a complete review of all KSI collisions; hence a small sample was selected for the detailed assessment of compliance against agency processes.

Only collisions involving cycles were examined, hence it is unclear whether similar findings would be prevalent within collisions involving other vehicles or pedestrians.

Services provided by the Courts and Tribunals Service were not assessed as the research team were unable to gain access to HMCS within the timeframe available.

The agreed purpose was not to review on the quality of police investigation or assess CPS process in reaching a charging decision. Other organisations such as the HMIC and HMCPSI are far better placed to assess the accuracy, completeness and decision making. This review does not make a judgement on whether sufficient evidence was gathered or the correct charging decision made.

Key findings

The majority of fatalities upon London's roads involve pedestrians, next riders of powered 2 wheeler vehicles (mopeds and motorbikes), followed by cyclists. The trend for cycle collision fatalities has in recent years declined below levels in 2000, whilst seriously injured cycle casualties have recently risen above 2000 baseline levels.

There is wide variation in cycle collision casualties across London's 33 boroughs which should be borne in mind from a policing and prosecution perspective. The capacity and expertise required by partner agencies to successfully investigate and prosecute needs to match this.

Where there is evidence to be considered, fatal cycle collisions are reviewed by the CPS ahead of reaching a charging decision. The proportion prosecuted has risen in recent years however a low number result in convictions. During 2007 only three out 14 (21%) of fatal collision investigations resulted in prosecution, with all of these resulting in a conviction. In 2008 and 2009, this improved with eight out of 13 (62%) investigations resulting in prosecution for both years, however only two of these had a conviction in 2008 and there was only one conviction in 2009 (see table 10). During 2010, three of the six prosecutions resulted in a conviction. The majority of collisions with no further action taken resulted in a decision of accidental death at Coroner inquests.

The proportion of serious personal injury collisions, as investigated by the MPS Traffic Serious Casework Unit, prosecuted has fluctuated in recent years although on average over a third of collisions investigated were prosecuted. The proportion of collisions prosecuted resulting in a conviction has increased year on year (from 53% in 2007 to 77% in 2010).

The police and CPS processes for investigating fatal and serious personal injury collisions are very thorough. This should be publicised to give greater confidence and public reassurance that they conduct careful and meticulous investigations and subsequent prosecutions.

The communication and correspondence between the MPS and CPS, when handling collision casework, is very positive. It is evident that their relationship developed from 2007 to 2009 with the frequency of communication increasing and directed to the relevant person thereby avoiding potential delays in the investigation and charging decision. The agencies interact with each other very well responding promptly to calls for advice or requests for further evidence. The CPS consistently delivers a charging decision within the statutory time limits.

The CPS has a good review process and continually reviews case files throughout the prosecution. Forms are completed detailing the latest progress the case has made and any actions for developing the case further.

With regards to serious personal injury cases the quality of information captured within each case file clearly improved between 2007 to 2009, suggesting an improvement in case investigation. This is further evidenced by the increase in the proportion of collisions prosecuted resulting in a conviction increasing year on year. Collision cases involving cyclists are being afforded an additional layer of quality assurance and scrutiny by the Traffic Criminal Justice Unit during investigations.

During the course of the research and the steering group meeting during 2010, further changes have been implemented by the CJS, and more planned. These changes will further enhance the quality and provide more vigour and support to investigations of the most serious life threatening and life changing injury collisions.

Agency improvements

There were several policy and process improvements undertaken in recent years (and planned for the future) to improve the investigation and prosecution of cycling collisions. The key improvements are listed below with more detail available in section eight of this report:

- Enhancement of the MPS Road Death Investigation Unit , increasing staff and assets, including more detectives and a specific intelligence team;
- Transfer of the investigation responsibility for the most serious personal injury collisions from the MPS Traffic Serious Casework Unit (TSCU) to local Borough Operational Command Units (BOCU) affording a higher standard of care than previously possible plus allows the TSCU to take on additional work particularly regarding collisions involving vulnerable road users (including cyclists);
- MPS plan to manage witnesses better at collision scenes through attendance of experienced detectives at every collision scene plus redesign of the MPS Scene Management Log book;
- The joint TfL / MPS Roads Reopening Protocol to ensure the prompt re-opening of the road network following fatal and serious collisions. This new protocol is designed to provide the framework for the MPS and TfL to work together with maximum efficiency

to ensure the collection of all available physical evidence whilst reducing the impact of the road closure against other users;

- Improved support for the City of London Police (CoLP) officers through better use of technology (case management system), specific training programmes and enhanced procedures;
- The Director of Public Prosecutions has extended the service for bereaved families at court to offer additional meetings with the CPS;
- The CPS has created an Optimum Business Model to ensure case progression processes are more robust, consistent across all units and strengthen aspects including compliance with Court orders and defence requests for information. This should ensure actions are dealt with effectively;
- The Director of Public Prosecutions issued Core Quality Standards which outline the level of service that the public and other criminal justice stakeholders can expect at each stage of the process; ranging from early advice to investigators at the outset of a case through to how the CPS will respond to complaints or feedback which might follow at the conclusion of a case. Performance against the standards are monitored and reported to the public at the end of each financial year; and
- The CPS Complex Casework Unit includes a Homicide Team that, from 1st April 2011, will deal with all fatal collision casework.
- The Criminal Justice System Efficiency Programme is currently taking place to make significant progress upon creating a digital CJS, streamlining case administrations and increase the use of video technology by April 2012.

Recommendations

A few areas for improvement were identified by this research, plus examples of good practice to be highlighted and disseminated more widely. These are summarised below with more detail available in the last section of this report.

Metropolitan Police

1. Continue the MPS review into the SOP for managing life threatening/changing investigation
    - Whilst a new Standard Operating Procedure (SOP) has been introduced ensuring BOCUs take on the investigation of the most serious SPIs (not dealt with by the Road Death Investigation Unit - RDIU), the MPS should review their resourcing of BOCU units responsible for life changing / life threatening personal injury collisions in light of the varied volume of serious injury collisions that were recorded in previous years to ensure that there are adequately trained resources to manage investigations within each borough. The MPS should consider how boroughs with different demand will develop and retain the necessary expertise to effectively investigate these collisions.

2. Improve reporting processes for prosecution decisions and court outcomes and conduct analysis upon outcomes
    - Through the research it is clear that even recent historic records have been difficult to obtain; this has led to an incomplete appreciation of the scale of prosecutions conducted for serious pedal cycle collisions and their ensuing

progress at court. With the move to BOCUs being responsible for certain collisions and any ensuing prosecution locally, it is even more important that the Traffic Criminal Justice Unit (CJU) considers centralised recording of all collision prosecutions across London and in turn analysing findings on a regular basis to identify any trends requiring further attention.

3. Improve communication with Serious Personal Injury (SPI) victims and documentation of contact made within the case file
    - There were a few instances from the historic case file review of inconsistent contact with victims; these should be reviewed to determine the circumstances and ensure these are not repeated in future. In some SPI cases reviewed, it was difficult to determine whether regular contact was being made and documented. This could reflect the change in recording systems and processes used rather than poor practice. Where the Summons Package electronic diary transcripts were included in files, it was evident that contact is frequently made; however this was not included in all the SPI case files reviewed. It is recommended that the TSCU ensure transcripts of the Summons Package electronic diary are included in all case files and updated with all new contact; this would also act as a useful form of back up should the Summons Package electronic diary be unavailable.

4. Review witness appeal boards prior to despatch
    - The single instance of a witness appeal board asking for witnesses following a collision involving a pedestrian, instead of a cyclist, may have prevented witness recall and been ineffective at identifying additional witnesses. Whilst this was an isolated incident it is recommended the RDIU Detective Inspectors provide quality assurance of witness boards before they are placed at the collision scene.

5. Review relationship with London Ambulance Service (LAS)
    - In both the fatal and SPI case file review there were instances of conflicting victim injuries reported to collision scene officers and a delay in provision of accurate diagnosis. Whilst accepting it can be challenging to accurately diagnose victim's injuries, it would be useful to review how the collision scene officers and LAS personnel engage with one another to identify any possibility of more accurate diagnosis being provided more quickly.

6. With the CPS, review support given to victims dissatisfied with charging decisions
    - In a few instances, SPI victims unhappy with the charging decision were treated poorly in terms of the length of time taken to supply requested case file information. It is recommended that the processes for engaging with victims dissatisfied with the service provided by the TSCU are reviewed to ensure that future requests for case file information are dealt with promptly and fairly. This would help improve victim satisfaction with the MPS plus help to reassure victims that the investigation into their case was conducted in the appropriate manner.

7. Improve collection of victim statements
    - The majority of SPI case files containing victim statements revealed gratitude from the victims at being able to put forward their point of view. In one case a victim had to request for her statement to be taken several times before it was finally collected. It is recommended that the process for offering and collecting victim statements is reviewed to ensure future collection of these is speedy and supportive to victims.

8. Update MPS SOPs by reference to the 2009 serious personal injury case file reviewed as an example of good practice
    - The final 2009 serious personal injury case file reviewed, was well documented and provided a great deal of support to a vulnerable cyclist. It is recommended that this case file is highlighted amongst investigators as an example of good practice to refer to when conducting future case file reviews.

9. Improve letters of court attendance sent to victims
    - Copies of letters sent to victims and witnesses to attend court appeared indistinguishable and standardised. It is recommended that standard information is included (such as, case reference number and court date), alongside tailoring the letters to the individuals being written to, especially in the case of victims.

City of London (CoLP) and Metropolitan Police

10. CoLP and MPS to conduct joint review of their investigation processes
    - Whilst both forces have collaborated together, particularly where collisions occur on the border of the City with MPS boroughs, there is little evidence of systematic learning from one another to help strengthen existing processes and provide a truly consistent approach to collision investigation across the whole of London. It would also be worthwhile the CPS London Traffic Unit (LTU) and City CPS unit establishing a joint review of processes to ensure CPS consistency in collision prosecution across London.

Crown Prosecution Service

11. Analyse outcomes of all fatal road traffic cases to identify learning points and disseminate lessons
    - As identified in the HMCPSI 2008 review, there was a need to ensure this happens for all fatal cases irrespective of outcome. Adverse outcomes are reviewed, however there should be consideration given to all fatal case files, where resources permit. This could be an opportunity to work jointly on these case reviews to ensure holistic appraisal.

12. The CPS should clarify and collate the guidance relating to its commitments to victims' families in road traffic fatality cases
    - A project is currently underway within CPS HQ that should aid delivery of this. The CPS Victim and Witness Project aims to streamline commitments to victims and witnesses regarding levels of support to bereaved families; this includes

plans to produce a public document setting out the standards of care that victims and witnesses are entitled to receive from the CPS and Witness Care Units.

13. Following any meeting with the victim's family, a letter should be sent confirming key points discussed
    - This does not currently happen, and when consulted the CPS LTU agreed this would be a useful idea to ensure that victim's families have a record of what was discussed, therefore it is recommended that this is undertaken following all future meetings held between victim's families and the CPS. The Homicide Team (see below) will continue to offer meetings as LTU have prior to 1st April 2011 and should consider this recommendation.

14. Review the recent transition of fatal collision prosecutions from the CPS London Traffic Unit to the CPS Complex Casework Unit Homicide Team
    - This recent change which occurred during the final writing of this report should be monitored to assess the impact, on how fatal collisions involving cyclists are progressed, and whether this will enable the LTU to deal more effectively with non-fatal collision casework.
    - This also presents an opportunity for the CPS to consider if the Homicide Team can take responsibility for life threatening / changing collisions prosecution or offer support to borough CPS teams conducting the prosecution, similar to how the MPS RDIU supports borough OCUs that lead the police investigation upon these types of collision.

15. Review outstanding recommendations from previous 2008 and 2010 HMCPSI reports
    - There were four recommendations, from the 2008 and 2010 HMCPSI reports into fatal collisions prosecutions and the London Traffic Unit, where progress could not be determined at time of writing this report. The CPS should review these and take action where required.
    - In particular there is still no national CPS training in relation to prosecuting bad drivers which is an opportunity to define the charging standards for careless and dangerous driving and ensure that there is consistency in approach between the CPS Complex Casework Unit, that deal with fatal collision cases, and local borough CPS teams dealing with all other personal injury collision cases.

Identified Good Practice

Metropolitan Police

1. Most serious SPI collisions investigated by BOCU
    - Since August 2010, the most serious SPI collisions not investigated by the RDIU are investigated by the BOCU where the collision occurred. This has enabled the TSCU to undertake additional work in respect of vulnerable road users and is envisaged to have positive impact upon victim satisfaction and confidence in how the police handled the investigation.

2. Improved efficiency of Collision Investigator's Reports (CIR) production

- Since March 2011, a new Standard Operating Procedure has clarified the role of the Collision Investigator (CI) within investigations conducted by the RDIU. A particular emphasis is now upon only relevant witness statements to be included within the CIR; previously the CIs waited for all witness statements to be compiled and used this information within their CIR which introduced unnecessary delays to the final report production.

3. Breath tests conducted in all reviewed fatal case files
    - There was evidence of these being conducted in every fatal case file reviewed in a timely fashion (within one hour of the collision).

4. Contacting next of kin and collaboration with UK and overseas police forces
    - There was evidence of excellent work undertaken to determine and then contact next of kin of fatal victims. This included good collaboration with other police forces in the UK and overseas.

5. Care of young witnesses
    - One case file revealed good processes to ensure traumatised witnesses were supported to provide their statements at a later date, plus specialist officers trained in dealing with young people were involved and properly briefed on the case details to ensure both the care of the witness and collection of evidence for the investigation.

6. Handover between Road Death Investigation Unit and Traffic Serious Casework Unit
    - Where cases were handed over from the RDIU to the TSCU, the use of a handover form documenting the material included and the reason for inclusion was invaluable for ensuring the case could be progressed promptly following handover. Given the increased involvement of BOCUs for investigating life changing / threatening collisions, that may be handed over to them by the RDIU, it is important that this process is followed in future.

7. Letters sent to victims and witnesses
    - There were some good examples of letters sent at the conclusion of case investigation and prosecution. It is recommended that the MPS identify examples of good letters, in terms of tone and content, and circulate these to relevant staff to ensure they follow these in future correspondence.

8. Road Death Investigation Unit record of incident attended form
    - Where included in the case files reviewed, this form provided excellent concise complete overview of the collision and the various parties involved. This form should continue to be used in all collision investigations to enable other officers to quickly gain appraisal of the nature of the collision.
9. Traffic Serious Casework Unit follow up of Form 966
    - There is excellent follow up and enquiry on all parties sent this form. This should be continued and shared with the BOCUs that investigate life changing / threatening collisions to enable gathering of all possible evidence.

10. Senior Investigating Officer Forums
    - This forum was established during 2010 where all the RDIU SIO's meet to receive relevant training, presentations and to share good practice; for example, the identified issue of eyesight tests being properly conducted has been addressed through this forum.

11. Management of investigations upon the CRIS system and regular investigation review
    - The RDIU now manage investigations upon the Crime Recording Information System (CRIS), with officers encouraged to enter upon this all information and actions taken relevant to the investigation; the Detective Sergeants and Detective Inspectors undertake regular review of the investigation progress and use a quality assurance checklist to ensure specific actions are undertaken. This process should ensure lines of enquiry such as this are followed and recorded for others to see.

12. Maintain the same Family Liaison Officer (FLO) throughout a case where possible
    - As reported in the fatal case file review findings there was evidence of a FLO changing throughout a case investigation and ensuing prosecution. The aim of the RDIU is to ensure that the same FLO is maintained throughout each case, and on the rare occasions this is not possible ensure the handover between FLOs is conducted efficiently to provide continuity in the support and relationship developed with the victim's family.

Crown Prosecution Service

13. Adherence to delivering prosecution charging decision within statutory time limits (STL)
    - Despite any delays in supply of evidential material from the police, the CPS LTU has consistently delivered a charging decision within the STL. This is in large part due to the tracker system in place monitored by both the TSCU and the CSP LTU, plus the co-location of MPS and CPS staff in the same premises ensures that regular face to face discussion can take place.

14. MPS and CPS case file surgeries
    - The monthly case file surgeries are a crucial forum for consultation on case progression and evidential requirements to enable CPS charging decision. These should be continued and adopted in the BOCUs with their local CPS colleagues when working upon life changing / threatening case file investigation.

15. Specialist Lawyers in the CPS Complex Casework Unit Homicide Team
    - Prior to 1st April 2011, there were three specialists in traffic law responsible for charging decision for all cases dealt with by the LTU. From 1st April, the case work concerning fatalities was moved to the CPS CCU Homicide Team. To ensure the continuity of input one of the specialists from the LTU was transferred to the Homicide Team. This move was undertaken to ensure that specialist input is maintained from pre-charge to disposal in the Crown Court; prior to this if the case proceeded to the Crown Court, the case would be allocated to a local borough unit to handle, at which point specialist input would be lost. The

specialist prosecutor is also deployed to the magistrates' court to assist with any trials heard.

- The City of London CPS Unit also has a trained traffic prosecutor working upon traffic prosecution cases thereby providing consistency in decision making across London.

16. Charging decisions (fatal collisions and dangerous driving serious personal injury collisions) are quality assured by the Legal Director
    - The Legal Director of the LTU reviews and quality assures every fatal collision charging decision made acting as another layer of quality assurance.

2 Introduction

2.1 Background

The Mayor's Cycle Safety Action Plan (CSAP)[2] sets out objectives to improve cyclist's safety within London. It builds upon the positive trend of increasing cycling levels set against a declining rate of casualties. The plan is being taken forward by Transport for London (TfL) and partners to reduce cycling casualties on London's roads. In order to meet these objectives the plan contains a number of commitments, including specific enforcement priorities of:

- The Metropolitan Police Service, with Traffic Operational Command Unit (OCU) taking the lead, undertaking targeted enforcement against careless and dangerous road user behaviour;
- Working with the London Criminal Justice Partnership to review "Killed and Seriously Injured " (KSI) collisions with a view to strengthening criminal justice arrangements for dealing with such cases; and
- Discussing with the Metropolitan Police Service (MPS) and cyclist organisations the most effective way of ensuring cyclists observe junction controls.

This report focuses upon the second priority listed above:

> *Working with the London Criminal Justice Partnership to review "Killed and Seriously Injured" (KSI) collisions with a view to strengthening criminal justice arrangements for dealing with such cases*

Ensuring there are robust processes in place, will deliver better support to cyclists and their families affected by bad driving, instil confidence that cases are investigated and prosecuted to the best of Criminal Justice Service (CJS) agencies abilities in an effective and fair manner.

2.2 Partnership approach

The aims of the CSAP will not be successfully achieved without a partnership approach, particularly with respect to this priority. A project steering group was established comprising of the key partners of the City of London Police (CoLP), the Crown Prosecution Service (CPS), the London Criminal Justice Partnership (LCJP), the Metropolitan Police Service (MPS), and TfL. This CSAP enforcement priority complements the existing objectives for each agency involved, in particular:

Transport for London

In addition to the CSAP, TfL also drive the Mayor's Transport Community Safety Strategy, entitled 'The Right Direction'[3], which sets out how the Mayor, working through the London Transport Community Safety Partnership will progress the aims of making travelling around London safer for all. Two particular objectives of 'The Right Direction' support this cycle safety priority:

[2] http://www.tfl.gov.uk/assets/downloads/corporate/Cycling/Cycle-Safety-Action-Plan.pdf
[3] http://www.tfl.gov.uk/assets/downloads/corporate/the-right-direction.pdf

- Reduce the volume of Londoners injured on London's roads as a result of criminal and anti-social behaviour (ASB); and
- Improve cyclists' safety and security through tackling crime and ASB

Furthermore, a new London Road Safety Plan will be published by TfL during summer 2011 which will set new road safety goals as required by the Mayor.

Metropolitan and City of London Police Services

One of the corporate objectives of the MPS is to make neighbourhoods safer through local and city-wide problem solving and partnership working to reduce crime, ASB and road casualties[4]. The MPS have a particular target to reduce the number of people killed or seriously injured in road traffic collisions, which is also shared by the City of London Police[5].

London Criminal Justice Partnership

The LCJP[6] primary aim is to make London safer by ensuring that Londoners receive an efficient and effective criminal justice service; and by working with local communities to reduce offending. The LCJP brings together London's criminal justice agencies, including the CPS, with other partners to deliver the strategic vision for a fair, timely and effective CJS which everyone has confidence in and that contributes to a safer London. To support delivery particular work is undertaken to ensure that the CJS is effective in bringing offences to justice, engages the public and inspires confidence, puts the needs of the victim at its heart and has simple and efficient processes.

