

**INTERIM ADVICE NOTE 166/14
Version 2 (Dec 2014)**

**HIGHWAYS AGENCY ROAD
DEATH INVESTIGATION (RDI)
GUIDANCE**

Summary

Guidance to Highways Agency staff, contractors and consultants who may have to give evidence at a Coroner's Court or Criminal Court.

Instructions for Use

This document supersedes IAN 166/13

This guidance is to provide advice and assistance to any person with the Highways Agency or their supply chain in the process from a fatality occurring on our network to giving evidence at a Coroner's court or criminal court.

HIGHWAYS AGENCY ROAD DEATH INVESTIGATION (RDI) GUIDANCE



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Oct 2014	1.6.3	Update to the Health and Safety Work Act following HA's change to a GoCo

CONTENTS

INTRODUCTION

BACKGROUND

PART 1: WHAT IS A RDI AND WHO IS INVOLVED?

- 1.1 Purpose of a RDI
- 1.2 Purpose of a Coroner's Inquest
- 1.3 Role of the Police
- 1.4 Role of the Highways Agency
- 1.5 Role of the Crown Prosecution Service (CPS)
- 1.6 Role of the Health and Safety Executive (HSE)
- 1.7 Role of the Coroner

PART 2: RDI PROCESS

Highways Agency RDI Procedure

- 2.1 Introduction
- 2.2 Who in the Agency needs to be aware of the RDI process
- 2.3 Points to consider about the guidance

PART 3: THE CORONER'S INQUEST

- 3.1 What is a Coroner's Inquest?
- 3.2 Who gets summoned?
- 3.3 What happens during the Inquest
- 3.3.1 Coroners Inquest with a jury
- 3.4 The verdict and the Coroner's Report
- 3.5 Responding to a Coroner's Report
- 3.6 What to do on receipt of a Coroner's Report
- 3.7 Other proceedings
- 3.8 The Corporate Manslaughter Act 2007
- 3.9 Gross negligence manslaughter

PART 4: AGENCY RDI SUPPORT

- 4.1 Training – evidence and witness statements
- 4.2 Staff handbook
- 4.3 24/7 support (Legal and media)
- 4.4 Counselling services

GLOSSARY

REFERENCES

ANNEXES

Documentation required by the Police under 3 example scenarios:

Annex 1 - New surface, structure and/or road furniture scenario

Annex 2 – Road profile scenario

Annex 3 – Winter maintenance scenario

Annex 3.1 – Winter maintenance: example list of documents required by a Police employed contractor

Annex 4 – Content outline of basic facts report

Annex 5 – Ministry of Justice’s Sentencing Guidance Council - Corporate Manslaughter Act Sentencing Guidelines

Annex 6 – Aide Memoires for Traffic Officers and Traffic Officer managers including checklists

Introduction

When a road death¹ occurs on the strategic road network, the Highways Agency will have some initial involvement with the Police Road Death Investigation (RDI)². Further involvement might be required depending on the development of the investigation from the preliminary findings. Staff could be involved:

1. in a witness capacity, having either been first on scene, or witnessing what occurred immediately post incident;
2. in providing 'expert' evidence regarding the network assets and/or operation of them; or
3. as a potential defendant either as an individual or as a representative of the Agency it is being treated as a potential defendant.

Of the three circumstances listed above, it is more than likely that any Agency involvement would be in relation to one of the first two categories, however staff should be aware of the latter. Each of the three categories is totally different and distinct from the next and as such, staff could find themselves with different expectations, pressures, timescales and level of input.

The nature and involvement in a RDI is such that it can potentially apply to any member of staff in the Agency. Attendance at court or at a Coroner's inquest will be decided by the Crown Prosecution Service (CPS) and/or Coroner based on the findings of the Police report submitted to them.

Within a RDI, there are three main documents that govern the investigation:

- Article 2 of the Human Rights Act (1998);
- the Corporate Manslaughter and Corporate Homicide Act (2007); and
- the Road Death Investigation Manual (2007).

The Road Death Investigation Manual (RDIM)³ is the Police procedures manual which informs them of the key roles, investigative principles and strategies/components required to assist an effective RDI. The RDIM is produced by the National Policing Improvement Agency (NPIA) which has been consulted during the development of this guidance.

The following guidance, along with the availability of 24/7 legal support, welfare support and training will ensure staff are suitably enabled to deal with a RDI. This document also provides information on the types of documents, etc that might be requested from Agency staff and will ensure a consistent and appropriate approach to a RDI is taken throughout the Agency. The need for doing so is based on our responsibility to comply with the documents already cited above as well as the Coroners Act (2009).

¹ The international definition of a road death, as adopted by the Convention on Road Traffic (Vienna, 1968), being where a person is killed outright or dies within 30 days as a result of an accident.

² For the purposes of this guidance, when referring to a Road Death Investigation (RDI), the RDI is in response to a fatal collision or a collision that is deemed fatal, and then becomes fatal.

³ www.itai.org/docs/RDIM.pdf

This guidance aims to provide Agency staff with:

- a suitable understanding of the processes regarding Road Death Investigations. In particular the roles of the CPS, the HSE, Coroner, Police and the Agency, and how they interact
- an overview of internal procedures available for the Agency to utilise in any RDI.

This document has been developed in consultation with the National RDI Project Group, NDD Delivery Teams, Customer Operations Management Division and DBFO Teams and DBFO service providers⁴, the HSE and NPIA. The RDI procedures have been developed in adherence to the Police Road Death Investigation Manual (RDIM).

This guidance has been produced by the Agency's Network Operational Solutions (NOS) team within Network Services Directorate, on behalf of Network Operations Directorate's Senior Responsible Owner for RDI. The guidance is considered a live document which will be reviewed and updated by the NOS Team to allow for any Government policy change, operational experience and future shared good practice.

In addition to this national RDI Guidance, The Agency's North West Region has produced the following document: 'Road Death Collision/Coroners Courts Interim Guidance on Submitting Expert Reports and Witness Statements (**NW Coroner's Guidance**)⁵. This aims to provide a consistent regional approach to preparing expert reports and witness statements by the Agency and its Service providers. It provides interim guidelines and procedures to assist asset delivery teams in producing expert reports and witness statements on highway matters for the Police, as part of a criminal/coroner investigation. While produced by the north-west team, it is relevant to other regions.