2.3 Aim and scope of the project

As stated, this report focuses upon the second enforcement priority of the CSAP

> *Working with the London Criminal Justice Partnership to review "Killed and Seriously Injured" (KSI) collisions with a view to strengthening criminal justice arrangements for dealing with such cases*

Methodology

The steering group decided the priority was best achieved by:

- Reviewing each CJS agency current policies and processes relating to the management and handling of criminal cases involving pedal cyclists that have resulted in a fatality or serious injury;
- Reviewing past HM Crown Prosecution Service Inspectorate (HMCPSI) inspection reports concerning road traffic offences prosecution and the London Traffic Unit, to determine progress upon previous recommendations;
- Reviewing collision investigation and prosecution case files for a sample of Killed and serious injured pedal cycle collisions between 2007 and 2009 and
- Identifying strengths, weaknesses and making recommendations for improvements.

[4] http://www.met.police.uk/about/documents/policing_london_business_plan_2009_summary.pdf
[5] http://www.cityoflondon.police.uk/NR/rdonlyres/F16EDF4F-FB30-4209-B24A-D63F7A656713/0/policing_plan_20102013.pdf
[6] http://lcjb.cjsonline.gov.uk/London/2703.html

The scope of this report covers:

- High level analysis of all KSI collisions to place cycle collisions into context, plus more in-depth analysis of all fatal and serious injury cycle collision cases as they passed through the CJS;
- End to end of the CJS process (focussing upon investigation through to prosecution and determination of guilt); and
- Role of victim support services provided.

Scope

The report findings are structured as follows:

- Explanation of methodology followed (section three);
- Narrative of all KSI collisions within London, including focus upon KSI collisions involving pedal cyclists and their journey through the CJS (this includes prosecution decisions, charging and outcomes). Section four is presented to place cycling collisions within London into context and highlight the importance of cycle safety; and sections five and six present the outcomes of police investigations and CPS prosecutions of cycling collisions between 2007 and 2009;
- CJS agency policy and processes used during cycling collision investigations, including victim codes of practice (section seven). This section broadly outlines the processes to highlight the key CJS agency actions that take place from the moment a collision occurs through to the decision taken to prosecute someone;
- Improvements made to agency processes (section eight). This section highlights the key changes undertaken to improve the CoLP, MPS and CPS processes for investigating collisions plus future planned changes, (CPS changes and planned developments are highlighted in the next section);
- Review of recommendations and agency responses from the recent HMCPSI review of Crown Prosecution Service (CPS) decision-making, conduct and prosecution of cases arising from road traffic offences involving fatalities, and the HMCPSI performance assessment of the CPS London Traffic Unit (section nine);
- Findings from the review of a sample of completed fatal and serious injury collisions case files from the period 2007 to 2009, including assessment of compliance against aforementioned policies (section ten);
- Recommendations for improvement to processes and acknowledgement of identified good practice (section eleven); and
- Checklists used to review case files and a list of abbreviations used throughout this document are included as appendices.

3 Review of case files methodology

The majority of the work to obtain and assess policies and processes, and conduct case file review was undertaken by TfL Community Safety, Enforcement and Policing (CSEP) analysts with support from the LCJP, in particular for the sourcing and secure storage of case files plus dedicated support for understanding the CJS. The CPS was also consulted to grant permission for supply of case files to undertake the research.

Obtaining and reviewing processes
The first step taken was to obtain and review the current policies and processes relating to the management and handling of criminal cases involving pedal cyclists by all the agencies involved.

The agencies and respective units engaged with included:

- MPS
    - Road Death Investigation Unit (RDIU, formerly known as the Collision Investigation Unit) which focuses upon all road traffic collisions involving fatalities
    - Traffic Serious Casework Unit (TSCU), based within the Traffic Criminal Justice Unit (CJU), which deals solely with prosecutions arising from fatal, serious life changing collisions and police collisions. A recent change has enabled the TSCU to investigate additional cases concerning vulnerable road users (including cyclists).
- CoLP
    - Roads Policing Unit (RPU)
- CPS
    - London Traffic Unit (LTU); a dedicated unit established to handle all traffic prosecutions in London.

Once documentation was obtained, consultation was conducted between TfL and agency representatives to ensure the policies were correctly understood. The processes in use by each agency are described briefly within section seven.

Criteria for reviewing case files against processes
Following this process review, a brief list was compiled of key items that would be used as a checklist to enable review of case files against the processes. The checklists contain key dates to note and key items within the files to examine. The key dates were noted in order to establish compliance according to statutory time limits (STL) and to establish if there were any delays in the investigation. The files were then examined for key items including log books, review sheets and witness statements in order to establish compliance with policies and processes and also to highlight any other delays not apparent from the analysis of key dates. The checklists used for fatal and serious personal injury (SPI) case file review are contained in Appendix A.

The key criteria each case file was assessed against are as follows:

- **Timeliness** (were the case files investigated in a timely fashion and in keeping with agreed processes timescales, including any STL);
- **Adherence to processes and standard operating procedures (SOPs)** (were all processes followed throughout the investigation and decision to charge);
- **Delays to the investigation** (was there evidence of processes not followed or other avoidable factors that had an impact on STL);
- **Delays to court** (was there evidence of case management impacting upon court hearings or causing unnecessary delay); and
- **Good practice and areas for improvement** (was there evidence of good practice and opportunities for process improvements).

It is important to note that the accuracy, completeness or decision making of the investigation was not reviewed as this remains outside of the expertise of resources used to undertake the review. For example, there was no judgement made upon whether sufficient evidence was gathered or the correct charging decision made.

Selection of case files

The next step was selecting case files for review. Prior to this stage, high level analysis was undertaken to understand: volume of case files investigated; the outcome of pre-charge consultation with CPS (for fatal collisions only); how many were prosecuted and the outcomes; results from Coroner Courts (fatal prosecutions only); and comparison of magistrates' courts used against outcomes for SPI collisions (as investigated by the MPS TSCU). These findings are presented in sections five and six.

Compared to the MPS, very few fatal and SPI collisions involving pedal cyclists occur within the City of London area, therefore it was decided to focus solely upon collisions investigated by the MPS.

Fatal case files

The initial focus was upon fatal collision case files given their severity plus the expectation of a huge volume of case file material to review. A selection of case files from the years 2007 to 2009 was made ensuring that a range of outcomes was present, ranging from 'no further action' taken, to a result at court; this was important for the review needed to focus upon case files which had passed through different aspects of the CJS to enable a balanced view of how fatal collisions are treated by the police and CPS.

It is important to note that not all fatal case files were reviewed with only six out of forty case files selected. Ideally all forty case files would have been reviewed, however, due to the limited resource available to undertake the review plus the sheer volume of case file material this was not possible. Also, had all fatal case files been reviewed little time would have remained to review SPI collision case files.

Serious Personal Injury case files

Once the fatal collision case files had undergone review, a selection of SPI collision case files was made.

Whilst there are over 400 serious injury collisions in London each year between 2007 to 2009, as seen in section 4.3 table 7, the definition of what constitutes 'serious' as used for the Department for Transport Stats 19 dataset is too broad for the purposes of police investigation. Hence the police, whilst respecting the Stats 19 approach, assess the nature of injuries sustained and will pay greater attention to those serious injuries that are either life threatening or life changing above all other serious injuries (for example, expected loss of a limb or likely permanent significant physical impairment or disability preventing independence). There is also a greater emphasis placed upon very young or old collision victims who are more vulnerable and likely to react badly to injuries sustained than other demographics.

Until mid-2010, the MPS TSCU investigated all life changing or other collisions involving vulnerable victims with a serious injury, hence only the most serious personal injury collisions were considered for this review.

As with the fatal case files reviewed, it was not possible to review every SPI collision case file investigated with only fifteen cases out of 194 selected for review. Given the high proportion of cases files that were not considered for prosecution (see section six, table 14); it was decided to select a sample from each year 2007 to 2009 to review. Cases were selected following high level analysis identifying cases where, following a CPS review, there was insufficient evidence of criminality to put the case before a Court or a not guilty outcome was recorded. Whilst both sample sizes for the fatal and SPI collisions were not large, they enabled the adherence to and applicability of processes for collision investigation to be examined.

Coroner Inquests

An inquest will take place if the police and CPS have decided there is no further action to take or will be postponed until conclusion of trial for those cases taken to court. Given this, it was decided to narrow the focus of the review to processes affecting the determination of any criminal proceedings and subsequent trial. A high level analysis of Coroner inquests can be found in section five (table 12) for all fatal collisions 2007 to 2009.

4 Road traffic and pedal cycle casualty statistics

Information concerning road traffic collisions and associated casualties is collated by the MPS and CoLP, and then reported to TfL (Better Routes and Places Directorate) who ensure data is entered into the Stats 19 national reporting system. Collision and casualty data for 2007 to 2010 has been extracted to enable the following high level statistics to be calculated describing the collisions involving pedal cyclists and placing these in context of all collisions and casualties.

4.1 Overall collisions and casualties

During 2010, 24,105 road traffic collisions involving personal injury were reported in Greater London; this represents a 3.7% increase on the 23,239 collisions reported in 2009.

The 24,105 collisions reported in 2010 resulted in 28,889 casualties (see table 1). Of these, 126 were fatalities, 2,760 were seriously injured, and 26,003 were slightly injured. While casualties in 2010 increased by 3.3% compared with 2009, the number of killed and seriously injured (KSI) casualties (2,886) comprised 31.5% fewer fatalities and 9.3% fewer serious injuries (3,043 to 2,760); while slight injuries increased by 5.1%.

Table 1. Casualties in Greater London 2007 to 2010

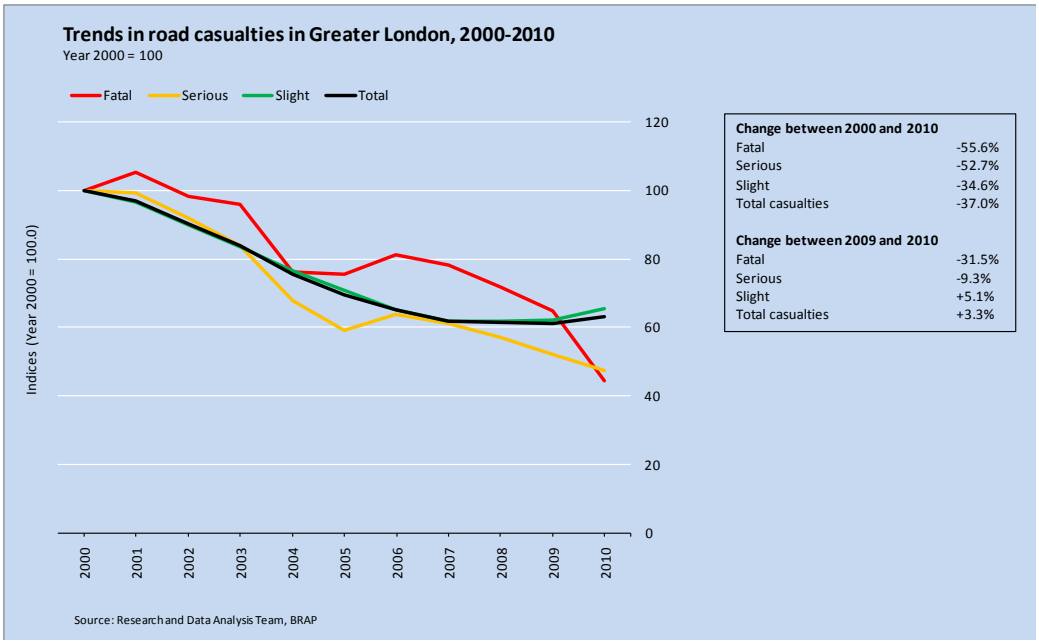
Casualties in Greater London by severity

Severity	2007	2008	2009	2010	Change over 2009
Fatal	222	204	184	126	-31.5%
Serious	3,562	3,322	3,043	2,760	-9.3%
KSI	3,784	3,526	3,227	2,886	-10.6%
Slight	24,577	24,627	24,752	26,003	5.1%
Total	**28,361**	**28,153**	**27,979**	**28,889**	**3.3%**

Source: Research & Data Analysis, BRAP

The long term trend is downwards with the number of KSI casualties across all transport modes reported during 2010 57% below the 1994-98 average baseline, and for pedal cyclists KSI casualties were 32% below the 1994-98 average, which should be seen in the context of the considerable increase in cycling over recent years. Figure 1 highlights that the trend is generally consistent across the different severity of casualty categories.

Figure 1. Trend in casualties in Greater London 2000 to 2010



4.2 Collisions and casualties by different modes of transport

There were 4,007 pedal cyclists injured during 2010 in road traffic collisions (see table 2). As a mode of travel, pedal cycles accounted for 14% of all casualties during 2010; this is disproportionate given that cycling represents 2%[7] of road use in Greater London (Travel in London Report 3, 2010:40).

During 2010, 96 out of the 126 fatalities (76%) were people outside of vehicles (pedestrians, powered two-wheeler users and pedal cyclists). For seriously injured casualties the equivalent figure was 69% and for slightly injured casualties 45%. For pedal cyclists only, the fatal, serious and slight casualty proportions were 8%, 17% and 14% respectively. The proportion of pedal cyclist fatalities against all fatalities has remained consistent the last 3 years, whilst seriously injured pedal cyclist casualties have risen slightly from 13% in 2007 and slightly injured pedal cyclist casualties have risen from 10% in 2007.

The severity ratio[8] is highest for pedestrians at 16.9% (see table 2). Motorcyclists and pedal cyclists also record a high severity ratio of 14.2% and 11.7% respectively in 2010. They are more vulnerable to death and serious injury than other road users who are better protected by safety measures such as being enclosed in a vehicle, seat belts and air-bags.

[7] This figure is based upon the proportion of pedal cyclists total travel volumes for 2009, against the total of other modes where a road traffic collision could result in injury (i.e. bus, taxi/Private Hire Vehicle, car (driver and passenger), motorcycle, cycle and walking). Aggregate travel volumes for rail, underground and DLR have been excluded to provide this figure.

[8] The severity ratio is calculated as the sum of fatal and serious casualties expressed as the proportion of all casualties.

Table 2. Casualties in Greater London 2009 by mode of travel, severity and % change over 2008

Casualties in Greater London 2010 by mode of travel, severity and percentage change over 2009

Mode of travel	Fatal		Serious		Slight		Total		%of total in 2009	Severity ratio
Pedestrian	58	-34.1%	855	-11.6%	4,478	7.8%	5,391	3.5%	18.7%	16.9%
Pedal Cycle	10	-23.1%	457	8.8%	3,540	9.4%	4,007	9.2%	13.9%	11.7%
Powered 2 Wheeler	28	-28.2%	587	-12.0%	3,722	-1.9%	4,337	-3.6%	15.0%	14.2%
Car	27	-34.1%	695	-10.6%	11,851	5.5%	12,573	4.4%	43.5%	5.7%
Taxi	1	100.0%	21	-27.6%	432	13.7%	454	11.0%	1.6%	4.8%
Bus Or Coach	0	-100.0%	98	-19.0%	1,303	-1.2%	1,401	-2.9%	4.8%	7.0%
Goods Vehicle	1	100.0%	27	-41.3%	570	7.1%	598	3.5%	2.1%	4.7%
Other Vehicle	1	100.0%	20	25.0%	107	0.9%	128	4.9%	0.4%	16.4%
Total	**126**	**-31.5%**	**2,760**	**-9.3%**	**26,003**	**5.1%**	**28,889**	**3.3%**	**100.0%**	

Source: Research & Data Analysis, BRAP

The severity ratio differences by mode are consistent over the last four full calendar years (see table 3). Pedestrians had the highest severity ratio of all modes of travel; in other words, those travelling by foot were more likely to be killed or seriously injured in collisions than those travelling by other modes. Importantly, all modes have seen the severity ratio decline over the last four years (with the exception of "Other Vehicle"), with those travelling by pedal cycle almost 4% less likely to be killed or seriously injured in collisions compared to three years ago.

Table 3. Casualties in Greater London by mode of travel and severity ratio 2007 to 2010

Casualties in Greater London by mode of travel and severity ratio, 2007-2010

	KSI				*Slight*				*Severity ratio*			
Mode of Travel	**2007**	**2008**	**2009**	**2010**	**2007**	**2008**	**2009**	**2010**	**2007**	**2008**	**2009**	**2010**
Pedestrian	1,292	1,208	1,055	913	3,960	3,919	4,154	4,478	24.6%	23.6%	20.3%	16.9%
Pedal Cycle	461	445	433	467	2,509	2,757	3,236	3,540	15.5%	13.9%	11.8%	11.7%
Powered 2 Wheeler	819	738	706	615	3,629	3,484	3,795	3,722	18.4%	17.5%	15.7%	14.2%
Car	952	880	818	722	12,224	12,149	11,230	11,851	7.2%	6.8%	6.8%	5.7%
Taxi	31	27	29	22	289	284	380	432	9.7%	8.7%	7.1%	4.8%
Bus Or Coach	134	152	124	98	1,274	1,340	1,319	1,303	9.5%	10.2%	8.6%	7.0%
Goods Vehicle	48	45	46	28	468	480	532	570	9.3%	8.6%	8.0%	4.7%
Other Vehicle	37	21	16	21	158	150	104	107	19.0%	12.3%	13.3%	16.4%
Private Hire	10	10	0	0	66	64	2	0	13.2%	13.5%	0.0%	0.0%
Total	**3,784**	**3,526**	**3,227**	**2,886**	**24,577**	**24,627**	**24,752**	**26,003**	**13.3%**	**12.5%**	**11.5%**	**10.0%**

Source: Research & Data Analysis Team, BRAP

Almost half (46.0%) of those killed in road traffic collisions in Greater London during 2010 were pedestrians, whilst 7.9% were pedal cyclists (see table 4).

Table 4. Fatalities by mode of travel in Greater London 2007 to 2010

Fatalities in Greater London by mode of travel, 2007-2010

Mode of travel	2007	2008	2009	2010	% of 2010 total	Mode of transport - share of daily journey stages* 2009 (%)
Pedestrian	109	94	88	58	46.0%	20
Car	52	39	41	27	21.4%	36
Powered 2 Wheeler	41	50	39	28	22.2%	1
Pedal Cycle	15	15	13	10	7.9%	2
Bus Or Coach	1	1	3	0	0.0%	21
Taxi	2	0	0	1	0.8%	1
Goods Vehicle	1	5	0	1	0.8%	0
Other Vehicle	1	0	0	1	0.8%	0
Total	**222**	**204**	**184**	**126**		

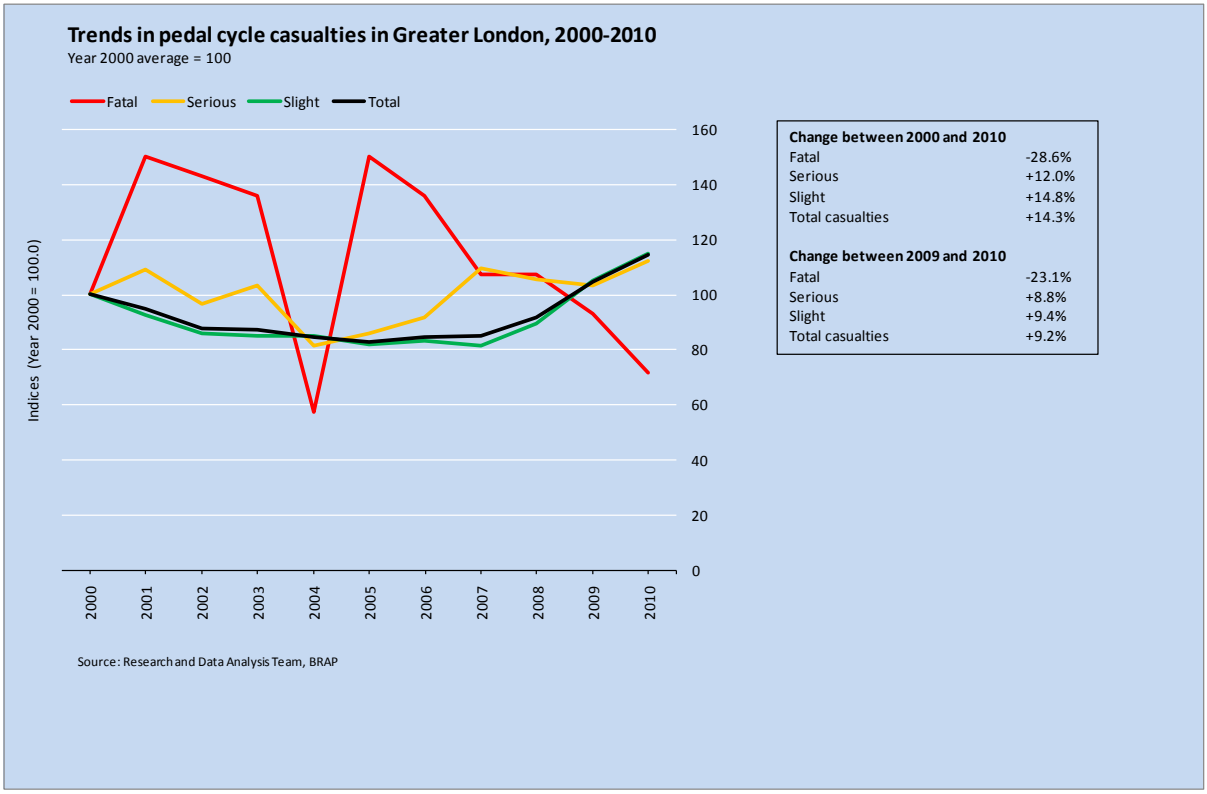
* A journey stage is a part of a trip made up by a single mode of transport

Source: Research & Data Analysis Team, BRAP

4.3 Pedal cycle collisions and casualties

As noted previously, the volume of pedal cyclists killed fell by 23.1% in 2010 compared to 2009, however slightly injured pedal cyclist casualties rose by 9.4%. Since 2000, the trend has been for fatalities to decline (to now 28.6% below 2000 levels), whilst seriously injured casualties initially declined to 2004 and then began to rise until being above 2000 levels during 2007 to 2010, and slightly injured casualties have steadily declined from 2000 until beginning to rise again in 2008 until being above 2000 levels in 2009 to 2010 (see figure 2).