If you have any comments or require further information regarding this national guidance document, please advise the NOS Team in the first instance.

⁴ Where Service Provider is mentioned in this guidance it means those companies which fulfil the Managing Agent Contractor/Asset Support Contractor (MAC/ASC) role; and where it is still in existence the Managing Agent (MA) and Term Maintenance Contractor role (TMC).

⁵ <http://share/Share/livelink.exe/overview/11423251>

Background

The Department for Transport (DfT) and the Highways Agency continuously monitor the trend of road fatalities and accidents and have a duty to ensure that steps are taken to reduce Killed and Seriously Injured (KSI) incidents on the road network.

When a collision results in an instant or subsequent fatality on the network, the Agency will become involved with the Police investigation and their report to the CPS and to the Coroner. The Agency may also become involved in any further investigation into the road fatality.

The Corporate Manslaughter and Corporate Homicide Act 2007 (see 3.8) was introduced in April 2008, making organisations more accountable for manslaughter in corporate scenarios. The offence section of the Act states “An organisation to which this section applies is guilty of an offence if the way in which any of its activities are managed or organised: causes a person’s death, and amounts to a gross breach of a relevant duty of care owed by the organisation to the deceased.”. Taking account of this, it is not inconceivable that a RDI involving the Agency could, exceptionally, be subject to the Act.

The Coroners Reform Act (2009) includes the modernisation of processes for coroners’ investigations and inquests and gives coroners new powers to obtain the evidence needed for investigations.

The Agency has a duty, at all levels, to respond with professionalism and diligence throughout any RDI it becomes formally involved in.

DfT and the Agency are currently capable of being charged with corporate manslaughter under the 2007 Act in respect of current Agency activities. Post 2015 (when the Agency becomes a GoCo, referred to here as ‘strategic highways company’) the strategic highways company will similarly be capable of being charged with that offence in respect of its highways activities. Among other things this is subject to the exclusions in the Act relating to public authorities and the exercise of public functions. Further, the offence will only be constituted if the high level management or organisation decisions on how those activities are carried out where a substantial element in the breach of a duty of care. Such high level management/organisation decisions are usually those taken by the strategic highways company board or senior executives, but it should be assumed that it includes relevant decisions taken by DfT in respect of the strategic highways company also. It should be noted that any offence committed is by the corporate body, not individuals. Individuals may have to explain themselves in giving evidence during any prosecution of the company and there may be indirect practical consequences for the individuals arising out of the case, but will not be charged as a criminal offence.

PART 1: WHAT IS A RDI AND WHO IS INVOLVED?

1.1 Purpose of a Road Death Investigation

A RDI is the duty of the Police to establish the circumstances which have led to a road fatality in line with the RDIM. This will involve collating the facts and possible causation factors, from which a final report is produced and sent for consideration to the CPS and the Coroner. Ultimately a RDI provides an explanation of what happened.

The CPS will determine if there are any criminal charges to answer by any party. If there is no case to answer, then the Coroner can proceed with the arrangements for a Coroners Inquest, if required.

With the 2007 version of the RDIM and the Corporate Manslaughter Act (see 3.8) coming into force, the Police are looking at situations in more detail. The RDIM serves to assist Police forces in developing policies and business processes to ensure fatalities on the road are investigated professionally.

The Police have a duty to conduct a thorough investigation to establish the circumstances that have led to a road death and discharge their responsibilities to the Coroner. The Agency will have an active part in a RDI supporting the Police, through either asset delivery/DBFO Teams and the Traffic Officer Service (TOS). The list below is just some of the possible areas that the Police will consider in their enquiries:

- (a) environmental factors, eg road condition, signage, weather conditions;
- (b) human factors, eg alcohol/drugs, fatigue, correct use of restraints; and
- (c) vehicle factors, eg roadworthiness and potential design fault.

It can take time to secure on-scene evidence, but this time is required as once the evidence is lost it is impossible to retrieve. Further information about the on-scene investigation processes that the Police can use is available in the RDIM.

In addition to the on-scene investigation the Police may also assess aspects such as:

- (a) design standards and any departure from them;
- (b) maintenance schedules;
- (c) winter maintenance and severe weather response protocols;
- (d) any appropriate policies; and
- (e) any defective equipment used in the maintenance or repair of the road.

The above lists are just examples of what might be required in any RDI and are by no means fully comprehensive lists (please refer to the Annexes for further information).

1.2 Purpose of a Coroner's Inquest

The Coroner will start making arrangements to convene an inquest after the CPS has concluded that there are no criminal charges to be answered. Depending on the nature of the case the inquest will be held either with or without a jury.

If it is found during the inquest that the fatality was road related or road infrastructure related, then the Coroner is legally bound to issue a safety improvement report to the Agency. The Agency is legally bound to respond to any such improvement report and must reply to the Coroner (see Sections 3.4 to 3.6 for further information).

Further information about the Coroner's Inquest is available in Part 3.

1.3 Role of the Police

1.3.1 What is the Role of the Police in a RDI?

In the instance of a road fatality, an inquest will be held because it is likely that the fatality was not from natural causes. The Police are duty bound, on behalf of the Coroner, to conduct a thorough investigation to establish the circumstances which have led to the fatality. On conclusion of the investigation the Police will send a case report to the CPS and the Coroner to determine whether any criminal offence has been committed by any party and whether a Coroner's Inquest needs to be convened.

The Police will carry out any RDI in line with the RDIM which provides the Police with a comprehensive framework to investigate a road fatality. They will investigate any fatal collision from the viewpoint of it being an 'unlawful killing' until it is proved otherwise. The starting point of the investigative evaluation is to establish: what is known and unknown; consistencies and inconsistencies and any conflict. To answer these questions the Police will consider the Why, When, Where, How, Who and What during the investigation.

During the investigation, where the Police determine that elements of the trunk road or motorway may have been a contributory factor, they will seek further information from the appropriate sources which will include the Agency. The information gathered from the Agency will be compiled and presented in the final investigation report.