Figure 2. Trend in pedal cycle casualties in Greater London 2000 to 2010



When the nature of pedal cycle collisions is investigated (see tables 5 and 6), the number of cars involved in a collision during 2010 is more than for any other vehicle (36% for all collisions; 20% for fatalities, 35% for serious injury collisions and 37% for slightly injured collisions). However, a disproportionate number of goods vehicles over 7.5 tonnes (HGVs) were involved in collisions that led to the death of a cyclist (9 in 2008, 6 in 2009, and decreasing to 2 in 2010). Of note, is the volume of certain vehicles involved in slightly injured pedal cyclist collisions that has risen in 2010 compared to 2009, namely powered two wheeler, cars, taxis, goods vehicles under 3.5 tonnes, goods vehicles 3.5t to 7.5t and bus/coach.

Table 5. Vehicles involved in collisions where one or more pedal cyclist was injured 2010 by severity and change over 2009

All vehicles involved in collisions where one or more pedal cyclist was injured - Greater London 2010 by severity and change over 2009

	Fatal		Serious		Slight		Total	
Vehicle involved	2010	% change	2010	% change	2010	% change	2010	% change
Pedal Cycle	10	-23.1	460	9.0	3,545	8.6	4,015	8.5
Powered 2 wheeler	0	-100.0	14	7.7	90	1.1	104	1.0
Car	4	100.0	312	9.5	2,540	5.3	2,856	5.8
Taxi	1	**	17	-29.2	198	19.3	216	13.7
Goods under 3.5t	0	**	44	37.5	353	14.6	397	16.8
Goods 3.5t to 7.5t	0	-100.0	8	100.0	49	53.1	57	54.1
Goods over 7.5t	2	-66.7	11	0.0	19	-13.6	32	-17.9
Bus or coach	1	0.0	21	5.0	133	11.8	155	10.7
Other vehicle	2	0.0	6	-33.3	24	-17.2	32	-20.0
Total	**20**	-23.1	**893**	8.9	**6,951**	7.9	**7,864**	7.9

Source: Research & Data Analysis, BRAP

Table 6. Vehicles involved in collisions where one or more pedal cyclist was injured 2010 by severity and proportion of vehicles involved

All vehicles involved in collisions where one or more pedal cyclist was injured - Greater London 2008, 2009, 2010 by severity and proportion of vehicles involved

	Fatal				Serious				Slight				Total			
				% of 2010				% of 2010				% of 2010				% of 2010
Vehicle involved	2008	2009	2010	total	2008	2009	2010	total	2008	2009	2010	total	2008	2009	2010	total
Pedal Cycle	15	13	10	50.0%	433	422	460	51.5%	2,786	3,265	3,545	51.0%	3,234	3,700	4,015	51.1%
Powered 2 wheeler	0	1	0	0.0%	8	13	14	1.6%	96	89	90	1.3%	104	103	104	1.3%
Car	7	2	4	20.0%	294	285	312	34.9%	2,071	2,413	2,540	36.5%	2,372	2,700	2,856	36.3%
Taxi	0	0	1	5.0%	21	24	17	1.9%	122	166	198	2.8%	143	190	216	2.7%
Goods under 3.5t	0	0	0	0.0%	44	32	44	4.9%	245	308	353	5.1%	289	340	397	5.0%
Goods 3.5t to 7.5t	0	1	0	0.0%	8	4	8	0.9%	34	32	49	0.7%	42	37	57	0.7%
Goods over 7.5t	9	6	2	10.0%	13	11	11	1.2%	32	22	19	0.3%	54	39	32	0.4%
Bus or coach	1	1	1	5.0%	25	20	21	2.4%	109	119	133	1.9%	135	140	155	2.0%
Other vehicle	0	2	2	10.0%	11	9	6	0.7%	39	29	24	0.3%	50	40	32	0.4%
Total	**32**	**26**	**20**	100.0%	**857**	**820**	**893**	100.0%	**5,534**	**6,443**	**6,951**	100.0%	**6,423**	**7,289**	**7,864**	100.0%

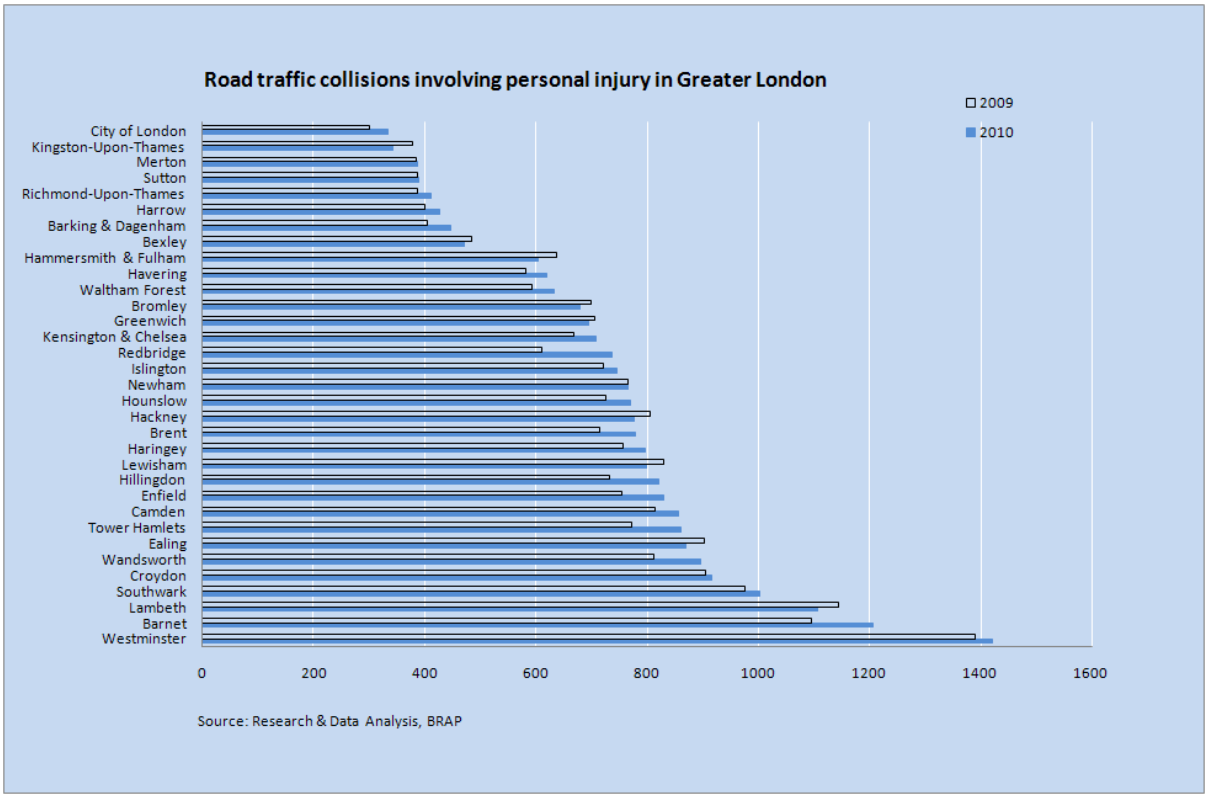
Source: Research & Data Analysis, BRAP

4.4 Collisions by Borough

It is important to consider the variation in collisions, by volume and change that occur across London, as partners across London will need to respond and tailor their activities accordingly to have best impact; this is important, particularly for the MPS, where investigations for most collisions involving non-fatal injuries will be conducted by the individual Borough Operational Command Units (BOCUs).

Figure 3 shows the borough of Westminster recorded 6% of collisions (1,421) in Greater London during 2010. It has broadly maintained this proportion of collisions during the last three years. Barnet, Lambeth and Southwark also recorded a disproportionate number of collisions during 2010. Barnet recorded a 10.2% (+112) increase over the previous year and Southwark 2.8% (+27). Lambeth reported a small fall in collisions of 3.3% (-38). The top 13 boroughs with highest volume of collisions represent over 50% of all collisions within Greater London.

Figure 3. Collisions involving personal injury by Greater London Borough 2010 compared to 2009



With just pedal cycle collisions involving personal injury, Westminster borough recorded the highest overall number of pedal cycle casualties during 2010 (see table 7). However, Barking and Dagenham recorded the highest percentage increase in total pedal cycle casualties with a 57% rise compared to 2009 (+16 collisions). The top nine boroughs of Westminster, Lambeth, Southwark, Wandsworth, Camden, Islington, Hackney, Kensington & Chelsea, and Tower Hamlets comprise over 50% of all pedal cycle collisions recorded in 2010.

Table 7. Pedal cycle casualties in Greater London by borough and severity, 2010 compared to 2009

Pedal cycle casualties in Greater London 2010 by borough, severity and percentage change over 2009

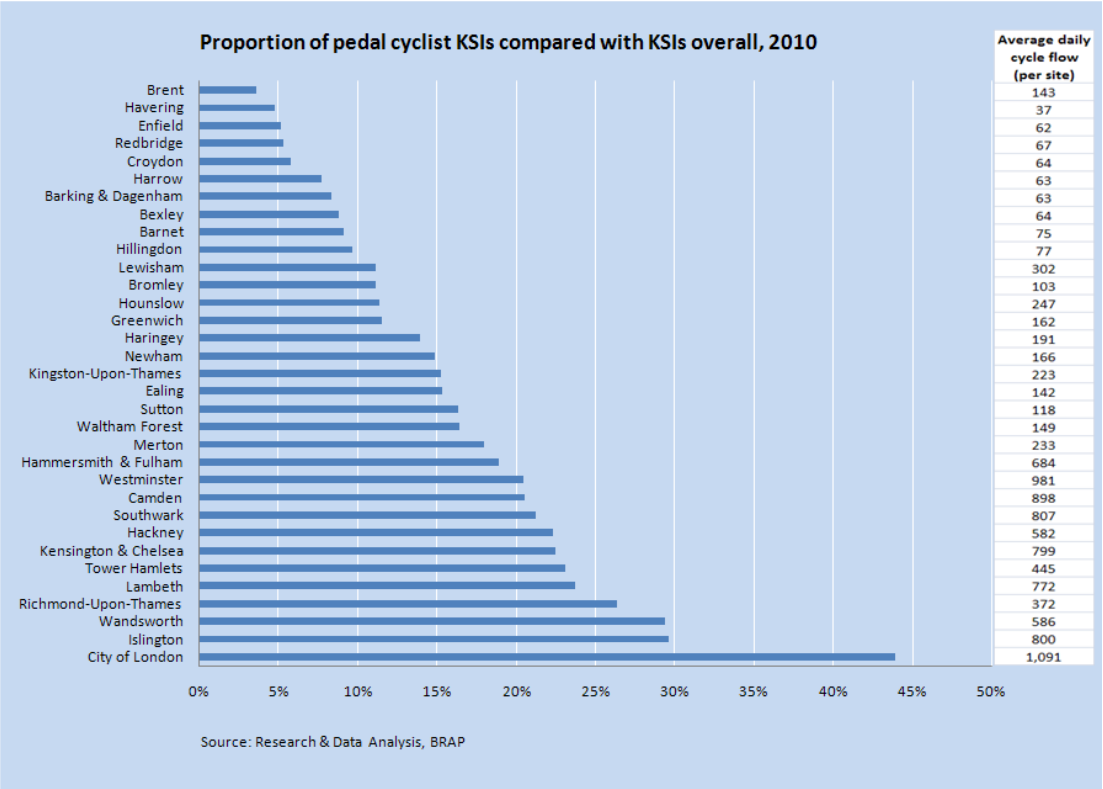
Borough	Fatal	% change	Serious	% change	Slight	% change	Total	% change
Westminster	2	100	36	-18	270	5	308	2
Lambeth	0	-100	37	16	236	-2	273	-1
Southwark	2	100	33	27	230	18	265	19
Wandsworth	0	∞	30	30	208	14	238	16
Camden	1	0	22	5	211	46	234	40
Islington	1	0	23	35	208	-2	232	1
Hackney	2	∞	21	-9	174	3	197	3
Kensington & Chelsea	0	-100	18	-18	169	13	187	9
Tower Hamlets	0	-100	21	50	156	9	177	12
Hammersmith & Fulham	0	∞	14	-33	153	13	167	7
City of London	0	-100	18	0	109	20	127	15
Lewisham	0	∞	12	9	111	7	123	7
Hounslow	0	∞	11	0	99	38	110	33
Richmond-Upon-Thames	0	∞	19	12	91	11	110	11
Ealing	0	-100	13	-13	87	-8	100	-10
Haringey	0	∞	11	175	85	-8	96	0
Newham	0	-100	12	100	78	1	90	6
Bromley	0	∞	10	100	78	34	88	40
Barnet	1	∞	11	175	70	21	82	32
Brent	0	∞	3	-25	78	20	81	17
Hillingdon	0	∞	8	14	72	11	80	11
Waltham Forest	0	∞	11	22	65	-23	76	-18
Greenwich	0	-100	12	9	60	0	72	-1
Croydon	0	∞	5	-29	66	-12	71	-13
Merton	0	∞	7	0	57	4	64	3
Kingston-Upon-Thames	0	∞	7	-22	54	-10	61	-12
Enfield	0	∞	5	150	50	39	55	45
Bexley	0	∞	6	-25	47	81	53	56
Barking & Dagenham	0	∞	4	0	40	67	44	57
Redbridge	0	∞	4	-50	38	15	42	2
Sutton	0	∞	8	167	32	-18	40	-5
Havering	0	∞	3	-50	31	24	34	10
Harrow	1	∞	2	100	27	-10	30	-3
Total	**10**	**-23**	**457**	**9**	**3,540**	**9**	**4,007**	**9**

Source: Research & Data Analysis, BRAP

The City of London recorded the highest percentage of pedal cyclists KSI (44%) compared with all injuries of this severity in 2010; however, this disproportionality needs to be seen within the context of the City of London's high level of cycle flow compared with other London boroughs (see figure 4). A borough with a greater flow of cyclists is more vulnerable to collisions involving injury to cyclists than boroughs with lower cycle traffic. A

combination of high cycle flow and increased vulnerability compared with other road users are likely to be factors here. It is unlikely that increased cycle flow can be attributed to the high percentage of cyclist KSIs recorded by Richmond upon Thames (26%), as this Borough has around a third of the cycle flow of City of London according to DfT cycle flow figures.

Figure 4. Proportion of pedal cyclist KSI casualties compared with overall KSIs, 2010



5 Fatal pedal cycle collision investigation and prosecution

The MPS TSCU deals solely in prosecutions arising from fatal and serious life changing personal injury collisions, plus collisions involving police vehicles; the RDIU is responsible for investigation of all fatal collisions. The following findings are primarily based upon collisions that were investigated by either the RDIU or TSCU. Other traffic injury collisions are investigated by the local BOCU.

Approximately the same level of collisions involved a pedal cyclist fatality during the years 2007 to 2010[9]. The majority of fatalities were the result of a collision between a pedal cycle and large vehicles (goods or other construction vehicles), although this declined during 2010 (see table 8). All of the investigation case files were reviewed by the CPS prior to making a charging decision, with the exception of 1 case during 2007 where the pedal cyclist was struck by a vehicle which failed to stop and the resultant investigation yielded no suspect.

Table 8. Vehicles involved in fatal pedal cycle collisions and subsequent CPS review and decision to prosecute, 2007 to 2010

Vehicles involved in fatal pedal cycle collisions and subsequent CPS review and decision to prosecute, 2007 - 2010

	2007				2008				2009				2010			
			Prosecuted				Prosecuted				Prosecuted				Prosecuted	
Cycle collision with:	**Count**	**%**	**Count**	**%**	**Count**	**%**	**Count**	**%**	**Count**	**%**	**Count**	**%**	**Count**	**%**	**Count**	**%**
Bus	-	-	-	-	1	7.7%	1	100.0%	1	7.7%	1	100.0%	1	10.0%	1	100.0%
Car	6	42.9%	3	50.0%	4	30.8%	3	75.0%	1	7.7%	0	0.0%	4	40.0%	3	75.0%
Car (Police)	-	-	-	-	-	-	-	-	1	7.7%	-	-	-	-	-	-
Cycle	1	7.1%	0	0.0%	-	-	-	-	-	-	-	-	-	-	-	-
Goods/other vehicles	7	50.0%	0	0.0%	8	61.5%	4	50.0%	9	69.2%	6	66.7%	4	40.0%	2	50.0%
P2W	-	-	-	-	-	-	-	-	1	7.7%	1	100.0%	-	-	-	-
Taxi	-	-	-	-	-	-	-	-	-	-	-	-	1	10.0%	-	-
Grand Total	**14**		**3**	**21.4%**	**13**		**8**	**61.5%**	**13**		**8**	**61.5%**	**10**		**6**	**60.0%**

Source: Traffic Serious Casework Unit, Met Police

During 2007 only three out 14 (21%) of fatal collision investigations resulted in prosecution, however all of these resulted in a conviction. In 2008 and 2009, this rose to eight out of 13 (62%) investigations resulting in prosecution for both years; two resulted in a conviction in 2008 and one resulted in conviction in 2009 (see table 9). During 2010, three of the six prosecutions resulted in a conviction.

[9] Please note that police and CPS investigation / prosecution statistics have been compiled where possible to include the calendar year 2010. At the time of writing this report, complete calendar year statistics for 2010 of collisions were not available from Stats19 hence the different time periods evident between this section and the previous.

Table 9. Proportion of fatal pedal cycle collision cases taken to court and outcome, 2007 to 2010[10]

Proportion of fatal pedal cycle collision cases taken to court and outcome, 2007 - 2010

			Outcome	
Year	**Action**	**Count / %**	**Conviction**	**Negative**
2007	Taken to court	3	3	-
	Total cases	14		
	% taken to court	21.4%		
	% successful	100.0%		
2008	Taken to court	8	4	4
	Total cases	13		
	% taken to court	61.5%		
	% successful	50.0%		
2009	Taken to court	8	2	6
	Total cases	13		
	% taken to court	61.5%		
	% successful	25.0%		
2010	Taken to court	6	3	3
	Total cases	10		
	% taken to court	60.0%		
	% successful	50.0%		

Source: Traffic Serious Casework Unit, Met Police

[10] Convictions are where the court returned a guilty verdict and associated sentencing

The range of offences charged against suspects and their outcomes varied by each fatal collision investigated (see table 10).

Table 10. Offences charged and outcomes of fatal pedal cycle collision cases taken to court, 2007 to 2010

Offences charged and outcomes of fatal pedal cycle collisions taken to court, 2007 - 2010

Year	Offence Type	Outcome
2007	S1 - Death by Dangerous Driving	£2,500 fine, 5 year disqualification
	S1 - Death by Dangerous Driving	30 months imprisonment, 6 month disqualification, extended re-test
	Without Due Care / Fail to Stop	18 weeks imprisonment (suspended 2 years), disqualification 12 months, 200 hours CSO
2008	Manslaughter & Death by Dangerous Driving	Guilty
	S2B - Death by Careless Driving	150 hours CSO, 12 months disqualification, extended re-test
	S2B - Death by Careless Driving / Fail to Stop	6 months imprisonment (suspended 2 years), disqualification 10 years
	S2B - Death by Careless Driving	Not guilty x 2
	Without Due Care	Guilty
	Without Due Care	Not guilty
	Without Due Care, Excess Speed, Fail to Comply Sign	Not guilty
2009	Defective Eyesight	£200 fine, £150 costs, £15 victim surcharge, 3 penalty points
	S1 - Death by Dangerous Driving / Fail to Report	Death by Dangerous Driving Dismissd, Fail to Report Discontinued
	S2B - Death by Careless Driving	7 years imprisonment, disqualified for life
	S2B - Death by Careless Driving	Case discharged
	S2B - Death by Careless Driving	Not guilty x 3
	S2B - Death by Careless Driving	Dismissed
2010	Open car door to danger	£300 Fine, £1137 costs, £15 Victim charge
	S1 - Death by Dangerous Driving	31 months imprisonment, 3 year disqualification, extended re-test
	S1 - Death by Dangerous Driving	Not guilty
	S2B - Death by Careless Driving	16 weeks imprisonment (suspended 24 months), 120 hours unpaid work, 12 months disqualification, extended re-test
	S2B - Death by Careless Driving	Case discharged x 2

Source: Traffic Serious Casework Unit, Met Police

Coroner inquests are conducted once the police and CPS investigation has concluded and there is no further action to take (i.e. the case is not taken to court), or if the case is taken to court, the coroner does not hold the inquest until court proceedings are finished. Table 11 shows the coroner results by year and court outcome. The majority of collisions with no further action taken (marked "n/a" in the table) resulted in a decision of accidental death. Of the positive court outcomes to date, during 2007 there was one accidental death decision and two prosecutions with no separate inquest, and during 2008 there was one traumatic death decision, one prosecution with no separate inquest and one unknown result. There were two convictions recorded in 2009, one with a traumatic death decision and the other unknown coroner decision. and during 2010 there was one accidental death decision, one prosecution with no separate inquest and one unknown coroner decision.

Table 11. Coroner's results and prosecution outcomes of fatal pedal cycle collision cases taken to court, 2007 to 2010[11]

Coroners results and prosecution outcomes, 2007 - 2010

	2007 Court outcome			2008 Court outcome			2009 Court outcome			2010 Court outcome			2007 - 2010	
Coroners Result	**Conviction**	**- ve**	**n/a**	**Conviction**	**- ve**	**n/a**	**Conviction**	**- ve**	**n/a**	**Conviction**	**- ve**	**n/a**	**Total**	**%**
Accidental death	1		10		2	4		2	4	1		2	26	65.0%
Traumatic road death				1	1		1						3	7.5%
Inquest only									1				1	2.5%
No separate inquest	2			2	1			1		1	1		8	20.0%
unknown			1	1		1	1	3		1	2	2	12	30.0%
Grand Total	**3**	**-**	**11**	**4**	**4**	**5**	**2**	**6**	**5**	**3**	**3**	**4**	40	100.0%

Source: Traffic Serious Casework Unit, Met Police

[11] Coroner results for several cases between 2007 to 2010 were not available.

6 Pedal cyclist serious personal injury collision investigation and prosecution

During 2010 there were 79 SPI collisions involving pedal cyclists investigated by the TSCU; slightly higher than in the preceding years. In every year over half involved collision with a car (see table 12).

Table 12. Vehicles involved in non-fatal pedal cycle collisions investigated by the TSCU and subsequent prosecutions 2007 to 2010

Vehicles involved in non-fatal pedal cycle collisions investigated by Traffic Serious Casework Unit and subsequent prosecutions 2007 - 2010

	2007			2008			2009			2010		
Cycle collision with:	**Count**	**%**	**% prosecuted**	**Count**	**%**	**% prosecuted**	**Count**	**%**	**% prosecuted**	**Count**	**%**	**% prosecuted**
Bus	3	4.5%	33.3%	2	3.2%	50.0%	7	10.6%	42.9%	5	6.3%	20.0%
Car	34	51.5%	50.0%	35	56.5%	57.1%	38	57.6%	34.2%	36	45.6%	41.7%
Car (fail to stop)	5	7.6%	0.0%	8	12.9%	37.5%	5	7.6%	20.0%	5	6.3%	0.0%
Coach (fail to stop)	-	-	-	-	-	-	-	-	-	1	1.3%	0.0%
Goods/other vehicles	15	22.7%	13.3%	11	17.7%	36.4%	9	13.6%	44.4%	14	17.7%	35.7%
Goods/other vehicles (fail to stop)	-	-	-	-	-	-	-	-	-	1	1.3%	0.0%
Motorbike	-	-	-	-	-	-	-	-	-	3	3.8%	0.0%
Pedestrian	2	3.0%	50.0%	5	8.1%	40.0%	3	4.5%	66.7%	1	1.3%	0.0%
Pedestrian (cyclist at fault)	-	-	-	1	1.6%	0.0%	-	-	-	2	2.5%	0.0%
Pedestrian (fail to stop - cyclist at fault)	-	-	-	-	-	-	-	-	-	1	1.3%	0.0%
Solo	4	6.1%	0.0%	-	-	-	3	4.5%	0.0%	2	2.5%	0.0%
Taxi	3	4.5%	0.0%	-	-	-	-	-	-	1	1.3%	0.0%
unknown	-	-	-	-	-	-	1	1.5%	0.0%	7	8.9%	14.3%
Grand Total	**66**		**31.8%**	**62**		**48.4%**	**66**		**34.8%**	**79**		**27.8%**

Source: Traffic Serious Casework Unit, Met Police

The proportion of the SPI collisions investigated by the TSCU and subsequently prosecuted was almost a third in 2007 (32%), rose to almost a half in 2008 (48%), fell to just over a third in 2009 (35%), and has fallen further during 2010 (28%). Convictions mainly resulted in fines and penalty points, with a few disqualifications (see table 13). It is important to note that whilst the proportion of cases prosecuted has fluctuated below 50%, the proportion of prosecuted cases resulting in a conviction has increased steadily year on year from 53% in 2007 to 78% in 2009, with a slight drop in the success rate to 77% in 2010.

Table 13. Non-fatal cases investigated by the TSCU 2007 to 2010[12]

Non-fatal cases investigated by Traffic Serious Casework Unit 2007 - 2010

Year	2007	2008	2009	2010
Taken to court	21	30	23	22
Total cases	66	62	66	79
% taken to court	31.8%	48.4%	34.8%	27.8%
Court outcome				
Conviction	11	19	18	17
Negative	3	3	2	3
Unknown	7	8	3	2
Positive case success rate at court	52.4%	63.3%	78.3%	77.3%
Taken to court outcomes breakdown				
Compensation			1	
Disqualification and fine/costs	1	2	5	
Fine and penalty points	8	13	10	16
Fine only	1	4	2	
Record only	1			
Warrant issued		1		
National Driver Awareness Course				1
Discontinued	1		1	1
Dismissed			1	1
Not guilty	1	2		1
Not proved	1			
Borough dealt with	1			
Still in court			3	2
Unknown	6	8		

Source: Traffic Serious Casework Unit, Met Police

The range of offences charged against suspects and their outcomes varies by each non-fatal collision investigated (see table 14). The most commonly prosecuted offence was WDC (Driving without Due Care and Attention).

[12] The 2010 prosecution figures for cases taken to court include 1 driving without due care and attention case which was dealt with through a National Driver Awareness Course; hence this was not heard at court but for the purposes of this analysis is considered a successful outcome so is included within all prosecution figures.

Table 14. Offences charged and outcomes of non-fatal pedal cycle collision cases taken to court, 2007 to 2010[13]

Offences charged and outcomes of non-fatal pedal cases investigated by TSCU, 2007 - 2010

Year	Offence Type	Count	Outcome
2007	WDC	11	5 x range of fines & PPT; 3 x unknown; Record only; Not guilty, Not proved
	DOA	2	£100 fine & 3 PPT; £200 fine & 4 PPT
	Open Door to Danger	2	£500 fine; unknown
	WDC & Fail to Comply ATSI	1	On unscheduled list - summons not served
	WDC & FTS	1	Borough dealt with - unknown
	WDC & No Insurance	1	Unknown
	WDC, No Insurance, DOA	1	Unknown
	Unknown offence	2	Discontinued; Disqualified 6 months, £60 fine & £300 costs
2008	WDC	21	14 x range of fines / PPT / disqualification; 2 x not guilty; 5 x unknown
	Open Door to Danger	2	£50 fine; unknown
	Careless Cycling	2	£65 fine; £50 fine
	DOA & No Insurance	1	Unknown
	DOA & WDC	1	DOA withdrawn as Slovakian driving license, WDC - £300 fine & 4 PPT
	FTS, FTR, No Insurance	1	£420 fine & 7 PPT
	FTS & No Insurance	1	Unknown
	No Insurance & Open Door to Danger	1	Proved in Absence - warrant issued & no result
2009	WDC	12	8 x range of fines / PPT / disqualification / costs; 1 x dismissed; 3 x awaiting court result
	DOA	2	£110 fine & 3 PPT; £610 fine & 8 PPT
	Open Door to Danger	2	£160 fine; £250 fine
	Careless Cycling	1	£380 compensation
	Defective Tyres	1	£250 fine & 3 PPT
	DOA & No Insurance	1	£100 fine & 6 PPT
	No Insurance	1	£220 fine & 6 PPT
	WDC & No Insurance	1	£75 fine, £115 costs & 4 PPT
	WDC, DOA & No Insurance	1	£450 fine & disqualification 2 years
	WDC & Careless Cycling	1	Discontinued
2010	WDC	18	14 x range of fines / PPT / victim support / costs; 1 x National Driver Awareness Course; 1 x dismissed; 1 not guilty; 1 x awaiting court result
	Dangerous driving	1	No result at present (trial late 2011)
	Riding on footway	1	£80 fine, £40 costs, £15 victim support
	WDC & Exceed speed	1	£310 fine, £85 costs, £15 victim support, 6 PPTS
	WDC & No insurance	1	Discontinued

Source: Traffic Serious Casework Unit, Met Police

The SPI collision prosecutions were conducted across several magistrates' courts in London (see table 15). Some of the courts exhibited higher proportions of convictions for SPI cases heard (see table 16). For instance, between 2007 and 2010 Hendon magistrates' court heard 11 prosecution cases for SPI collisions against pedal cyclists and 82% resulted in a conviction, whereas the City of Westminster magistrates' court heard 20 prosecution cases with 50% resulting in conviction (albeit with eight cases with an unknown result). Of the 95 cases prosecuted over the last four years, just over two thirds (67%) have resulted in a conviction, with approximately one in ten dismissals.

[13] Abbreviations explained: WDC – Driving Without Due Care & Attention, DOA – Driving Otherwise than in Accordance with a licence, ATS – Automatic Traffic Signal, FTS – Fail to Stop, FTR – Fail to Report, PPT – Penalty Points

Table 15. Prosecution court and outcomes of non-fatal cases investigated by the TSCU 2007 to 2010

Prosecution court and outcomes of non-fatal cases investigated by Traffic Serious Casework Unit 2007 - 2010

	2007				2008				2009				2010			
		Outcomes				Outcomes				Outcomes				Outcomes		
Court	Cases	Conviction	Negative	Unknown	Cases	Conviction	Negative	Unknown	Cases	Conviction	Negative	Unknown	Cases	Conviction	Negative	Unknown
Barking	1	1														
Bexley					3	1	1	1	3	3			10	8	2	
City of London	1	1							1			1	1	1		
City of Westminster	7	3		4	4	2	1	1	7	5	1	1	2			2
Croydon	1		1		1			1								
Hendon	3	2		1	3	3			3	2	1		2	2		
Kingston	2	1	1		2	2			1	1			2	1	1	
Redbridge	2	1		1	7	4	1	2	7	6		1	2	2		
Wimbledon	3	1	1	1	8	7		1	1	1			2	2		
Unknown	1	1			2			2								
Total	**21**	**11**	**3**	**7**	**30**	**19**	**3**	**8**	**23**	**18**	**2**	**3**	**21**	**16**	**3**	**2**

Source: Traffic Serious Casework Unit, Met Police

Table 16. Prosecution court and outcomes of non-fatal cases investigated by the TSCU total for 2007 to 2010

Prosecution court and outcomes of non-fatal cases investigated by Traffic Serious Casework Unit 2007 - 2010

Court	Cases	Conviction	Negative	Unknown	% Convictions	% Negative	% unknown
City of Westminster	20	10	2	8	50.0%	10.0%	40.0%
Redbridge	18	13	1	4	72.2%	5.6%	22.2%
Bexley	16	12	3	1	75.0%	18.8%	6.3%
Wimbledon	14	11	1	2	78.6%	7.1%	14.3%
Hendon	11	9	1	1	81.8%	9.1%	9.1%
Kingston	7	5	2	0	71.4%	28.6%	0.0%
City of London	3	2	0	1	66.7%	0.0%	33.3%
Unknown	3	1	0	2	33.3%	0.0%	66.7%
Croydon	2	0	1	1	0.0%	50.0%	50.0%
Barking	1	1	0	0	100.0%	0.0%	0.0%
Total	**95**	**64**	**11**	**20**	**67.4%**	**11.6%**	**21.1%**

Source: Traffic Serious Casework Unit, Met Police

7 Policies and Processes Followed During Collision Investigation

For the purposes of this review, the MPS processes are described according to whether a fatal or SPI collision has occurred.

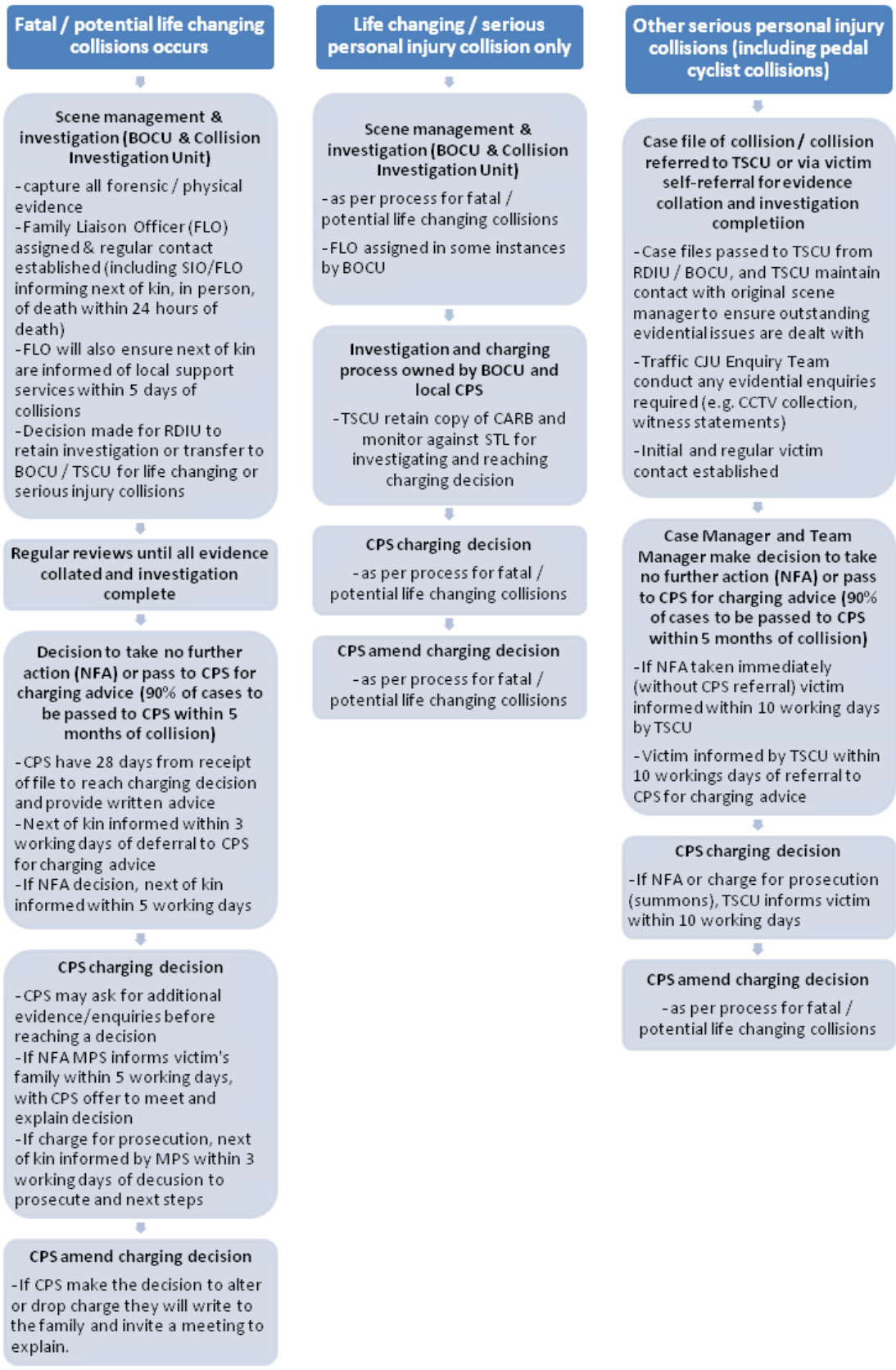
Whilst the CoLP case files were not reviewed, the processes used by the RPU were examined. The RPU fulfils the same functions of both the MPS RDIU and TSCU[14] and broadly follows the same processes and procedures employed to investigate road traffic collisions. As with the MPS TSCU, the CoLP RPU maintains a close relationship with the CPS keeping them informed of every new fatal and personal serious injury collisions and progress upon investigation prior to handing over for charging advice. In recent years the City of London CPS has employed a trained traffic prosecutor providing key specialist advice specifically for prosecuting road traffic offences.

7.1 MPS Investigation and CPS Prosecution of Collisions

The injuries sustained to those involved in a personal injury collision will determine which section of the MPS investigates; the RDIU, the BOCU where the collision occurred or the TSCU. The diagram below (see figure 5), depicts broadly the processes described in the following sections.

[14] The combination of functions within one unit can be justified due to the size of the police force, and the geographical area it covers plus, during 2008 and 2009 it consistently had the lowest volume of road traffic collisions involving personal injury compared to all 32 of the MPS boroughs

Figure 5 Flowchart of police road traffic collision investigation



7.2 Police investigation of fatal pedal cycle collisions

The RDIU will always investigate fatal collisions unless there are exceptional circumstances including:

- An outside police force investigating an incident involving MPS officers (to ensure independence of the enquiry);
- Death occurring as a result of natural causes; or
- Fatal police collisions.

In 2007, the National Police Improvement Agency published the Road Death Investigation Manual (RDIM), to standardise investigation of road death across England and Wales[15]. The MPS Traffic OCU used this guidance to create their own RDIU Manual of Guidance to assist officers engaged in the investigation of fatal road traffic collisions; this is a companion volume to the RDIM providing guidance that is relevant to the manner in which the RDIU is resourced, managed and deployed, as well as taking account of instructions and working practices unique to the MPS.

The abiding principles followed by the RDIU are to ensure that:

- All fatal collisions are investigated as 'unlawful killing' until the contrary is proved;
- All fatal collisions are investigated thoroughly and effectively;
- The necessary support is provide to all personnel involved in an investigation
- Families of victims of road death are provided with a high level of support from trained officers; and
- Every incident has an investigation plan, ensuring that the investigation is:
    - Managed effectively by trained officers;
    - Adequately resourced;
    - Thoroughly and impartially investigated; and
    - Monitored to ensure effectiveness.

Fatal collision investigation roles, responsibilities and timelines

The MPS investigation of fatal collisions follows the same processes irrespective of whether a pedal cycle or other vehicle was being driven by the victim(s).

The following describes the processes, timelines and responsibilities that should take place by the police and CPS to enable a prosecution decision to be made.

1. A fatal or potentially fatal collision has occurred

Once a fatal or potential life changing collision occurs there will be a varied set of responsibilities conducted by different officers to fully investigate the collision scene.