1.3.2 Who is involved within the Police?

Any Police investigation will be led by a Senior Investigating Officer (SIO) who is responsible for conducting the investigation and where one exists the SIO will be from the Roads Policing Unit. However, as each RDI is unique, a classification system to identify the most appropriate person to perform the role of SIO may be used by the respective police force.

The basic RDI Police team will usually consist of a Collision Investigator, Family Liaison Officer and an Investigation Officer. The aim of the investigation is to collect and collate a range of information, including:

- evidence from the collision scene;
- evidence from vehicle examination;
- intelligence gathering, eg tacographs; and
- witness statements.

1.3.3. What are their powers?

Police have extensive powers to seek out and secure evidence. Any requests for information by the Police should always be responded to in a timely manner as soon as is possible. Delivery should be within the timescales agreed with the Police. In the event this cannot be achieved the SIO must be informed so the investigation is not hindered and the Coroner can be kept informed.

In **extreme** circumstances the Police can use powers to access premises, homes of staff, secure and remove IT equipment, clone servers and interview staff at all grades to obtain information for the final report. The Corporate Manslaughter Act increases the risk for organisations to be prosecuted for manslaughter. A Police investigation may also consider staff fulfilling senior management roles “and whether their acts or omissions contributed to the fatality⁶”.

1.3.4 What happens next?

Once the report is complete it is sent to the CPS and the Coroner. In the case of the CPS they judge from the report whether there are any criminal charges to answer and the Coroner judges the cause of death and if an inquest needs to be held.

It is important to remember that since the Police carry out RDIs on behalf of the Coroner it is very likely that the Agency will have had minimal interaction with the Coroner prior to the inquest.

1.4 Role of the Highways Agency

1.4.1 What happens when a road fatality occurs?

When a road fatality occurs on the strategic road network, the Agency and/or its service providers may have some involvement either through the Traffic Officer Service or service provider; or asset delivery teams in providing specialist advice on certain aspects of the network. However, depending on the police force, in some areas a ‘first report of fatality’ may be received by the asset delivery team up to 7 days after the fatality.

⁶ Taken from Companies and Fatal Road Traffic Accidents document
http://www.cps.gov.uk/legal/a_to_c/corporate_manslaughter/index.html#as18#as18

Whilst the Agency and its service providers are not an investigatory body, the nature of work means that staff could be called as witnesses. The Police will be seeking to collate information in line with RDIM guidelines and in developing good practice will work closely with responders such as the Traffic Officer Service.

1.4.2 What the Agency needs to do

Given the development in policy over the recent years such as the change in responding to Coroners reports⁷, and the reform of the Coroners Act in 2009, it is even more crucial now that the Agency properly considers the findings of a RDI. By doing so, it will enable the Agency to identify any additional safety improvements that might not have been previously apparent. The Agency should provide a programme of scheduled works if it includes works planned for the future in the area where a fatality takes place. For example, if a vehicle hits a bridge parapet directly, the programme of scheduled work may show that the Agency had already recognised this as a risk and are planning to put in safety barriers in front of the parapet or along that stretch of road. This will show that the Agency already planned to improve this section of road where the fatality took place.

Identifying when the Agency's standards or guidance may have contributed to a fatality or serious incident involving a road worker/road user

The Agency works with those parties, including contractors, to learn from the investigations that are undertaken. Where there are issues that arise from such investigations (including recommendations from Coroners Courts) about the technical standards/guidance produced by the Agency, the relevant group within Network Services will be responsible for addressing the issue/s and taking action where changes to documents are required. The National Health and Safety team will inform the relevant Divisional Director when such cases occur.

Deciding what changes are needed to the standard or guidance; consulting stakeholders on the proposed changes; and making the changes to the standard or guidance

These three actions are covered by our existing processes within the knowledge programme which require a project brief to be created for a task such as updating/creating a new standard or guidance (including the use of QMR forms where appropriate to highlight the costs, risks and benefits), the use of a technical project board to consult with the relevant stakeholders and then monitoring of the completion of the task.

The Agency must be proactive in its role as the road operator for the strategic road network, including its response to a RDI. There may be a requirement to collate and provide further information to the Police beyond initial witness statements and/or continuity statements from those on scene. The Agency's cooperation will be evident when the CPS consider whether there is a criminal case to be answered. Any lack of cooperation could be interpreted as 'something to hide'.

⁷ See Part 3 Section 5 – Responding to a Coroner's Report

1.4.3 How should the Highways Agency respond to a RDI evidence request?

The Agency must provide any potential evidence requested by the Police in support of their investigation. An indication of the kind of documentation that might be requested by the Police is available in annexes 1-3. A further list of information which could be requested when the police have employed contractors as part of the investigation is at annex 3.1, Any request from the Police and its contractor (where employed) must always be responded to in a timely manner, as soon as is reasonably possible.

Depending on the complexity of the case it can take approximately 3 months from the initial requests for a RDI report to be completed by the Police.

1.5 Role of the Crown Prosecution Service (CPS)

1.5.1 What is the role of the CPS in a RDI?

On receipt of the investigation report from the Police, the CPS will consider whether any criminal charges should be brought. This could, for example, include any charges of Corporate Manslaughter (see 3.8) against the Agency or any Gross Negligence Manslaughter (see 3.9) charges against an individual employee. The Corporate Manslaughter Act “is intended to work in conjunction with other forms of accountability such as Gross Negligent Manslaughter for individuals and other Health and Safety legislation”⁸.

When considering a charge of Corporate Manslaughter, the CPS is looking at “the way in which the Agency’s activities are managed or organised by its senior management and whether they are a substantial element”⁹ that contributed to the fatality.

If the HSE has not been involved in the Police investigation stage, the CPS will liaise with them to determine whether there has been any breach of the Health and Safety at Work Act (HSWA).

1.5.2 What are their powers?

The CPS will consider the management and organisation of the Agency’s activities relevant to the case. By doing so, they are looking to determine whether they attributed to or directly caused the fatality, therefore amounting to a gross breach of the relevant duty of care owed by the Agency to the deceased. If a case is answerable, the CPS will apply to the Director of Public Prosecutions (DPP) for their consent to take the case to court.

⁸ The CPS : Corporate manslaughter.
http://www.cps.gov.uk/legal/a_to_c/corporate_manslaughter/

⁹ Section 1(1) of the Corporate Manslaughter and Corporate Homicide Act (2007).
http://www.opsi.gov.uk/ACTS/acts2007/pdf/ukpga_20070019_en.pdf

1.5.3 What happens next?

If the decision is taken that there are no charges or criminal offence to answer, then the CPS could pass the report to the HSE for consideration as to whether there is a case to answer under the HSWA [see 1.6]. If there is no case to answer under the HSWA, the Coroner and Coroner's Office can proceed with arrangements to hold an inquest.

1.6 Role of the Health and Safety Executive (HSE)

1.6.1 What is the role of the HSE in a RDI?

The HSE does not attend road traffic collisions, but they may be involved with the investigation. The types of road traffic collision that the HSE can be involved in are those which have involved specific work activities. In addition, the HSE has arrangements with the Police so they are informed and can be involved in the investigation of any fatal collision, where the Police believe one of the following is a factor:

1. there is sufficient indication that failures in safety management by the employer have significantly contributed to the incident; and
 - (a) these failures cannot be addressed by the 'cause and permit' provisions in the Road Traffic legislation, and
 - (b) the risks are foreseeable and beyond the direct control of the driver;

and/or

2. there is a serious continuing risk, eg one that could result in a similar incident occurring in similar circumstances, which cannot be addressed by the Police using Road Traffic legislation, or by another appropriate enforcing authority, eg Vehicle & Operator Services Agency (VOSA).

1.6.2 What are their powers?

The HSE is responsible for enforcing Health and Safety legislation. In extreme circumstances the HSE has powers of entry to properties and, like the Police, can take any document, item or equipment they consider of potential assistance to them in their investigation.

1.6.3 What happens next?

The CPS will have consulted with the HSE whilst considering the RDI report and whether any criminal charges should be brought. The HSE will then decide whether a breach of the Health and Safety at Work Act (HSWA) has occurred and whether a Crown Enforcement notice or Crown Censure should be applied to the Agency¹⁰.

The reason for taking either of these two options is that they are vital in assisting in maintaining employee and public confidence in the health and safety regulation of Crown bodies.

¹⁰ See HSE enforcement and investigation for further information about the HSE.
<http://www.hse.gov.uk/enforce/enforcementguide/investigation/index.htm>

The Highways Agency, as an executive agency of the Secretary of State for Transport is part of the Crown and cannot be prosecuted for breaches of the HSWA (1974). However, the new Strategic Highway Company (SHC) **will not** be part of the Crown, so it can be prosecuted under HSWA and will be subject to other enforcement action, such as improvement and prohibition notices. The position of employees of the SHC will remain the same (that is, they can be prosecuted). There appears to be no reason why employees of the SHC would be more likely to be prosecuted than employees of the Secretary of State since the powers and sanctions are the same for both sets of employees.

The HSE will take a decision whether any breach of the HSWA has occurred and what subsequent action to take. If the CPS and HSE decide to prosecute for offences from the same incident, they will liaise to consider holding a joint prosecution. If the CPS decides not to prosecute under the Corporate Manslaughter Act, then the HSE will wait for the outcome of the Coroner's Inquest before taking a final decision as to whether there is a case to answer or not.

1.7 Role of the Coroner

1.7.1 What does the Coroner do?

The primary function of the Coroner is to establish:

- the deceased's identity;
- when, where and how the death occurred; and
- whether any recommendations for action are required to prevent further recurrences.

However, if it appears that ***“one or more persons acting on behalf of the State are, or may be, in some way implicated in a death by their actions or inaction”*** the State has an obligation under Article 2 of the European Convention on Human Rights to hold a full Public Investigation¹¹. If this is the case then the Coroner will not only seek to determine the three points above, but also the circumstances in which the fatality occurred.

1.7.2 Who is involved from the Coroner's Office?

Coroners are primarily barristers or solicitors, but can sometimes be doctors and are independent Judicial Officers. This means they cannot be directed as to what they should do, but they must follow the applicable laws and regulations. Each Coroner has a Deputy and an Assistant Deputy¹² who may take their place when they are engaged in other coronial work. They are also assisted by Officers who receive the Police investigation report and make enquiries on behalf of the Coroner.

Where a Coroner decides that a death is natural and is supported by a doctor's certificate, the Coroner will advise the Registrar who will register the death. Alternatively a Coroner may decide that a pathologist should examine the body. Upon examination, if it is found that the deceased died of natural causes, then it is unlikely that an inquest will be held. Where it is found that the cause of death is not natural, the Coroner will arrange and hold an inquest.

¹¹ Taken from www.hse.gov.uk/enforce/enforcementguide/wrdeaths/Coroner.htm.

¹² The Coroner's office organisational structure will alter in 2010 in response to the new Coroners Act.

PART 2: RDI PROCESS

2.1. Introduction

This part of the guidance provides an overview of the procedures and processes that Agency asset delivery teams may be involved in when a Road Death Investigation is being conducted. The full process overview is illustrated, and subsequently considered in individual sections up to the Coroners Court Summons with explanatory notes and guidance.

If electronically accessing this document please click on the hyperlinks in the process flow chart to access the individual sections and explanatory notes.

2.2 Who needs to be aware of the RDI process

The process is principally written from the viewpoint of Asset delivery teams and their service providers. This is because they are considered most likely to have the majority of Agency involvement within RDIs, because of their operational responsibility for the Agency's road network. It is also recognised that Traffic Officer Service colleagues may well find themselves exposed to the RDI process, in a witness capacity, for example.

The link below shows the process that Traffic Officers and RCC staff use when an incident takes place on the strategic road network.

[Traffic Officer Guidance](#)¹³

Other Agency directorates also need to be aware of these procedures as RDIs can, in theory, affect the majority of Agency business areas (policies associated with maintenance, for example, could be considered as having a direct link to the condition of the network at the time and location relating to a particular RDI).

It is advisable to open a case-specific file at the start of each RDI to enable evidence to be centrally located.