First officer(s) on scene

- The first officer(s) to attend the scene of a fatal or life threatening collision will initially place high priority upon the safety of themselves, colleagues and members of the public.
- They must ensure any vehicle remains in its original post incident position until specialist officers have secured all available evidence.

[15] Available from www.npia.police.uk/en/docs/Road_Death_Investigation_Manual_2007_PA.pdf

- They must commence a crime scene log book to document all people present and other information as appropriate.
- Following the initial assessment and dissemination of information, the officers should then:
    - keep vehicles and / or pedestrians away from the scene;
    - ensure the CAD room is updated;
    - inform the Duty Officer;
    - call a traffic unit to the scene;
    - identify drivers of vehicles;
    - identify all possible witnesses and where possible obtain an outline of evidence each witness can provide;
    - record details of all index marks of vehicles; and
    - ensure all significant statements are recorded in accordance with the Police and Criminal Evidence Act.

Duty officer

- Responsible for overseeing all initial action and:
    - Using the scene management log (book 115) to record all actions and rationale for decision-making;
    - Considering an alternative traffic plan to divert traffic and maintain integrity of the scene; and
    - Briefing and handover of investigation, including any outstanding enquiries, to the Traffic Senior Investigating Officer (SIO) who, initially, will be a Traffic OCU supervisor.
- After handover, the duty officer ceases to be responsible for the investigation but continues to provide resources and support for the Traffic SIO.

Traffic supervisor

- A traffic supervisor attends the scene of all fatal and potentially fatal collisions.
- In most cases, BOCU resources will be requested by the traffic supervisor to support the investigation along lines such as:
    - Road checks;
    - Immediate local enquiries to identify offenders or trace witnesses; and
    - Securing and viewing CCTV.
- They are responsible for ensuring next of kin are informed and regular contact maintained. Additionally a Family Liaison Officer (FLO) is provided.
- On occasion some collisions initially treated as potentially fatal are no longer considered as such due to medical advice, however the injuries can still be very serious or life changing. When this happens the traffic supervisor will discuss with the BOCU supervisor who assumes responsibility for continuing the investigation. In most cases BOCU officers will undertake the investigation with support from specialist officers from the Traffic OCU and staff from the Traffic CJU. When this happens the case papers should be handed over within 48 hours of the collision occurring.
- Ensure that the drivers involved in the collision are required to take the roadside eyesight test, if practicable.

Senior Investigating Officer (SIO)

- The SIO attends and assume responsibility for the investigation from the start.
- Before going off duty, the traffic supervisor should handover all relevant information for the investigation to a RDIU SIO.
- The SIO will:
    - Review all information and police actions taken;
    - Establish facts of the incident;
    - Ensure all forensic and physical evidence has been captured;
    - Visit the scenes significant to the investigation; and
    - Evaluate all available evidence to ensure all investigative opportunities are being explored.

Collision Investigator (CI)

- The CI will attend the scene of all fatal / potentially fatal collisions and be the initial forensic lead for the RDIU.
- They will capture the position of all evidence at the scene, where possible using Total Station surveying equipment to record information such as vehicle position, marks on the road and debris.
- They will also search vehicles for other items such as mobile phones and satellite navigation equipment and conduct tests where appropriate that may assist the investigation. Any equipment found will be seized as evidence by the SIO.
- Create a Collision Investigator's Report (CIR) containing a reconstruction of the collision based upon all the physical and forensic evidence gathered.

Family Liaison Officer (FLO)

- The MPS have a positive duty to communicate effectively with the bereaved family and next of kin and this is achieved by deploying a FLO.
- It is a Traffic OCU policy requirement that personal contact is made with each bereaved family by the SIO and or the FLO within 24 hours of the death, or subsequent identification of the next of kin, wherever possible.
- The FLO will continue to maintain regular contact with the next of kin throughout the entire investigation.

2. Full investigation post collision scene investigation

Regular (at least weekly) meetings are held between the SIO and RDIU Inspector until the investigation is completed to:

- Track case progression and ensure outstanding actions are completed to progress the investigation within agreed timescales prior to the expiry of the STL; and
- Ensure the next of kin; CPS and Coroner are kept appraised of the investigation progress.

3. Investigation submitted to CPS London Traffic Unit for prosecution decision

Until recently the CPS LTU was responsible for reviewing all fatal collisions with a view to determine whether there is to be a prosecution and to decide charges in all but minor and routine cases. From April 1st 2011, the CPS Complex Casework Unit (CCU) comprising the Homicide Team deal with all fatal collision cases; the following described CPS process describe how the LTU dealt with fatal collision cases prior to this date.

The Director of Public Prosecutions (DPP) is responsible for issuing the Code for Crown Prosecutors (the Code) under section 10 of the Prosecution of Offences Act 1985. The Code gives guidance to prosecutors on the general principles to be applied when making decisions about prosecutions. In making that decision, a Crown Prosecutor will apply the tests and guidance set out in the Code and sees whether there is enough evidence against the suspect, and if it is in the public interest to bring that person to court.

Case papers from all fatal collisions investigations by the RDIU are supplied to the TSCU for forwarding to the CPS (for charging decisions); the TSCU retain and store all case papers irrespective of the outcome being prosecution or 'no further action' (NFA). The police now make the decision not to prosecute in cases where the enquiry clearly shows no third party culpability.

In cases where there is no identifiable suspect the file will not be passed to the CPS for advice, or in cases where there is only one person involved (the driver / victim) and there are no auxiliary offences.

To aid case file management, the LTU maintains a spreadsheet record of pre-charge cases advised upon during a calendar year, noting the dates on which files were received and subsequently returned. The MPS TSCU also uses a more detailed spreadsheet as a 'case-tracking' system and shares this information with the CPS. Both systems have assisted prioritisation and minimised delays submitting cases for consideration and the time taken by CPS to complete an advice, which had been recognised by both agencies as a weakness that required improvement in previous years.

To aid decision making the CPS LTU holds three face-to-face advice surgeries each month divided into serious casework, police collisions and regional traffic unit cases (including less serious personal injury collisions) for police investigating officers to receive advice upon whether a case can be prosecuted or whether further evidential material is required to enable decision to be made.

The CPS LTU has three senior crown prosecutors, each of whom has experience dealing with the most serious traffic cases, with the majority of all pre-charge advice work distributed equally between them. Once allocated, the lawyer will remain with the case and deal with all pre-charge aspects, including early conferences with senior traffic investigators where appropriate.

Statutory guidelines state that summary offences are statutory time limited to 6 months from the date of the collision so a charging decision should be made within that time. Following completion of the investigation, the SIO will quality assure and submit investigation files to the CPS for advice; this should take place within 4 months of the date of the collision (in 70% of cases) or within 5 months (for 90%). Within 28 days the CPS should advise police upon the charging decision to ensure the STL is met.

When the case file is sent to the CPS for advice, the next of kin will be notified within three working days.

Where CPS are unable to reach a decision, or it cannot be made on the papers submitted the CPS will provide an action plan to the SIO detailing the outstanding evidence/enquiries required before definitive advice can be given.

To assist with reaching charging decisions, the Legal Director of the LTU reviews and quality assures every fatal collision charging decision made. Once a charging decision is approved, the police are informed in person or via telephone discussion, and the police should then inform the family of the charging decision; the SIO will inform the suspect driver and next of kin at the earliest opportunity

4. Decision to prosecute

This stage is largely undertaken by the CPS in consultation with police colleagues. The vast majority of fatal prosecutions are undertaken by the local CPS with support from the BOCU CJU; the TSCU only become involved should a 'Summary' offence (s.1 Magistrates' Court Act 1980) alone be identified by the CPS.

If the CPS decides to prosecute, the police will inform the victim's family of the decision to charge and the next step, with the case then taken to the appropriate court. Cases charged for prosecution are passed to local CPS borough units to manage, and the borough allocates a CPS lawyer. The CPS are responsible for preparing cases promptly and in accordance with the Criminal Procedure rules so that guilty pleas can be entered at the earliest opportunity and fair trials can take place on the appointed dates.

Prosecutors are supported by paralegal and administrative staff dealing with tasks such as:

- Tracking the progress of cases;
- Liaising with other agencies;
- Matching incoming material to case files;
- Service and disclosure of evidence and unused material;
- Preparing papers for court hearings;
- Preparing Instructions for advocates in the Crown Court; and
- Responding to court orders.

The responsibility for subsequent decision making remains with the borough CPS lawyer although they can refer to the original CPS LTU reviewing lawyer for advice.

5. No prosecution decision

If the MPS decide to take no further action, the next of kin should be advised as soon as possible by the RDIU, and within five working days at the latest.

The RDIU SIO will add a paragraph to next of kin letters, stating that if there are concerns regarding the CPS decision, contact should be made with the SIO so that an appointment with the CPS can be made to explain the decision.

The CPS will meet any bereaved family requesting an explanation of the CPS decision regarding prosecution in accordance with the Direct Communication with Victims policy and

Victims' Charter. These meetings will be held at the CPS offices or at a convenient venue for the next of kin.

6. Coroner Court

Once a prosecution has been completed, or if the case was not prosecuted, the Coroner Court will conduct an inquest. There are some instances whereby if the case is indictable, the Coroner may take the prosecution as a 'public enquiry' and not hold a separate inquest.

7.3 Police investigation of non-fatal pedal cycle collisions

The TSCU deals solely with prosecutions arising from fatal and SPI collisions, and police collisions.

The TSCU deals with the following cases:

- All fatal collisions where the driver died of natural causes;
- All SPI collisions, particularly those involving victims considered to be vulnerable road users; and
- All police collisions except those where the employee is off duty, and those investigated by the Directorate of Professional Standards and Independent Police Complaints Commission.

The TSCU also deal with all other traffic prosecutions apart from 'either way offences', and those where the defendant is arrested or is being prosecuted for drink driving, which equates to over 40,000 traffic offence related summonses issued each year by the TSCU.

With respect to SPI collisions involving vulnerable road users, from 1st January 2011 the TSCU also took on responsibility for investigating[16]:

- All pedal cyclist personal injury cases where a Collision Accident Report Book (CARB) is completed (including cases where a cyclist injures a pedestrian); and
- All personal injury cases where a CARB has been completed and the incident involves a person aged 70 or over (irrespective of whether the person aged 70 or over is a driver or pedestrian).

All other less serious personal injury collisions are investigated by the five Traffic Regional Criminal Justice Units of the Traffic Criminal Justice OCU (CO16).

Since August 2010, all collisions involving a life threatening / changing injury are investigated by the BOCU where the collision occurred; prior to this the TSCU investigated these collisions[17]. Should a collision victim with life threatening injuries die, the RDIU will assume full ownership and investigation responsibility (only if the death is as a result of the road traffic collision). This transition of responsibility is made easier by RDIU officers attending all life threatening collisions to ensure the highest level of post collision investigation is possible should the injuries be downgraded and then a subsequent fatality

[16] This work does not include those pedal cycle / people aged 70 or over collision cases that fall under the new definition of life changing / life threatening

[17] Prior to this process change life threatening / changing collisions represented approximately 10% of TSCU case load.

result. The vast majority of SPI case investigations remain under the responsibility of the TSCU with approximately 10% of these being investigated by BOCUs.

The change from TSCU to BOCU investigating these collisions was introduced due to an organisational learning process initiated by the MPS Directorate of Professional Standards. It has enabled the TSCU to take on additional work in respect of vulnerable road users, including pedal cyclists, and deliver an enhanced level of victim care in these cases. It is also envisaged that this change will have a positive impact on victim satisfaction and confidence. This process change is currently under review to ensure the new arrangements are working well and will be strengthened where required.

The definitions used to determine what constitutes life threatening / changing is as follows:

Life threatening injuries
An injury which has been the subject of a full and formal assessment by a medical professional and as the result of that assessment is deemed to be, on the balance of probability, a critical and high risk to life.

Life changing injuries
An injury which has been the subject of a full and formal assessment by a Doctor and as a result of that assessment is, expected to result in the loss of a limb or likely to result in a permanent significant physical impairment or disability which will prevent that person from being independent.

After fatal collisions, life threatening / changing and police relieved driver collisions are given the highest priority for action and are monitored by use of a 'tracker' spreadsheet to ensure the target is met of case disposal decision or referral to CPS within four months of the collision date. The team manager is responsible for monitoring the progress of investigations in relation to the STL (6 months from the date of the collision to commence proceedings).

Non fatal collision investigation roles, responsibilities and timelines

1. A non fatal serious personal injury collision has occurred
RDIU officers will decide whether they need to attend the collision scene and aid the investigation and support BOCU officers should the collision injuries be either life threatening / changing[18]. If an arrest is made by the BOCU, the responsibility for case progression will remain with the BOCU and be processed by the local CPS. The case papers will be filed and retained by the BOCU; TSCU will retain a copy of the CARB and monitor progress against STL for investigation and reaching charging decision.

[18] Should the life threatening injury become a fatality, then the RDIU will assume responsibility for the investigation. If the initial life threatening / changing assessment is downgraded then the TSCU will be responsible for investigation of the collision.

If the collision is reported by means of officers attending a collision scene, the police will complete a CARB, conduct PNC checks, interview and take statements from available victims and witnesses[19][20], and provide an officer summary statement. Breath tests for driving in excess of the alcohol limit are undertaken in every personal injury collision, with the exception of those collisions where a party had facial injuries requiring hospital treatment; in this situation the police would seek authority for a blood test. Mobile phone records analysis is also not conducted in every instance, again, only where there is reasonable cause to suggest usage of mobile phone preceding the collision.

Other collisions will come to the attention of the police due to a telephone call from the victim or their family following the incident. In these cases, a Computer Aided Despatch (CAD) report will be obtained so that initial enquiries can commence by the TSCU.

2. Full investigation post collision scene investigation

The case file papers are passed to TSCU from either the RDIU or BOCU. The Team Manager will allocate each case to a Regional Manager to continue the investigation.

TSCU will contact victims by a combination of letter and telephone and this initial contact should occur within 5 days of the collision being brought to their attention. The following information is provided and discussed:

- Outline of investigation and procedures;
- Target timescales for investigation completion;
- Agreed regularity and means of contact;
- Name of case manager and contact details and their usual office hours availability (including any planned annual leave); and
- The case reference number.

Further contact is made at least once every 28 days to keep victims aware of progress and when key decisions are reached, including:

- TSCU decision to issue a court summons, take no further action or refer to the CPS for disposal advice (and subsequent decision taken); and
- Dates of all court hearings and whether the victim is required to give evidence.

All contacts made should be recorded within the Summons Package electronic 'Diary' detailing date, nature and purpose of contact made, and who the contact was with (either the victim or member of victim's family and the name of the TSCU representative).

Traffic CJU Enquiry Team officers are used where required to collect evidence such as urgent statements and CCTV collection. CCTV evidence is sourced and checked wherever this is found to be available at the initial collision site investigation. Unfortunately not all collisions occur within sight line of operating CCTV cameras.

[19] There are separate books for recording witness and victim statements.

[20] Following the initial recording of information, the witnesses may be sent an additional form (form 966) to enquire for further details. At the end of each investigation, irrespective of outcome all witnesses that supplied a completed 966 form are sent letters expressing thanks for their support and cooperation.

Checks are undertaken upon CAD records, all contact details of the persons involved and insurance details of drivers. One key aspect undertaken is that of gathering witness statements, as sometimes it is not possible to fully record these at the initial collision scene.

Where case file papers suggest the driver may have been under the influence of alcohol, or blood samples taken, TSCU will execute enquiries with the BOCU, and where excess alcohol / drugs is confirmed papers are transferred back to the BOCU for charging.

3. Decision to prosecute

Once all available evidence is collated the case manager makes a recommendation as to how the case should progress, and the team manager then makes the decision whether to refer to the CPS for advice (either through formal referral or attending CPS surgeries held three times a month), issue a summons without CPS advice, or take no further action.

Fatal and SPI road traffic collisions are worked upon by the CPS largely in the same way, the key distinction being that whilst all fatal collision case files are subject to CPS review (with exception of cases not passed for advice where the fatality was due to natural causes, or there is no evidence against a third party to proceed), not all SPI collisions need referral to the CPS (see next sub-section).

The victim should be notified by the police of the decision to prosecute within 10 working days including decisions taken to dispose of the case by a non-court process, such as a National Driver Alertness Course or warning letter.

4. Consultation with CPS London Traffic Unit for prosecution decision

With cases where the decision on how to progress is unsure, regular surgeries are held with the CPS LTU located in the same office as the TSCU. Cases are discussed between MPS and CPS colleagues to aid reaching decision upon charging individuals.

The victim is notified within 10 working days of the papers being submitted to the CPS for a disposal decision.

Any cases deemed to be dangerous driving or more serious have to be referred to the CPS for their approval over final charging decision; in all other instances CPS advice is optional.

5. Decision to prosecute

The victim will be notified within 10 working days of a summons being issued and advised of the date of the first hearing. Victims are encouraged and supported in creating a personal statement (previously known as 'impact statements') explaining the impact that the collision and any resultant injuries have had upon their quality of life. These are often used to assist sentencing options where cases go to trial and defendants are found guilty.

6. No prosecution decision

The victim will be notified within 10 working days of either the TSCU or CPS reaching decision not to prosecute anyone; this contact is made by the TSCU. A decision to take no further action will typically occur where no one is found to have committed an offence. This

is usually due to there either being a lack of evidence of criminality, or insufficient evidence of criminality to pursue prosecution.

7.4 Communication with victims and bereaved families

The CPS and the police abide by the Code of Practice for Victims of Crime[21]. This explicit guidance states how victims and bereaved families should be supported throughout an investigation and any subsequent prosecution.

In cases where, following discussions between an investigating officer and a Crown Prosecutor, the decision is taken that there is insufficient evidence to bring any proceedings for a relevant criminal offence it is the responsibility of the police to notify the victim of this.

The CPS has an additional obligation in relation to cases involving death allegedly caused by criminal conduct, such as murder, manslaughter, dangerous driving or careless driving, cases of child abuse, sexual offences, racially or religiously aggravated offences and offences with a homophobic or transphobic element. The CPS must offer to meet the victims of these types of cases to explain a prosecution decision in the following circumstances:

- where the prosecutor decides not to bring any proceedings in respect of criminal conduct, following the provision of a full evidential report by the police to the CPS for a CPS decision on charge (in accordance with guidance issued by the DPP, and other than during a face to face consultation with an investigator); or
- where a decision is made to drop or substantially alter charges in respect of relevant criminal conduct; unless the prosecutor concludes that in all circumstances a meeting ought not to take place in which case he or she must record in writing the reason for that conclusion.

In other words where the decision is taken by the CPS to discontinue or substantially alter a charge, the CPS will write to all victims, including bereaved family members, and in cases, as with fatal cycle collisions, where there has been a death the CPS must offer a meeting with the family to explain the decision.

[21] http://www.cps.gov.uk/victims_witnesses/victims_code.pdf

8 Agency Improvements to Processes

8.1 Recent changes undertaken by the Metropolitan Police

Increased the number of detectives and slight reduction in the number of Collision Investigators within the RDIU
This is to increase and enhance the capabilities of the investigation team. The main unit members responsible for progression of an investigation are the detectives, whilst CIs provide a supportive function.

Crime Team created within the RDIU
The homicide and crime squad have been merged to form one crime team comprising a mobile group of experienced officers and detectives that can be deployed anywhere in London to ensure all evidence is captured.

Specific Intelligence Team
The RDIU has been enhanced by the introduction of this team with specialist intelligence investigators from a variety of disciplines including a financial investigator. Previously the RDIU detectives would undertake research and intelligence gathering and this new dedicated team can produce results quicker, allowing detectives to focus upon other aspects of the investigation.

Changed rota system
Officers are placed on duty when they are needed based upon analysis undertaken to identify busy times for service to ensure the appropriate resources are available to help keep the roads open. This initiative also makes best use of the specialised officers' time.

Transfer of most serious personal injury collision cases from TSCU to BOCUs
A new SOP has been devised to ensure serious injury collisions that RDIU don't take responsibility for are recorded on CRIS and that individual BOCUs take responsibility for the investigation.

Previously the most serious personal injury cases, generally life threatening / changing (including cyclists) were dealt with by the MPS TSCU. These cases are now transferred to local BOCUs with the RDIU providing a supporting role to ensure the highest standard of investigation is undertaken.