2.3 Points to consider about this guidance

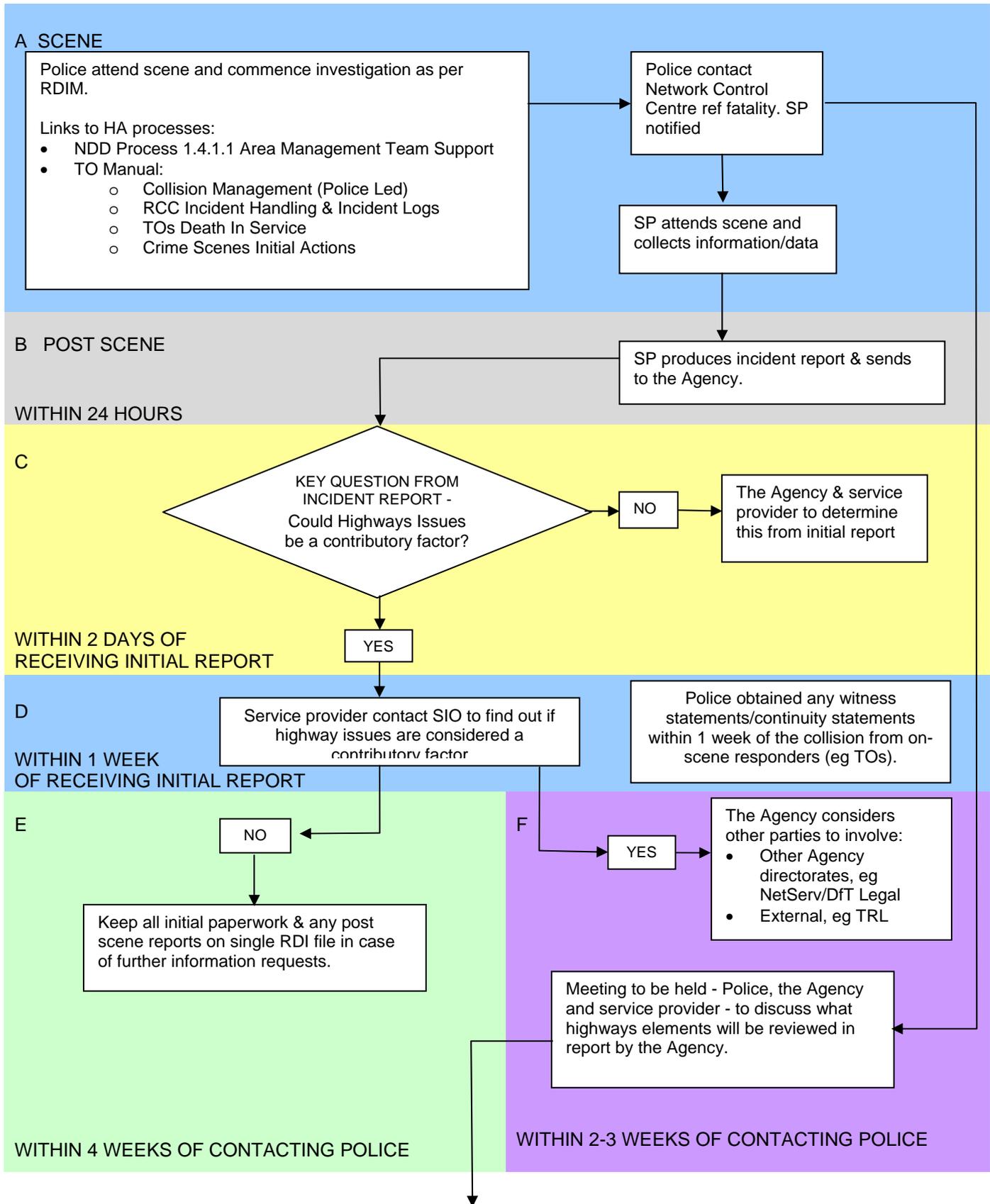
1. The procedure is a framework. It is primarily intended to be used as a model for asset delivery teams as stated at 2.2. It can be developed or adapted as required to meet individual Police force operations/procedures/timeframes.
2. Asset delivery teams should seek to establish with the Police what the exact timescales for the RDI are likely to be. Initially, a RDI can take approximately 3 months for the Police to be in a position to present their findings.
3. It is recognised that asset delivery teams are only available during weekday 'office hours', while the Traffic Officer Service and service providers give a 24/7 response.