This is a positive development as it ensures that very serious life threatening / changing collisions receive a higher standard of care than previously possible, and allows the TSCU to take on additional work in respect of vulnerable road users (including cyclists) and provide an enhanced level of victim care due to a lower case load.

TfL / MPS Roads Reopening Protocol
In early 2011, TfL and the MPS developed a Roads Reopening Protocol to ensure the prompt re-opening of the road network following fatal, life threatening or life changing collisions, and to seek opportunities for a progressive reopening of sections of the carriageway during

an investigation when possible. Road closures are necessary for the police to conduct a full and proper investigation to bring offenders to justice plus keep resources (including the London Ambulance Service) safe whilst working at the collision scene. This new protocol is designed to provide the framework for the MPS and TfL to work together with maximum efficiency to ensure the collection of all available physical evidence whilst reducing the impact of the road closure against other users.

8.2 Planned changes by the Metropolitan Police

Witness management at collision scene
There is an identified need to manage witnesses better at the collision scene; hence for each fatal collision there is a requirement for experienced detectives fully trained in evidence gathering from witnesses to attend. The redesign of log book 115 (see next item below) will assist in this initiative.

Redesign of the Scene Management Log (book 115)
The Scene Management Log (book 115) is used for detailing decisions taken and their rationale by officers attending the scene of a collision. This log book is important as the notes taken are used to influence subsequent decisions taken by the scene manager and others. This is being redesigned to remove any redundant sections and improve the recording of decisions taken and their rationale.

8.3 Recent changes undertaken by the City of London Police

Use of electronic case management system since 2007
Prior to 2007 there was no case management system used thus weakening the procedural aspects of investigations; since then HOLMES[22] has been used and supported efficient investigation of complex enquiries.

Improved training of Roads Policing Unit supervisors to become Senior Investigating Officers
Prior to 2007 supervisors tasked with investigating fatal or serious collisions had received no training in how to manage an investigation. Since training there has been improvement and increased efficiency with a more methodical approach to investigations.

SIOs have also received training in the correct completion of investigation policy logs that can be used in court to support the decisions and rationale undertaken by SIOs. These are an important element of the investigation as incorrectly completed logs can have an adverse effect if challenged in court.

Rewrite of Standard Operating Procedure for Road Death Investigation
In 2008, the SOP was rewritten to include the use of detectives as investigation supervisors. The combination of professionally trained detectives with RPU officers with knowledge of road traffic law has enabled a good mix of skills to support effective fatal and serious injury

[22] Home Office Large Major Enquiry System

collision investigation. The new SOP has also incorporated a review process for learning from closed investigations with areas for improvement identified and acted upon to improve the evidence gathering ability of the RPU.

8.4 Planned changes by the City of London Police

Internal review of processes against current ACPO guidance
A review of adherence to all ACPO guidance is currently underway to ensure the RPU is working as best as it can with any areas of weak compliance addressed. This regular review of activities is good practice and ensures processes are current and fit for purpose.

8.5 Recent changes undertaken by the Crown Prosecution Service

Enhanced Service for Bereaved Families
The Director of Public Prosecutions announced in July 2011 the Crown Prosecution Service is extending its service for bereaved families at court.

The CPS is already committed to keeping victims and witnesses informed of the progress of their case, in all cases, and supporting them through the court process. For bereaved families the CPS also offers face-to-face meetings at any stage of the process, but specifically:

- Following a CPS decision not to charge
- Following a charge in cases heading for the Crown Court
- If charges are dropped or substantially changed
- Following conviction

The CPS will now be enhancing the scheme to also offer the following additional meetings:

- Following a charge in cases likely to be heard in the magistrates' court
- Following acquittal
- Following reconsideration of a case after acquittal
- Following leave to appeal to the Court of Appeal being granted

Creation of Optimum Business Model
In efforts to improve case progression systems, so as to ensure timely compliance with Court orders and defence requests, the CPS have recently created an Optimum Business Model (OBM); this prescribes the process to be adopted so that for all cases progressing to trials, the actions (such as disclosure and defence letters replies) are picked up earlier and dealt with efficiently. As part of case preparation (OBM stage), the DVDs provided are checked to ensure that they are in good order for Court and CPS will liaise with the Courts to ensure that the correct equipment is available.

Creation of CPS Core Quality Standards
In April 2010 the DPP issued Core Quality Standards (CQS) which outline, broadly in chronological order, the level of service that the public, and other criminal justice stakeholders can expect at each stage of the process: from early advice to investigators at

the outset of a case; through to the appeals process; and how the Service will respond to complaints or feedback which might follow at the conclusion of a case.

The CQS set out in plain language the key requirements for a successful prosecution and inform members of the public about the level of service they can expect from the CPS. Likewise, members of staff can be clear about what is required and the standard of work expected; it also provides Unit Heads with a structured approach for assessing the quality of casework on their Unit (a crucial part of the Unit Head's role is to ensure that the casework being produced is meeting the CQS and, if not, action is being taken to improve performance). CQS requires the Head of each casework unit to sample six case files each month, and assess each of these against 34 pre-determined questions which reflect key commitments in the CQS.

These are an important tool for improving the quality of service delivered to the public with performance against the standards monitored and reported to the public at the end of each financial year.

The Criminal Justice System Efficiency Programme

The Lord Chancellor announced in February 2011 that the Government wants to modernise and reform the CJS and tackle its bureaucracies and inefficiencies. The riots in August 2011 put this into sharper context which showed what the CJS can achieve. As a result, a number of reforms are currently taking place across the CJS. One of these branches of reforms relates to the efficiency of the CJS which seeks to transform and modernise the way CJS agencies work. This will be delivered through the CJS Efficiency Programme which includes 3 priority work streams:

- **Creating a digital CJS** removes the dependency on paper and in so doing frees up time to deal with cases in a faster smarter manner
- **Streamlining case administration** will assist the development of a digital file, improve case progression and reduce unnecessary work, duplication and rework.
- **Increasing use of video technology** will reduce the number and cost of the unnecessary movements of people across the system

The CJS Efficiency programme has Ministerial supervision and senior level commitment from across the MOJ and the Home Office, and from HMCTS, CPS, NOMS and ACPO. CJS agencies in London, supported by the London Criminal Justice Partnership, are currently working hard to deliver this challenging programme and to make significant progress on all 3 strands by April 2012.

Movement of fatal case prosecution from London Traffic Unit to Complex Casework Unit

The CPS Complex Casework Unit (CCU) is comprised of the following teams:

- Homicide Team
- Special Casework
- Police Complaints
- Rape and Serious Sexual Offences
- Fraud

From 1st April 2011, the CCU Homicide Team deals with all fatal collision cases. This transition will also involve the movement of one of the CPS LTU Senior Crown Prosecutors to accompany this work and continue this area of specialism. It is too early to indicate the impact of this new change.

9 HM Crown Prosecution Service Inspectorate (HMCPSI) review reports

There were two key reports identified as part of the project; the first report focuses upon the analysis and assessment of CPS work nationally upon road traffic offences involving fatalities, and the second report is a more in-depth local assessment of the CPS LTU. Both of these reports contain recommendations which were discussed with the LTU to determine progress made. The following subsections focus upon each these recommendations and whether further work is required. The response given by the CPS LTU is within *italics*.

9.1 The second thematic review of Crown Prosecution Service (CPS) decision-making, conduct and prosecution of cases arising from road traffic offences involving fatalities, 2008[23]

This national review was undertaken to analyse and assess the quality of the decision-making, conduct and prosecution by the CPS of road traffic offences involving fatalities. Within the report several key recommendations and identified local good practice (for possible adoption nationally) were listed. The following tables outline the current progress and adherence to the HMCPSI recommendations.

Key recommendations

	Recommendation and *CPS LTU response (in italics)*
1	Area specialists should be responsible for making pre-charge decisions in all road traffic cases involving fatalities and they should, where feasible, retain conduct of the case including advocacy or attendance at significant hearings such as trial or sentencing in the magistrates' court, until the conclusion of the proceedings. *There are three specialists who are collectively in charge of cases involving a fatality or serious injury; they deal with all pre-charge advice and charge decisions (the Legal Director quality assures all final charging decisions, including fatal cases that are recommended NFA). If the case is complex, it is retained and will be followed through by the charging lawyer; if the case is relatively straightforward, it would be passed to the local CPS, and the CPS LTU charging lawyer would be available for assistance.*
2	Each area should appoint one specialist to assume the role of area coordinator, responsible for coordinating area cases and providing a focal point for ongoing consideration of legal developments in relevant law and practice. *As with recommendation (1), with supervision by the Legal Director and Head of the LTU.*
3	All specialists in road traffic cases involving fatalities should receive training to

23 http://www.hmcpsi.gov.uk/documents/services/reports/THM/RTO_thm_Nov08_rpt.pdf?PHPSESSID=6ec40478dc2b7116fa9dcaccf45e27d5

	incorporate CPS legal guidance, national policy, communication skills, media handling, coroner's inquests, and expert evidence. *All the specialists have received all available CPS training but there is still no national CPS training in relation to traffic fatalities. This training should cover the charging standards for careless and dangerous driving.* *There could be an opportunity to link with MPS colleagues for joint traffic training at Sidcup and also involve the CoLP and City of London CPS Unit.* ***[Recommendation 15 – see section 11.1]***
4	Prosecutors should make charging decisions in road traffic fatality cases within 21 days of receipt of sufficient evidence to enable the prosecutor to reach a decision in all but the most substantial cases (time period to include approval by the Chief Crown Prosecutor). *Within the CPS LTU all charging decisions are made on cases within 28 days (a local agreement approved due to the high volume of cases dealt with in London). A tracker system has been developed in agreement with the police to monitor cases to ensure this deadline is achieved.*
5	The Director, Policy should expand the CPS guidance on prosecuting cases of bad driving to include instances of driving that created a significant example of a single bad mistake or error within the bullet pointed examples, as well as the examples of driving cited by the Sentencing Guidelines. *It is incorporated into current guidelines dated 2006 and there are periodic reviews of these guidelines.*
6	Chief Crown Prosecutors should ensure that all fatal road traffic cases are considered after finalisation of proceedings, in order to analyse outcomes, identify any learning points and disseminate any lessons. *Adverse outcomes are always looked at as part of quality assurance.* ***[Recommendation 11 – see section 11.1]***
7	The CPS should clarify and collate the guidance relating to its commitments to victims' families in road traffic fatality cases. *There is a victim's code of practice covering criminal cases and various other guidance (such as the Prosecutors' Pledge, No Witness No Justice, Victim Focus Scheme and the CPS victim and witness strategy 2008-11), but no single document.* ***[Recommendation 12 – see section 11.1]***
8	The CPS should issue guidance to clarify all the circumstances when letters should be sent to victims' families and when a meeting with the prosecutor should be offered. *If a case is terminated or significantly affected, and when the charging decision is made, letters will be sent explaining what has been done, why it has been done and the possible outcomes. If a decision is made to take no further action, then the police would notify the family and the CPS would offer to explain the decision in a*

	meeting with the family if required. ***[Recommendation 12 – see section 11.1]***
9	Chief Crown Prosecutors and area coordinators should agree with the police, or update, an area service level agreement or protocol on handling cases involving road traffic fatalities, which deal with: • identification of a single point of contact or coordinator in each organisation; • arrangements for obtaining early advice or seeking a consultation with a specialist prosecutor including outside normal office hours; • standards of timeliness and quality covering investigation, file submission, charging, first hearing and other stages; and • grievance or appeal procedure where this differs from standard procedure under statutory charging *A surgery is held three times a month with the MPS TSCU. There is a point of contact for out of office hours. At least one of the three specialists and Head of the LTU are in the office during normal office hours.*
10	Chief Crown Prosecutors should liaise with chief constables and establish a strategy group to be the primary forum for review of the area service level agreement or protocol on handling cases involving road traffic fatalities. It should deal with: • Joint analysis of case outcomes; • press and media handling; • relationships with HM coroners; • joint training of staff; • quality of forensic collision investigator's reports and other expert evidence; • operation of the Victim Focus scheme and victim and witness care in general; • new legislation and policy; • engagement with community groups representing victims' families; and • analysis of outcomes of meetings with bereaved families *The Head of LTU was awaiting confirmation on this item at time of report completion.* ***[Recommendation 15 – see section 11.1]***
11	Chief Crown Prosecutors should engage with coroners who represent jurisdictions within the CPS area and as a minimum: • Identify a single point of contact to act as a first line of communication with the coroner's office in their area; • reinforce to prosecutors the guidance about the timing of inquests in summary proceedings; • notify coroners of all CPS charging decisions in cases involving road traffic fatalities and decisions to take no further action in such cases; and • invite coroners to any area strategy group meetings or events *The Head of LTU was awaiting confirmation on this item at time of report completion.* ***[Recommendation 15 – see section 11.1]***

Good practice

	Good practice and *CPS LTU response (in italics)*
1	The continuity of prosecutor from the decision to prosecute to the conclusion of proceedings, including conducting the trial in the magistrates' courts. *This is carried out in all circumstances except when workloads are such that another lawyer has to pick up the file. All notes and documentation are kept in order for this purpose. To change lawyer would require consent from the charging lawyer at the LTU.*
2	The formal policy in North Yorkshire whereby there is early consultation (within 72 hours) between the police and the CPS in all fatal road traffic cases in order to inform the way the case is investigated. *Do not have early consultation as a matter of course. The police are able to ask for guidance if there was evidential/legal advice but would not necessarily do so within 72 hours.*
3	The practice in CPS London of holding formal advice surgeries once a month for advice to be given in ongoing investigations. *The advice surgeries are now held three times a month. There are six or seven appointments in each surgery which are booked ahead with a lawyer and the MPS TSCU manager present. Allows police force work to be directed and prioritised. Aspirations to hold four surgeries a month have not been possible due to work loads.*
4	The protocol with the Met Police in CPS London whereby timescales and targets have been agreed for the submission by the police of the full investigative files and the provision by the CPS of advice. *Within 4 months the police supply the file to the CPS, and the CPS then have 28 days to return it with the charging decision. The decisions are made and given face-to-face. They rarely go over the 6 month statutory time limit due to the tracker system in place for monitoring progress.*
5	The circulation of good examples of letters written to victims' families. *The Head of the LTU will review all letters as seen and highlight any examples of good practice at team meetings.*
6	The sending of a letter after a meeting with the victim's family in order to confirm the key points discussed. *As a matter of good practice this would be useful, however the victim's family will have been sent a letter (under the Direct Communications with Victims scheme) prior to the meeting. If they request a further communication after the meeting to confirm key points then this can be done.* ***[Recommendation 13 – see section 11.1]***

Other items of note

	Other items of note and *CPS LTU response (in italics)*
1	CPS London has its own unique system. In 2002 it established the London Traffic Prosecution Service (LTPS), based in Sidcup, to deal with all traffic summonses for London. The LTPS deals with all advice work and prosecutions in the magistrates' courts. If the Service advises prosecution of a case in the Crown Court it is handled by the local borough unit in CPS London. *The fatal traffic incidents will be transferred to the homicide unit. This should have taken place with effect from 4th April 2011. However there is period of transition and this has not yet taken place although it will shortly take place.*
2	Areas do not routinely keep records of cases and outcomes. There is some limited record keeping - for example, of charging decisions - and in one a record is kept of outcomes, although no analysis is undertaken. It would appear that the police are also not maintaining records or routinely collating outcomes, although in London they use a 'tracker' which is available to the CPS. In another area, because of concerns about timeliness of decision-making, there is a proposal for a quarterly review of numbers and quality by a strategic group including the CCP and the Head of Road Policing. *There is an appeals tracker held by the MPS which operates similarly to the case tracker. The CPS often gets late notice, but the appeals tracker shows if cases have been appealed so CPS can get hold of it.* ***[Recommendation 11 – see section 11.1]***

9.2 CPS London borough performance assessment report 2009 – London Traffic Unit[24]

This review of local performance was undertaken to analyse and assess the quality of the decision-making, conduct and prosecution by the CPS LTU. Within the report several aspects for improvement and strengths were listed. The following tables outline the current progress and adherence to the HMCPSI recommendations.

Aspects for Improvement

	Aspects for improvement and *CPS LTU response (in italics)*
1	Unit managers should utilise the police pre-charge decision-making performance data to assist in analysing PCD (pre-charge decision) outcomes. *Prosecution Team Performance Meetings (PTPM) occur monthly to govern performance and examine all aspects of decision making.*
2	The unit should implement an effective system to monitor and progress cases that have been returned to the police for further action. *Electronic diaries and the tracker system are used to monitor cases. All personnel have access to these and reminders and alerts are used to pre warn of important dates. A duty prosecutor deals with files and letters to ensure consistency.*
3	The unit should put steps in place to ensure that associate prosecutors in the LTU maintain the full range of skills associated with that role and have the opportunity to progress and develop their career. *Skills are being augmented and extended where possible, for example, when prosecutors attend court they remain there once their case is concluded to view other cases as part of their continuing professional development.*
4	The LTU should negotiate with HM Courts Service over Gateway listing arrangements to enable efficient resource deployment and maximise the number of sessions available for trial work. *The dialogue with the HM courts service is ongoing. Discussion is usually held locally with the courts to maximise the potential of the hearings.*
5	The LTU should work with CPS London senior management team and the relevant regional director to adopt a common memorandum of understanding with all appropriate CPS London boroughs, setting out the principles governing the transfer of work between traffic and borough courts. *All cases are different so a common memorandum does not fit business needs.*
6	Steps need to be taken to ensure compliance with the prosecution's disclosure obligations and to quality assure those disclosure decisions effectively, providing feedback, where necessary, to individual prosecutors. *The Head of the LTU quality assures disclosure decisions by dip sampling case files.*

[24] http://www.hmcpsi.gov.uk/documents/services/reports/LDN/TRFC_LBPA_Mar10_rpt.pdf

	Disclosure issues are captured within the case file for quality assurance.
7	The unit head should review compliance with the direct communication with victims scheme in fatal collision cases where pre-charge advice is for no further action and take steps to ensure that: • the correct method of providing pre-charge advice is noted on the MG3 form or advice note; and • a record is made on the file, CMS or decisions log stating that the reviewing lawyer has offered the family the option of a meeting. *The Head of the LTU quality assures compliance by dip sampling case files. Quality assurance is also given by the Legal Director reviewing all final charging decisions.*
8	Formal arrangements need to be established between the LTU and Witness Service. *The Head of LTU was awaiting confirmation on this item at time of report completion.* ***[Recommendation 15 – see section 11.1]***
9	The unit's quality assurance process for pre-charge advice cases should include an appropriate proportion of no further action decisions so that these cases are properly monitored. *The pre-charge cases are quality assured by a legal director. As part of case work quality assurance pre-charge cases can be considered.*
10	The unit management team should ensure that staff are adequately informed and consulted about new initiatives throughout the planning stages. *Staff are consulted and informed of relevant matters when required.*

Identified Strengths

	LTU identified strength *(in italics)*
1	The quality of the monthly face-to-face advice surgeries held with the police delivering guidance on serious and complex cases. *Surgeries provide an opportunity to provide early advice in order to build robust cases and also to terminate cases that have no realistic prospect of success.*

10 Fatal and Serious Personal Injury Case File Review Findings

Within this section the findings of the fatal and SPI case file review are examined; the findings are grouped by agency and with key positive and aspects for improvement identified.

Each case file was assessed against key criteria mentioned in section three; timeliness, adherence to processes and SOPs, and delays to the investigation and court.

10.1 Fatal case file review findings

Overall six case files involving a cyclist fatality were reviewed for the period 2007 to 2009 (two per year from a total of forty for the whole three-year period). The case files were selected randomly from all cases that did not result in a positive prosecution ensuring that there was a representative sample from each year.

Of the six files, four were marked as NFA, one resulted in a not guilty verdict by a jury and one a not guilty verdict in a magistrates' court. Charges for the cases reviewed vary from causing death by careless driving to without due care and attention (see table 17 below).

Table 17. Charging decisions and court result of fatal case files reviewed

Charging decisions and court result of fatal case files reviewed 2007 - 2009

Year	CPS Review	Decision	Court Result	Court
2007	Y	NFA	N/A	N/A
2007	Y	NFA	N/A	N/A
2008	Y	Without due care and attention	Not Guilty	Bexley Magistrates Court
2008	Y	NFA	N/A	N/A
2009	Y	NFA	N/A	N/A
2009	Y	Death by careless driving	Not Guilty	Inner London Crown Court

Source: Fatal Case Files, Met Police and Crown Prosecution Service

Not all files contained all the relevant information, as referred to within the agency processes. For example, some documents such as FLO log books listing key contact between the FLO and victims family were listed as sensitive material and not disclosed in the case file. Of importance is whether the case files examined contain the information deemed relevant for the CPS to make a decision. No judgements were made on the 'missing' information as they were not deemed necessary to reach a charging decision.

10.1.1 Aspects for improvement of MPS Fatal Collision Investigation

Collision Investigator's Reports [RDIU responsibility]
The CIR is a crucial report summarising the evidence captured at the collision scene in order to simulate the collision and establish the timeline of events before, during and after the collision. The CIR within all six files was detailed, often containing extracts from witness statements and their account of events. Whilst the CIRs contain useful information on the physical evidence gathered for collision simulation, from road markings and damage to vehicles involved, there is a heavy reliance on the use of witness testimony in order to complete the collision simulations; this can therefore have an adverse impact on the delivery of completed CIRs. Within the six case files, three CIRs were completed within four months, two completed within five months, and one CIR took six months to complete. Due to this, two case files were sent to the CPS for a charging decision without the CIR included, which put unnecessary pressure and delays on the proceedings as the CPS had to wait for the completed CIR in order to make their decision.

Eyesight tests [RDIU responsibility]
There is a section in the CARB for noting if an eyesight check has been carried out at the scene by police officers. Four case files stated that either the test had not been carried out or this section was left blank. The transcripts of the interviews with the accused demonstrated officers asking about eyesight in all but one case. In one case the accused stated they did not know when their eyesight was last checked and yet no eye test was subsequently conducted during the investigation. The collisions predominantly occurred during the morning or evening rush hour with traffic at its peak density, emphasising the need to be able to see and therefore the importance of conducting eye tests, especially as it is part of the MPS policy to conduct eye sight tests of drivers, where practicable, at the collision scene.

Family Liaison [RDIU responsibility]
Whilst, on the whole the FLOs conducted professional relationships, according to procedures, there were times when inconsistencies had an impact on the relationship with the victim's family. In one case, the victim's family consistently had to phone the FLO requesting information as the FLO had not contacted the family when they said they would. Whilst the FLO had no information to pass on to the family, and was awaiting information from colleagues, the family felt that they should have been kept informed. At the conclusion of the investigation, the family stated to the FLO that a phone call to report that there is no update is better than no phone call at all.

In another case, the victim's family asked for information to be passed to the officer in charge (OIC) concerning evidence of the cyclist's ability and proficiency. It appears that this information was not passed on as the charging lawyer stated the cyclist was inexperienced in the charging decision narrative, despite the family having their own evidence to the contrary.

There is no evidence of letters to families at key points of the investigation, particularly with regards to decisions made, such as not to prosecute. Whilst the letters may exist elsewhere, it is difficult to be reassured that appropriate contact with families has taken place.

Completeness of enquiries during the investigation [RDIU responsibility]
There were two cases with actions identified by the OIC to source specific evidence to support the investigations that were not followed up:

1. A case involved a cyclist who may have been listening to an iPod prior to collision. The OIC asked for witnesses and the accused to be asked if they remember seeing ear phones or hearing music but there is no evidence of this taking place as recorded in the witness statements.
2. A second case involved CCTV images from a bus situated behind the collision showing that the vehicle that collided with the cyclist did not indicate. This could have been due to time delay in the CCTV footage taken and the resultant gap between the images thereby giving the impression of no indication, or because the indicator was indeed turned off. The OIC highlighted this as an issue in the scene management log book and asked for witnesses and the accused to be questioned around the use of the vehicle indicator. There is no evidence within the witness statements or the transcript of the interview with the accused that the vehicle indicating was brought into question.

Whilst the witnesses may have been questioned about these issues there is nothing of note in the statements available. It is therefore suggested that if there are specific questions and actions that need to be followed through when questioning a witness, that the response is noted regardless of the answer, be it positive or negative.

Timely Investigation of road conditions [RDIU responsibility]
In one case there was uncertainty over the road conditions and whether a cyclist could have wobbled into the vehicle because of a faulty road. The cyclist did not die immediately therefore questions were raised over whether the RDIU should have been involved from the outset. When RDIU officers did arrive to conduct examination, the damaged road had already been repaired by TfL and the ridges and indentations could not be measured or even photographed to support the view of a faulty road surface contributing to the collision.

Relationship between MPS and London Ambulance Service [BOCU / RDIU responsibility]
There are multiple instances within the case files reviewed regarding the role of the London Ambulance Service (LAS) which will be expanded on in the SPI case file review findings section. Within the fatal files the extent of injuries allowed the LAS staff to be precise over the life threatening nature of the cyclist injuries. Not all cyclists died at the scene as most (four), were taken to hospital and treated by medical professionals before being declared deceased. The average time between the time of death declared at the hospital and the officers at the scene being made aware took 12 minutes; there was one exception however, where it took over 45 minutes. There were also inconsistencies within this case as the CAD message documentation contained within the case file showed conflicting messages from the hospital, compared to the collision scene log books containing detailed information from the continuity officer.
[Recommendation 5 – see section 11.1]

10.1.2 Positive Aspects of MPS Fatal Collision Investigation

Breath tests [RDIU responsibility]
Whilst there was not always evidence of eye tests being carried out, breath tests were carried out in all six cases (all of which showed a negative result). The tests were all undertaken within an hour of the collision at the collision scene.

Contacting the next of kin [RDIU responsibility]
There is evidence of excellent contact with other UK police forces and even abroad, when making contact with the next of kin. Details of telephone conversations and emails correspondence with other forces revealed that next of kin were informed within 24 hours of the death, even when the family lived abroad.

Witness support [BOCU / RDIU responsibility]
In one case there was excellent treatment of two young witnesses (aged under 14). Their contact details were obtained after their parents had arrived and then they were allowed to leave the scene without making a statement due to being upset and traumatised (as reported within the case file documentation). The witnesses were brought into the police station at a later date to provide a full statement, and were interviewed by an officer with specialist training. This specialist officer was unfamiliar with the case details, hence had observed other officers interviewing the accused in order to gain an overview and understanding of the case. It was this overview and introduction to the case that then allowed the officer to lead the questioning and interview with the young witnesses in an effective manner.

Continuity of care to next of kin [RDIU responsibility]
In one case the FLO changed personnel from one member of staff to another and this was arranged smoothly and efficiently. Despite the second officer being available straight away, the first officer continued in their role a little longer as they had promised to meet the victim's parents as they arrived at the airport. Following this, a handover report was completed to enable the FLOs to thoroughly discuss the case and pass it over whilst ensuring the continuity of service to the family.

10.1.3 Aspects for improvement of CPS Fatal Collision Prosecution

Responding to Judge's orders
The main problem noted in the case files was the delay in responding to Judge's orders. These orders arose due to a lack of timely response by the CPS to the defence. Delay in responding to Judge's orders and replying to the defence, whilst may have caused some disruption to the defence, did not actually result in any delay to the trial or change to the court dates.

Responding to disclosure requests
There were delays in the CPS responding to disclosure requests from the defence. Unused material was requested by the defence which the CPS had to obtain from the MPS. Whilst there were frequent delays in their responses with the required information, there was no impact upon the court dates.

Contact with victim's families
There is no evidence of letters to the families or the offering of a meeting to explain key decisions affecting the case.
[Recommendations 12 and 13 – see section 11.1]

10.1.4 Positive Aspects of CPS Fatal Collision Prosecution

Relationship between the CPS and MPS
The communication and correspondence between the MPS and CPS is very positive. The relationship developed from 2007 to 2009 with communication more forthcoming and directed to the relevant person thereby avoiding potential delays. The agencies interact with each other very well responding promptly to calls for advice or requests for further evidence. Despite any delays from the MPS, for example with regards to the delivery of CIRs, the CPS continued to deliver a charging decision within the statutory time limits.

Reviewing progression of case files
The CPS has a good review process and continually reviews case files throughout the prosecution. Forms are completed detailing the latest progress the case has made and any actions for developing the case further.

Submitting Further evidence
Further statements and evidence received from the MPS to support the case were served to the defence on time. The new evidence that was served gave the CPS sufficient time to sort the information and serve to the defence, and also gave the defence enough time to review the information before any trial dates.

10.1.5 Conclusions of fatal case files review
Overall, it is encouraging to note that the fatal cases examined were handled well, both keeping within statutory time limits without a great delay and in accordance with policies and processes. Whilst the CIRs and eye tests are an issue across most cases that were reviewed, the other negative aspects were isolated instances and occurred within individual cases; hence it is difficult to suggest many recommendations for improvement.

10.2 Serious Personal Injury case file review findings

Overall nine files involving a seriously injured cyclist were reviewed for the period 2007 to 2009 (three files per year from a total of 194 for the whole three-year period). Table 18 shows the year and outcome of each case.

Table 18. Charging decisions and court result of SPI case files reviewed

Charging decisions and court result of SPI case files reviewed 2007 - 2009

Year	Prosecution	Offence	Court Result	Court
2007	Y	Without Due Care	Not Guilty	Kingston magistrates Court
2007	Y	Without Due Care	Guilty	City of Wesminster Magistrates Court
2007	Y	Without Due Care	Not Guilty	Croydon Magistrates Court
2008	All three cases were not prosecuted - NFA			
2009	All three cases were not prosecuted - NFA			

Source: TSCU Serious Personal Injury Case Files, Met Police

10.2.1 Aspects for improvement of MPS Serious Personal Injury Collision Investigation

Collision scenes boards requesting witnesses [RDIU responsibility]
Boards have been added to numerous collision sites as an appeal for witnesses to come forward following a collision. There is evidence within the files of witnesses contacting the MPS having seen a board demonstrating their importance. In one case however, a board was ordered that said they were after witnesses following a collision involving a ***pedestrian*** rather than a ***cyclist***; whilst a slight oversight, it is important to be as precise as possible in order to gather useful evidence.
[Recommendation 4 – see section 11.1]

Effective scene management [BOCU / RDIU responsibility]
In one case an officer was collecting evidence of a wing mirror from a car that had failed to stop at the scene (this evidence had had already been photographed). A vehicle that had not been involved with participants that had witnessed the collision was parked nearby, and after providing their witness statement another officer then gave this vehicle permission to leave upon which they drove over the evidence. It is unclear however, whether this impacted the investigation.

Communication with officers at the collision scene [BOCU / RDIU responsibility]
Whilst processes concerning call-out of RDIU specialists have recently improved, there are some areas of concern that will have benefitted from this change. One case in 2008 demonstrated miscommunication regarding the presence of the RDIU at the collision scene. A fail to stop collision had resulted in debris being left on the road with obvious skid marks and associated damage from a vehicle that had fled the scene. Before the victim had been confirmed as life changing/threatening, the OIC requested personnel from the RDIU in order to assist with identifying the vehicle and simulating the collision using the available evidence. The RDIU however, did not respond positively as the case was not confirmed to

be critical and therefore felt they should not attend. In just under two hours the victim's condition deteriorated and the collision was then deemed life changing, at which point the RDIU did respond to the call and attend the collision scene. This delay increased the amount of time the road was closed and delayed the potential for catching the suspect. The collision occurred at 17:45, the Inspector initially requested RDIU assistance at 18:50 to examine the physical evidence at the scene, and then again an hour later before the CI arrived at the scene at 20:20; at 21:53 the CI left the scene and the road was reopened.

Relationship between the MPS and London Ambulance Service [BOCU / RDIU responsibility]

The relationship between the MPS and the LAS is inconsistent throughout the cases. A few detailed CAD report logs reveal heated debates with medical personnel trying to ascertain the extent of the injuries whilst the LAS seemed reluctant to commit to any injuries. Whilst it can be difficult to ascertain exact injuries to collision victims soon after the collision, it is unclear if the LAS are aware of the necessity to provide some information on the extent of the injuries to assist the police investigation. The injuries and the nature of the injuries dictate the MPS personnel and representatives that deal with the collision therefore it is important to establish the extent of the injuries as soon as is practically possible. ***[Recommendation 5 – see section 11.1]***

Transfer of case files between RDIU and TSCU [RDIU / Traffic CJU responsibility]

There is evidence that the transfer from the RDIU to TSCU works well as a form provides details on the handover and of the files that are being transferred. There is one case however where there were numerous emails documented between the RDIU and TSCU trying to trace the paperwork including the log books and witness statements; it can be presumed the missing items were found as the case file contained as much information as the others reviewed.

Case outcome following a fail to stop [BOCU / Traffic CJU responsibility]

In a fail to stop case, a relative of a suspect attended the police station to reveal their identity and provide officers with contact details. The officer alerted the OIC so an arrest could be made but there was little enthusiasm with police officers stating they were too busy to make the arrest. There is a brief mention that an officer did attend the address but did not find the suspect and they would circulate the suspect as wanted in the future. There is no further evidence within the file to suggest the suspect was arrested, and no final outcome was given.

Victim contact and communication [Traffic CJU responsibility]

From the case file documentation available, evidence of the contact between the MPS and the victim, in most cases was at a bare minimum. It should be acknowledged that this could be due to a change in policy related to computer recording practices between 2007 and 2009; eleven of the fifteen SPI case files reviewed were recorded and processed on an internal information system that ceased to be used during 2009 with all case files subsequently recorded and processed via an older legacy system. The examples given below are all derived from the legacy system that enabled better transcripts of victim communication to be captured compared with the now obsolete system, hence the reader

should be aware that the volume of victim communication information examined within this review is not wholly reflective of the true extent of victim contact.

The victims were often spoken to on the day of the collision, if possible and then sent a form a couple of months later to complete as a witness. There was little information provided about the progress of the case and any updates throughout the investigation.

In one case the victim contacted the TSCU and requested they give their personal statement three times before an officer attended their home address to take the statement. It is important to understand the needs of the victims and the personal statement may provide a release and sense of closure on the collision.

In one case there is evidence that the victim was spoken to at the collision scene in order to obtain their contact details as they were too unwell to provide any other information at that time. There is no evidence in the case file of any further contact with the victim, including letters, personal statement or even a form 966[25].

A letter was sent to a victim at the conclusion of a trial in the magistrates' court informing them that the trial had finished. The victim was sent well wishes but they were not informed of the outcome of the case itself.

And in a final case demonstrating poor communication, a letter was sent to the victim following the conclusion of the case detailing the outcome. The victim however had died eight months previously, of which the TSCU were aware of as there were questions contained in the case file documentation concerning whether the victim's injuries were as a result of the collision some four months prior to their death or if the victim had died of natural causes.
[Recommendation 7 – see section 11.1]

Victims appeal of charging decision [Traffic CJU responsibility]
In three cases victims unhappy with the charging decision requested detailed information on the case investigation. In two cases the victim received a very slow service from the MPS in response to the request for police reports and statements from the investigation. This added unnecessary delays to the victim before they received closure.
[Recommendation 6 – see section 11.1]

Invitations to attend court [Traffic CJU responsibility]
Whilst letters have been sent to the victim and witnesses to attend court, the letters are identical and standardised. It would be encouraging for letters to the victims to show some empathy towards their injuries and provide a contact number for further information on why they had to attend court.
[Recommendation 9 – see section 11.1]

[25] Form 966 is a form sent to witnesses of the incident that asks for their opinions on where the blame lies, what they were doing and from what angle they saw the collision, the conditions with regards to traffic and weather, if they spoke to the accused or victim, if they waited for the police to arrive, an account of what happened and a simple sketch of the collision.

Confirmation of death following a serious injury collision [Traffic CJU responsibility]
In a previously mentioned case, in which the victim passed away four months after the collision, there is confusing correspondence regarding the cause of the victim's death. A letter from the TSCU to the defendant states that due to a computer error, there is no longer an option to plea by post and they should make their plea in court, as the case is now being treated as a fatality. The CI report however, states that the victim died of natural causes. The reviewing lawyer made attempts to obtain copies of the post mortem report and death certificate, evidenced by emails, yet there are no copies of these documents in the case file to clarify the cause of death.

10.2.2 Positive Aspects of MPS Serious Personal Injury Collision Investigation

Victim personal statements [BOCU / Traffic CJU responsibility]
The victims that completed a personal statement appeared very grateful at being able to put their point of view across and to express how they feel. This is vital in enabling victims to feel they can have their say and contribute to the investigation.

TSCU case file quality assurance [Traffic CJU responsibility]
One case reviewed had been subject to TSCU dip sampling; this involved using a checklist of items that should appear in the case and ensuring the relevant material is available.

Handover form between RDIU and TSCU [RDIU / Traffic CJU responsibility]
A handover form from the RDIU to the TSCU details the documents that are being handed over and the reasons why. This form is valuable in the case file documentation and provides a formal way of handing the case from one department to another. There were five cases where this was used and one case the borough dealt with the case therefore this form would be irrelevant. In one case without this completed form, there were numerous emails trying to trace paperwork as mentioned in the negative aspects sub-section.

Focus on vulnerable victims [Traffic CJU responsibility]
A case was submitted to the CPS for advice and charging decision as the case related to a young child with serious life changing injuries. Whilst there was evidence to suggest the case should have no further action taken, the TSCU requested advice due to the sensitive nature of the case with a vulnerable victim. Vulnerable victims are now covered within the revised policy for TSCU handling of case file investigation, as detailed previously in section seven.

Differing letters of communication to different parties [Traffic CJU responsibility]
In two case files letters were sent to all parties at the conclusion of each case. The letter to the victims stated the outcome of the case along with well wishes. Letters to the witnesses thanked them for their assistance in helping the MPS and a letter to the defendant gave them the outcome and a contact number for further information.

RDIU record of incident attended form [RDIU responsibility]
Two case files contained a form called a 'RDIU: Record of incident attended'. This form provided detailed information on all aspects of the incident, including personnel and the times they were called, arrived and left the scene, details of witnesses and the victim and suspect and details of the vehicles involved including make, model and any damage noted. This form provided an overview of the collision and the various parties involved in a brief and concise manner.

TSCU follow up of form 966 [Traffic CJU responsibility]
The TSCU send out 966 forms to the victim, accused and witnesses of the collision. Each form is sent with a cover letter asking for the form to be completed and returned within 10 days. Uncompleted forms are followed up by the TSCU with new letters sent. If there is still no response the addresses are checked and phone numbers obtained to trace the witnesses. Every effort is made to obtain completed 966 forms.

Reviews of cases [BOCU / RDIU responsibility]
Numerous reviews have been carried out on the cases at various stages in the investigation. One case was reviewed three times; the Senior Collision Investigator completed an initial case review and two further case management reviews were detailed. The senior collision investigator's review involves examination of scene notes, draft plans, scene photos, skid and drag test, vehicle examiner notes and any other relevant information to ensure the case can progress. The first case management review in one particular case highlighted the need to obtain the CARBs and update AccStats data (for recording in Stats 19). Both of these actions were then followed through to completion. The final case management review, in the same case gave concluding statements as to the findings in the investigation with regards to the victim's health, the witness statements received, the account of the accused and a suggested outcome.

Monitoring victim's progress in hospital [Traffic CJU responsibility]
In multiple cases the hospital was contacted on a daily basis to monitor the progress of the victim. A form was completed showing the contact details of the hospital and the specified time of the checks. The checks ceased when the victim's condition was no longer life threatening.

10.2.3 Aspects for improvement of CPS Serious Personal Injury Collision Prosecution

There are no negative aspects to the CPS and their performance with regards to serious personal injury cycling collisions from the SPI case files reviewed.

10.2.4 Positive Aspects of CPS Serious Personal Injury Collision Prosecution

Communication between MPS and CPS [Traffic CJU / CPS responsibility]
They maintained contact with the MPS where relevant and provided early advice on some cases. The advice surgeries allow the TSCU and CPS to meet and direct police enquiries to ensure collaborative and comprehensive investigations. As there is input from the CPS from the start, it allows quick decisions to be made with regards to charging. The correspondence reviewed between them is precise, accurate and efficient as there is a constant flow of information between the two parties.

Reviews of each case
Multiple reviews were carried out on the cases establishing the key facts for each area of the investigation to ensure that all evidence had been obtained and all leads were followed, albeit in some instances there were items that did not appear to be rigorously followed up, as highlighted in the negative aspects sub-section.

10.2.5 Conclusions of Serious Personal Injury case files review

There is an improvement in the quality of information captured within each case file as they progressed from 2007 to 2009 implying an improvement in case investigation. The final case file reviewed from 2009 contained no negative aspects; it was clear every procedure was followed and the prosecution team went to extra lengths in order to deliver justice for a

vulnerable cyclist who had suffered terrible life threatening injuries. This case file is suggested as best practice, alongside the future developments and changes made since that are noted in the following section.