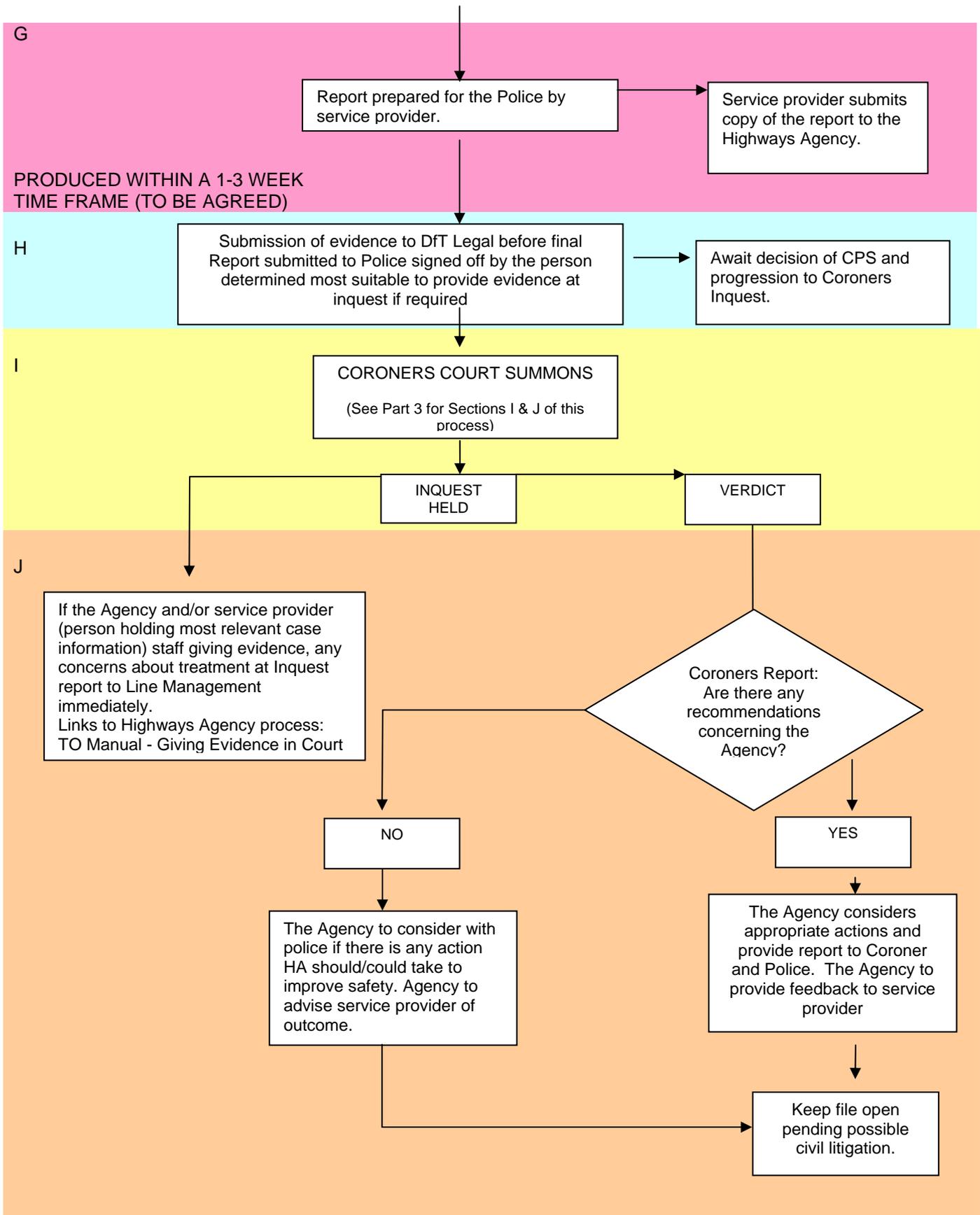
¹³

http://portal/portal/server.pt?open=space&name=CommunityPage&id=2&cached=true&in_hi_userid=17570&control=SetCommunity&PageID=0&CommunityID=914&WG_link=http://portalweb/minisite/hawww/www/TO/processes/Manage_Traffic_On_The_Network/.../APTR/SADCHALETS.htm

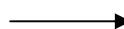
4. Due to the nature of a RDI, it is recognised that some of the steps in the following overview link to existing Agency procedures and practice. Where possible, these have been referenced to show the links.
5. Each RDI is unique and the process model cannot, therefore, cater for each individual RDI although the majority of processes will be the same or similar.
6. It is expected the Agency will utilise its service providers in RDIs and it is likely they may gather and prepare much of the information, although in theory there is nothing to prevent Agency staff from doing this themselves depending upon individual scenarios.
7. Whilst it is recognised and expected that service providers are most likely to carry out the majority of gathering and preparation of information required for the RDI, **the responsibility and liability remains with the Agency, except in the case of Design, Build, Finance and Operation (DBFO)** where liability and responsibility may remain with the DBFO companies in many instances. Liaison with stakeholders is covered in the contract. It is therefore strongly advised that Agency asset delivery teams ensure they are kept fully aware of all developments and sighted on information being collated/submitted to ensure that all requirements placed upon the Agency are met regarding the RDI.
8. It is important that DBFO managers (wherever they site) have the oversight and awareness of developments around RDI issues. PFI and PPP contracts have more risks transferred to the contractors by their nature but reputational risks still sits with the Secretary of State and the Agency. This document does not seek to introduce any further requirements than those set out in the contract or legislation. DfT Legal advice is that each case will be taken on its merits if put before a court to ascertain where responsibility lies; this could be either the DBFO company or Secretary of State. A key deliverable of this process activity, proof of record keeping is strongly advised and those involved in this process should enable those documents to be readily available when requested.
9. Within the RDI context, service providers may also be separately considered (as individual organisations rather than purely representing the Agency).
10. The following RDI process diagrams indicate elements that would typically be expected to fall within the respective remits of asset delivery team and service providers.

HIGHWAYS AGENCY PROCEDURE FOR THE INVESTIGATION OF ROAD DEATH COLLISION ON THE STRATEGIC ROAD NETWORK AND CORONERS INQUEST



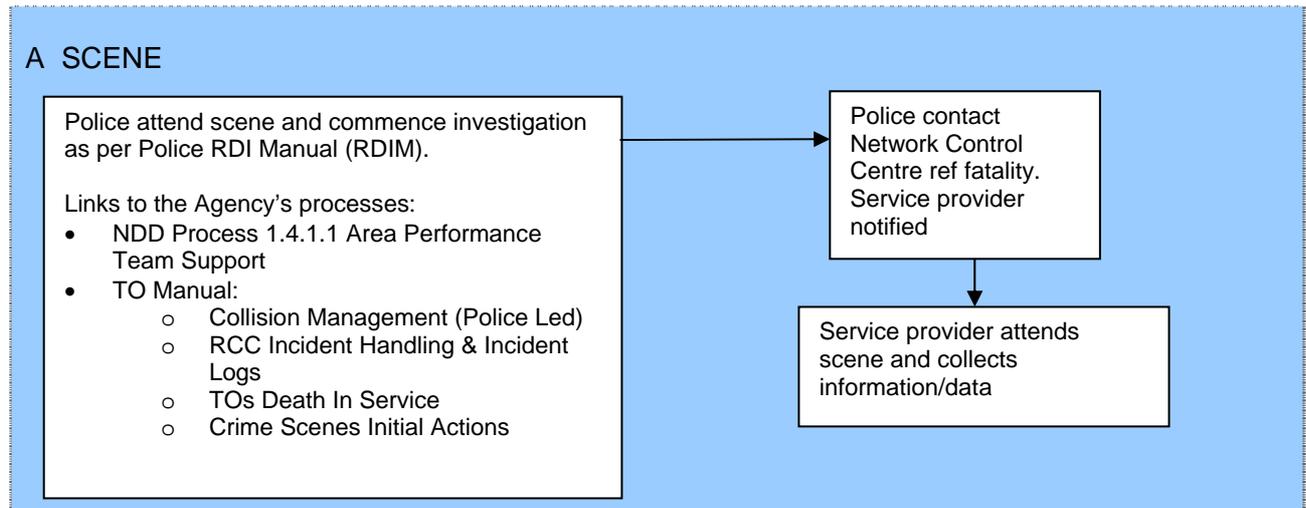


*** PLEASE NOTE TIMINGS GIVEN ARE APPROXIMATE. THE POLICE SIO WILL DETERMINE THE EXACT TIMESCALE AND THE AGENCY SHOULD CONSULT WITH THEM.**