The negative aspects identified in both the fatal and SPI case files reviewed have been considered with recommendations for improvement suggested, alongside examples of identified good practice; these are highlighted in section eleven.

11 Recommendations and Identified Good Practice

11.1 Recommendations

11.1.1 Metropolitan Police Service

1. ***Continue the MPS review into the SOP for managing life threatening/changing investigation [BOCU / Traffic CJU responsibility]***

Whilst a new SOP has been introduced ensuring BOCUs take on the investigation of the most serious SPI's (not dealt with by the RDIU), the MPS should review their resourcing of BOCU units responsible for life changing / life threatening personal injury collisions in light of the varied volume of serious injury collisions that were recorded in previous years to ensure that there are adequately trained resources to manage investigations within each borough.

For instance, during 2009 the eight boroughs of Westminster, Lambeth, Southwark, Wandsworth, Hackney, Kensington & Chelsea, Camden and Hammersmith & Fulham collectively represented 50% of all serious pedal cycle casualties across London, as recorded for Stats 19; conversely some boroughs experience relatively few serious pedal cycle casualties. Therefore, the MPS should consider how boroughs with different demand will develop and retain the necessary expertise to effectively investigate these collisions.

2. ***Improve reporting processes for prosecution decisions and court outcomes and conduct analysis upon outcomes [Traffic CJU responsibility]***

Through the review it is clear that recent historic records have been difficult to obtain; this has led to an incomplete appreciation of the scale of prosecutions conducted upon serious pedal cycle collisions and their ensuing progress at court. With the move to BOCUs being responsible for certain collisions and any ensuing prosecution locally, it is even more important that the Traffic CJU considers improving centralised recording of all collision prosecutions across London and in turn analyse findings on a regular basis to identify any trends requiring further attention (e.g. a fall in prosecutions resulting in conviction when dealt with by certain boroughs). In contrast, fatal collisions results were relatively easy to obtain and report upon.

3. ***Improve communication with Serious Personal Injury victims and documentation of contact made within the case file [Traffic CJU responsibility]***

There were several instances found of inconsistent contact with victims. These instances should be reviewed to determine the circumstances to ensure these are not repeated in future.

Also, in most of the SPI cases reviewed, it was difficult to be reassured that regular contact was being made and documented, although as acknowledged this could be reflective of the change in recording systems and processes used. Where the Summons Package electronic diary transcripts were included it was evident that contact is frequently made, however this was not included in all the SPI case files reviewed. It is recommended that the TSCU ensure transcripts of the Summons Package electronic diary are included in all case files and

updated with all new contact; this would also act as a useful form of back up should the Summons Package electronic diary be unavailable.

4. Review witness appeal boards prior to despatch [RDIU responsibility]

The instance of a witness appeal board asking for witnesses following a collision involving a pedestrian, instead of a cyclist, may have prevented witness recall and been ineffective at identifying additional witnesses. Whilst this was an isolated incident it is recommended the RDIU Detective Inspectors provide quality assurance of witness boards before they are placed at the collision scene.

5. Review relationship with London Ambulance Service [RDIU / Traffic CJU responsibility]

As seen in both the fatal and SPI case file review there were instances of conflicting victim injuries reported to collision scene officers and a delay in provision of accurate diagnosis. Whilst accepting it can be challenging to accurately diagnose victim's injuries, it would be useful to review how the collision scene officers and LAS personnel engage with one another to identify any enhancement to providing quicker and more accurate diagnosis, which may help the MPS conduct more efficient investigation. This recommendation is solely directed at enhancing the relationship between the LAS and MPS to improve the working relationship; it is important to acknowledge that the MPS will always err on the side of caution and if an injury appears serious will treat it as such until told otherwise.

6. With the CPS, review support given to victims dissatisfied with charging decisions [Traffic CJU / CPS responsibility]

In a few instances, SPI victims unhappy with the charging decision were treated poorly in terms of the length of time taken to supply requested case file information. It is recommended that the processes for engaging with victims dissatisfied with the service provided by the TSCU are reviewed to ensure that future requests for case file information are dealt with promptly and fairly. This would help improve victim satisfaction with the MPS plus help to reassure victims that the investigation into their case was conducted in the appropriate manner.

7. Improve collection of victim statements [Traffic CJU responsibility]

The majority of SPI case files containing victim statements revealed gratitude from the victims at being able to put forward their point of view. In one case a victim had to request for her statement to be taken several times before it was finally collected. It is recommended that the process for offering and collecting victim statements is reviewed to ensure future collection of these is speedy and supportive to victims.

8. Update the MPS SOPs by reference to the 2009 serious personal injury case file reviewed as an example of good practice [BOCU / Traffic CJU responsibility]

The final 2009 serious personal injury case file reviewed contained no negative aspects, was well documented and provided a great deal of support to a vulnerable cyclist. It is recommended that this case file is highlighted amongst investigators as an example of good practice to refer to when conducting future case file reviews.

9. Improve letters of court attendance sent to victims

Copies of letters sent to victims and witnesses to attend court appeared indistinguishable and standardised. It is recommended that standard information is included (such as, case reference number and court date), alongside tailoring the letters to the individuals being written to, especially in the case of victims.

10. Review of factors that could have prevented fatality / collision

As part of the collision investigation it would be beneficial for the police to note what could have prevented the death in a collision, if not the collision itself. This information could prove useful in shaping future collision prevention activity.

11.1.2 City of London Police and Metropolitan Police Service

11. CoLP and MPS to conduct joint review of their investigation processes (CoLP and RDIU / Traffic CJU responsibility]

Whilst both forces have collaborated together, particularly where collisions occur on the border of the City with MPS boroughs, there is little evidence of wider regular learning from one another to help strengthen existing processes and provide a truly consistent approach to collision investigation across the whole of London.

It would also be worthwhile the CPS LTU and City CPS unit establishing a joint review of processes to ensure CPS consistency in collision prosecution across London.

11.1.3 Crown Prosecution Service

12. Analyse outcomes of all fatal road traffic cases to identify learning points and disseminate lessons

As identified in the HMCPSI 2008 review, there was a need to ensure this happens for all fatal cases irrespective of outcome. Adverse outcomes are reviewed, however there should be consideration given to all fatal case files. This could be an opportunity to work jointly on these case reviews to ensure holistic appraisal.

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

As identified in the HMCPSI 2008 review, there are multiple documents concerning commitments to victims that should be considered for distilling into one overarching guidance document with management checks established to ensure compliance. A project is currently underway within CPS HQ that should aid delivery of this. The CPS Victim and Witness Project aims to streamline commitments to victims and witnesses regarding levels of support to bereaved families; this includes plans to produce a public document setting out the standards of care that victims and witnesses are entitled to receive from the CPS and Witness Care Units.

14. Following any meeting with the victim's family, a letter should be sent confirming key points discussed

This does not currently happen, and when consulted the CPS LTU agreed this would be a useful idea to ensure that victim's families have a record of what was discussed, therefore it is recommended that this is undertaken following all future meetings held between victim's families and the CPS. The Homicide Team (see below) will continue to offer meetings as LTU have prior to 1st April 2011 and should consider this recommendation.

15. Review the recent transition of fatal collision prosecutions from the CPS London Traffic Unit to the CPS Complex Casework Unit Homicide Team

This recent change which occurred during the final writing of this report should be monitored to assess the impact, both negative and positive, upon how fatal collisions involving cyclists are progressed, plus whether this will enable the LTU to deal more effectively with non-fatal collision casework.

This also presents an opportunity for the CPS to consider if the Homicide Team can take responsibility for life threatening / changing collisions prosecution or offer support to borough CPS teams conducting the prosecution, similar to how the MPS RDIU supports borough OCUs that lead the police investigation upon these types of collision.

16. Review outstanding recommendations from previous 2008 and 2010 HMCPSI reports

There were four items, from the 2008 and 2010 HMCPSI reports into fatal collisions prosecutions and the LTU, where progress could not be determined at time of writing this report. The CPS should review these and take action where required.

In particular there is still no national CPS training in relation to prosecuting bad drivers which is an opportunity to define the charging standards for careless and dangerous driving and ensure that there is consistency in approach between the CPS Complex Casework Unit, that deal with fatal collision cases, and local borough CPS teams dealing with all other personal injury collision cases.

11.2 Identified Good Practice

11.2.1 Metropolitan Police Service

1. Most serious SPI collisions investigated by BOCU

Since August 2010, the most serious SPI collisions not investigated by the RDIU are investigated by the BOCU where the collision occurred. This has enabled the TSCU to undertake additional work in respect of vulnerable road users and is envisaged to have positive impact upon victim satisfaction and confidence in how the police handled the investigation.

2. Improved efficiency of Collision Investigator's Reports (CIR) production [RDIU responsibility]

Collision Investigators (CI) are based in 4 offices with pan-London responsibilities for attending collision scenes to capture evidence and objectively determine the nature of the collision which is presented in a CIR. Until recently the CIRs, whilst being well structured and thorough, often took long to complete and needed to become more objective. Since March 2011, a new SOP has clarified the role of the CI within investigations conducted by the RDIU. A particular emphasis is now upon only relevant witness statements to be included within the CIR; previously the CIs waited for all witness statements to be compiled and used this information within their CIR which introduced unnecessary delays to the final report production.

3. Breath tests conducted in all reviewed fatal case files [RDIU responsibility]

There was evidence of these being conducted in every fatal case file reviewed in a timely fashion (within one hour of the collision).

4. Contacting next of kin and collaboration with UK and overseas police forces [RDIU responsibility]

There was evidence of excellent work undertaken to determine and then contact next of kin of fatal victims. This included good collaboration with other police forces in the UK and overseas.

5. Care of young witnesses [RDIU responsibility]

One case file revealed good processes to ensure traumatised witnesses were supported to provide their statements at a later date, plus specialist officers trained in dealing with young people were involved and properly briefed on the case details to ensure both the care of the witness and collection of evidence for the investigation.

6. Handover between Road Death Investigation Unit and Traffic Serious Casework Unit [RDIU / Traffic CJU responsibility]

Where cases were handed over from the RDIU to the TSCU, the use of a handover form documenting the material included and the reason for inclusion was invaluable for ensuring the case could be progressed promptly following handover. Given the increased involvement of BOCUs for investigating life changing / threatening collisions, that may be handed over to them by the RDIU, it is important that this process is followed in future.

7. Letters sent to victims and witnesses [Traffic CJU responsibility]

There were some good examples of letters sent at the conclusion of case investigation and prosecution. It is recommended that the MPS identify examples of good letters, in terms of tone and content, and circulate these to relevant staff to ensure they follow these in future correspondence.

8. Road Death Investigation Unit record of incident attended form [RDIU responsibility]

Where included in the case files reviewed, this form provided excellent concise complete overview of the collision and the various parties involved. This form should continue to be used in all collision investigations to enable other officers to quickly gain appraisal of the nature of the collision.

9. Traffic Serious Casework Unit follow up of Form 966 [Traffic CJU responsibility]

There is excellent follow up and enquiry on all parties sent this form. This should be continued and shared with the BOCUs that investigate life changing / threatening collisions to enable gathering of all possible evidence.

10. Senior Investigating Officer Forums [RDIU responsibility]

This forum was established during 2010 where all the RDIU SIO's meet to receive relevant training, presentations and to share good practice; for example, the identified issue of eyesight tests being properly conducted has been addressed through this forum.

11. Management of investigations upon the CRIS system and regular investigation review

As reported in the fatal case file review findings there was evidence to suggest that some lines of enquiry, such as identifying whether a victim had been wearing ear phones, had not been followed up. The RDIU now manage investigations upon the Crime Recording Information System (CRIS), with officers encouraged to enter upon this all information and actions taken relevant to the investigation; the Detective Sergeants and Detective Inspectors undertake regular review of the investigation progress and use a quality assurance checklist to ensure specific actions are undertaken. This process should ensure lines of enquiry such as this are followed and recorded for others to see.

12. Maintain the same Family Liaison Officer throughout a case where possible [RDIU responsibility]

As reported in the fatal case file review findings there was evidence of a FLO changing throughout a case investigation and ensuing prosecution. The aim of the RDIU is to ensure that the same FLO is maintained throughout each case, and on the rare occasions this is not possible ensure the handover between FLOs is conducted efficiently to provide continuity in the support and relationship developed with the victim's family.

11.2.2 Crown Prosecution Service

13. Adherence to delivering prosecution charging decision within statutory time limits
Despite any delays in supply of evidential material from the police, the CPS LTU has consistently delivered a charging decision within the STL. This is in large part due to the tracker system in place monitored by both the TSCU and the CSP LTU, plus the co-location of MPS and CPS staff in the same premises ensures that regular face to face discussion can take place.

14. MPS and CPS case file surgeries
The monthly case file surgeries are a crucial forum for consultation on case progression and evidential requirements to enable CPS charging decision. These should be continued and adopted in the BOCUs with their local CPS colleagues when working upon life changing / threatening case file investigation.

15. Specialist Lawyers in the CPS London Traffic Unit
There are three specialists in traffic law responsible for charging decision for all cases dealt with by the LTU. The City of London CPS Unit also has a trained traffic prosecutor working upon traffic prosecution cases thereby providing consistency in decision making across London.

16. Charging decisions are quality assured by the Legal Director
The Legal Director of the LTU reviews and quality assures every fatal collision charging decision made acting as another layer of quality assurance.

Appendix A - Checklists used for case file review

Collisions Involving Cyclist Fatality – Review Methodology

To enable effective measurement of case files against the key criteria of: timeliness; adherence to processes and SOPs; and delays to the investigation, the following items were sought[26].

Key dates to note

- Date, time and location of collision
- Date of death
-
- Date of Family Liaison Officer (FLO) contact
    - Initial contact and assignment of FLO
    - Contact when key decisions made
        - Decision to take no further action (NFA) / file sent to CPS / charging decision made by CPS
- Date of victim/victim family contact[27]
    - Initial contact *(should be within 5 – 10 days of collision date)*
    - Contact at least once every 28 days *(may be difficult to identify if recorded electronically)*
    - Contact when key decisions made
        - Decision to take no further action (NFA) / file sent to CPS for advice[28] *(should be within 10 days of decision to NFA or send to CPS for advice)*
        - Summons issued *(should be within 10 days of this decision made)*
        - Charging decision made by CPS *(within 10 days)*
        - If defendant issued summons to appear in court, and victim required to give evidence *(should be within 5 working days of receipt of information from CPS)*
        - Dates of all hearings *(should be made within 5 working days of receipt of information)*
        - Notification of court result *(should be within 10 working days of receipt of information)*
        - If court issue warrant *(should be notified within 10 working days of receipt of information)*
        - If warrant leads to arrest of defendant *(should be notified within 10 working days of receipt of information)*
- Date of Collision Investigation Report completion
- Outcome of investigation with dates decisions made

[26] Where available - some case files would have incomplete information, which may not necessarily have affected the overall quality of the case file investigation.

[27] According to TSCU policy 00/16, "contact with all parties by telephone, letter or other agreed means of communication must be recorded within the relevant Summons Package electronic 'Diary' **and printed off at regular intervals and placed on the case file**."

[28] Not all serious personal injury collisions will be consulted with CPS, hence this information and some subsequent evidence of interaction with the CPS will not be found.

    - No further action
    - Date passed to CPS for charging decision
    - Date CPS returned charging decision
- Dates of all hearings / court dates and type of court

Key items within case file to seek and review against timelines

- All available log books (e.g. crime scene log 197, scene management log 115, log 118/118D, FLO log book 192 etc.)
- Any test conducted (e.g. testing for alcohol / drugs by driver involved, testing of mobile phone records etc.)
- Witness statements
- When decision to prosecute, evidence of completed:
    - Statement of facts
    - Prepared case file
    - MG3 / MG5 forms completed
    - Court ready checklist
- Outcomes/actions/tasks from Collision Investigator Unit Inspector review and follow-through of these
- Any additional information required by CPS to reach charging decision

Collisions Involving Cyclist Serious Personal Injury – Review Methodology

To enable effective measurement of case files against the key criteria of: timeliness; adherence to processes and SOPs; and delays to the investigation, the following items were sought[29].

Keys dates noted

- Date, time and location of collision
- Officer in charge / Senior Investigating Officer / TSCU Case Manager
- Date case file papers delivered to TSCU *(should be within 48 hours of collision)*
- Date of victim/victim family contact[30]
    - Initial contact *(should be within 5 – 10 days of collision date)*
    - Contact at least once every 28 days *(may be difficult to identify if recorded electronically)*
    - Contact when key decisions made
        - Decision to take no further action (NFA) / file sent to CPS for advice[31] *(should be within 10 days of decision to NFA or send to CPS for advice)*
        - Summons issued *(should be within 10 days of this decision made)*
        - Charging decision made by CPS *(within 10 days)*
        - If defendant issued summons to appear in court, and victim required to give evidence *(should be within 5 working days of receipt of information from CPS)*
        - Dates of all hearings *(should be made within 5 working days of receipt of information)*
        - Notification of court result *(should be within 10 working days of receipt of information)*
        - If court issue warrant *(should be notified within 10 working days of receipt of information)*
        - If warrant leads to arrest of defendant *(should be notified within 10 working days of receipt of information)*
- Date of Collision Investigation Report completion *(if deemed necessary to prepare at initial collision investigation)*
- Evidence collation key dates
    - E.g. any enquiries for alcohol / blood tests (from BOCU) or enquiries for CCTV made by CJU Enquiry Team
    - Subsequent dates evidence requested was delivered
- Outcome of investigation with dates decisions made
    - NFA

[29] Where available - some case files would have incomplete information, which may not necessarily have affected the overall quality of the case file investigation.

[30] According to TSCU policy 00/16, "contact with all parties by telephone, letter or other agreed means of communication must be recorded within the relevant Summons Package electronic 'Diary' **and printed off at regular intervals and placed on the case file**."

[31] Not all serious personal injury collisions will be consulted with CPS, hence this information and some subsequent evidence of interaction with the CPS will not be found.

    - Date charging decision made by TSCU, e.g. summons (not all case files require CPS advice) or decision to refer to CPS *(should be made within 4 months of collision date)*
    - Date passed to CPS for charging decision
    - Date CPS returned charging decision
- Dates of all hearings / court dates and type of court
    - If victim required by Court Service to give evidence at court

Key items within case file to seek and review against timelines

- All available log books created at the crime scene and passed to MPS TSCU (e.g. crime scene log 197, scene management log 115, log 118/118D)
- Any test conducted (e.g. testing for alcohol / drugs by driver involved, testing of mobile phone records etc.)
- Witness statements
- When decision to prosecute, evidence of completed:
    - Statement of facts
    - Prepared case file
    - MG3 / MG5 forms completed
    - Court ready checklist
- Any additional information required by CPS to reach charging decision

Appendix B – Abbreviations used within this report

ACPO	Association of Chief Police Officers
ASB	Anti-Social Behaviour
BOCU	Borough Operational Command Unit
CAD	Computer Aided Despatch
CARB	Collision Accident Report Book
CCU	Complex Casework Unit
CI	Collision Investigator
CIR	Collision Investigator's Report
CJS	Criminal Justice Service
CJU	Criminal Justice Unit
CoLP	City of London Police
CPS	Crown Prosecution Service
CSAP	Cycle Safety Action Plan
CSEP	Community Safety, Enforcement and Policing
DfT	Department for Transport
DPP	Director of Public Prosecutions
FLO	Family Liaison Officer
HMCPSI	Her Majesty's Crown Prosecution Service Inspectorate
HOLMES	Home Office Large Major Enquiry System
KSI	Killed or Seriously Injured
LAS	London Ambulance Service
LCJP	London Criminal Justice Partnership
LTPS	London Traffic Prosecutors Service
LTU	London Traffic Unit
MPS	Metropolitan Police Service
NFA	No further action
OBM	Optimum Business Model
OCU	Operational Command Unit
OIC	Officer in Charge
PCD	Pre-charge decision
PNC	Police National Computer
PTPM	Prosecution Team Performance Meetings
RDIM	Road Death Investigation Manual
RDIU	Road Death Investigation Unit
RPU	Roads Policing Unit
SIO	Senior investigating officer
SOP	Standard Operating Procedure
SPI	Serious Personal Injury
STL	Statutory time limit
TfL	Transport for London
TSCU	Traffic Serious Casework Unit
VCOP	Victim Code of Practice
WDC	Without due care and attention