SCENE

Section A: At Scene



Where a fatal, or potentially fatal, collision has occurred on the network the Police are called to attend the scene. In the first instance the Police will work to six key principles which are critical to the investigation. They include:

- conduct an initial assessment
- make the scene safe and preserve life
- preserve the scene
- secure material and identify witness(es)
- identify the victim(s); and
- identify any suspect(s)

The Police then continue to proceed with their investigation in line with the Road Death Investigation Manual (RDIM), produced by the National Policing Improvement Agency (NPIA).

It is important that the Agency is notified of the collision as soon as possible, due to the need to assess potential damage to the road surface or infrastructure and establish adequate safety measures until it is possible to conduct repairs. However, as previously stated earlier in section 1.4 depending on the police force, in some areas a 'first report of fatality' may be received by the asset delivery team up to 7 days after the fatality.

Access for the service provider, and/or Agency asset delivery team representatives, to the scene for damage infrastructure assessment must be with the permission of the leading commanding officer and may not be until a later stage of the investigation. If the scene has been declared a crime scene, Agency and service provider staff may have to be accompanied by Police. On arrival and departure, Agency and service provider staff must report to the SIO.

Whilst the Agency is not an investigatory body, information should be collected at scene by the service provider. This includes, but is not limited to:

- A photographic record of the site (but not of victims).
- Detail photographs (failed components, any unusual features, items with maintenance or design implications).
- Traffic details, traffic management, details of the approach to the site (including photographs and preferably a video record).
- Weather conditions (at the time of and prior to the accident).
- Details of unusual aspects of the incident.
- Malfunctioning highway equipment (eg lighting, signs).
- Winter maintenance operations in progress, if appropriate.
- Retention of damaged/failed components that may benefit further investigation.

Annex 4 contains a number of questions that should be considered when preparing an initial report.

The service provider must obtain agreement from the Police SIO before proceeding to collect any information/data. **At all times the service provider must comply with the directions of the Police.**

Taking photographs at the scene of incidents is an important part of cost recovery. Service provider staff working on behalf of the Agency have a right to take photos at the scene of an incident to record the damage caused and the detail of the vehicle(s) that cause damage, to enable cost recovery as an “aggrieved party”.

When Police are present, they have overall responsibility for the scene. All images taken by anyone (including the media) may be subject to seizure as evidence by the Police. In order to avoid this, the senior service provider representative at the scene should seek permission from the Police Officer in charge before images are taken. The need to remain compassionate and respectful for the other parties/people involved in the incident is essential and permission will not, therefore, be sought until after casualties have been removed.

Once the Police have handed the lead for management of the incident to the Agency, images should be taken in consultation with the Agency TO at the scene (where present). Unless there is a valid reason this request will not normally be refused.

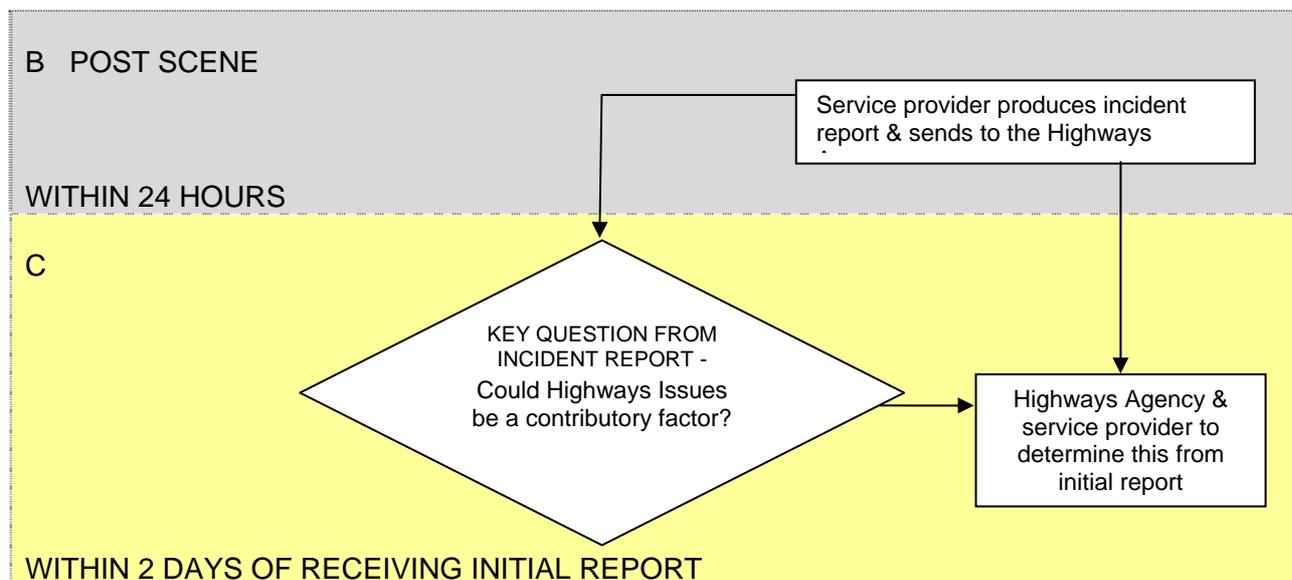
Important Actions

- If there is any immediate concern of a legal nature by Agency staff, DfT Legal should be contacted as set out in Section 4.1.
- Agency asset delivery teams and service providers must ensure that there is a dedicated service provider contact that the Police, NTIS or RCC will notify of the incident.
- Agency asset delivery teams must seek confirmation from the Police that they will notify the nominated/dedicated service provider contact.

- The appropriate asset manager (AM) or assistant asset manager (AAM) in the asset delivery team will be notified and updated on the incident at the first possible opportunity.
- A central file should be opened by the Agency on which all RDI information is recorded and kept including that received from the service provider.

POST SCENE

Section B & C: Initial incident report



Once the service provider representative has collected the information an initial incident report should be produced and sent to the asset delivery team as soon as is reasonably possible. Annex 4 contains a number of questions that should be considered when preparing an initial report. At this stage the initial report will be a basic facts report as opposed to a full in-depth report.

From the initial report it is important that the Agency considers whether highways issues could be a contributory factor and whether the Police will be requesting further information which could lead to the service provider having to submit a full report to the Agency in the first instance. With this in mind, the Agency should consider:

- the variety of different information types required;
- accessibility of the information; and
- the information being auditable

The Agency must be proactive in the collating and provision of data which is required by the Police.

It is recommended that each asset delivery team regularly check the administrative processes to ensure the accurate recording, storage and accessibility of general information and specialist information. This will ensure that the information can be quickly and easily produced when required. Annexes 1-3 provide lists of information the Police can request, under 3 example scenarios, and that the Agency should collate.

Where a contractor, employed by the Police, is involved, a list of the documents they might request is also available at annex 3.1. By ensuring the administrative processes are regularly checked, the Agency ensures that it does not delay the RDI and actively contributes to it.

Contributing to any RDI is a **legal obligation** and failure to comply in a timely manner could give an adverse impression when considering potential charges at a later stage. The Police report from the RDI is sent to the Crown Prosecution Service (CPS) and Coroner for consideration as to the next step in the legislative process. This report contains a number of documents including any factual information or report prepared by the Agency in regard to highways issues. If the Agency is not able to submit the RDI report when requested there is a high risk that the file will be submitted to the CPS and Coroner without any input from the Agency which could be problematic for a number of reasons:

- the Agency is best placed to provide information regarding highways issues. If Agency information is omitted however, the Police, Coroner and family of the deceased could make their own assumptions regarding highway issues without hearing the required factual information that the Agency can provide; and
- the credibility of the Agency would be undermined as the cause of delay in an investigation.

Important actions

- Asset delivery teams and service providers should collate the information likely to be requested by the Police immediately or at the very least be in a position to be able to locate the information without delay. This should be borne in mind particularly where historic information is required from service providers who previously held the role under a previous contract.
- Asset delivery teams and service providers should also ensure that full records are kept in relation to each route as the Police often require information relating to when the road was last maintained. It is therefore vital that historic records are properly kept regarding highway inspections.

Section D: Contact with the Police

D

Service providers contact SIO to find out if highway issues are considered a contributory factor.

Police obtained any witness statements/continuity statements within 1 week of the collision from on-scene responders (eg TOs).

WITHIN 1 WEEK OF RECEIVING INITIAL REPORT

Throughout this procedure it is vital the Agency establishes, through its service provider as appropriate, and maintains, good communication with the Police. With regards to the police investigation, within a week of the collision the Police should have obtained any witness and/or continuity statements¹⁴ from any on-scene responders (for example, TOs).

It is important for asset delivery teams to make early contact with the SIO as opposed to waiting for the Police to contact the Agency. This will enable the Agency to be properly involved with the investigation from the early stages and raise awareness with the Police and Coroner of the information/services that the Agency can provide. The Agency should make/be first contact with the Police, and only exceptionally should this be undertaken by the service provider. In these cases the service provider should make sure the Agency is kept fully informed without delay.

Through the initial contact the following should be ascertained:

- The exact details of the incident including:
 - location,
 - number of fatalities and other injured parties,
 - number of vehicles involved,
 - very brief summary of what happened; and
- If the Police consider at this stage whether any highways issues could be a contributory factor.

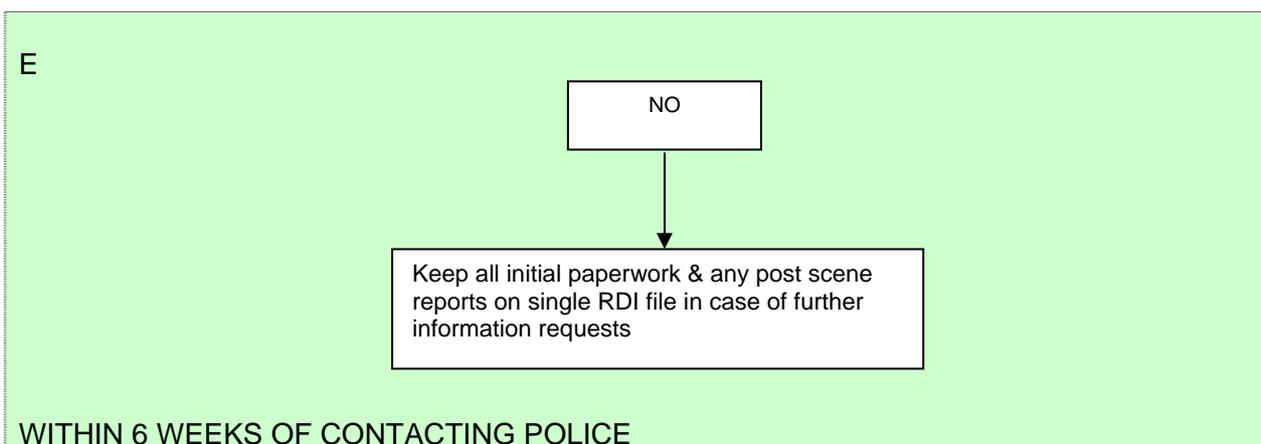
Important actions

- Asset delivery teams should seek to ascertain how each local Police force in their area conducts RDIs. For example is there a dedicated RDI unit that will be called upon to carry out the investigation, or is the investigation team taken from a pool of trained officers who are appointed to the investigation when a road fatality occurs.
- This will enable asset delivery teams to establish contacts within each Police force regarding road fatalities. The contact will either be someone from the dedicated unit or an officer who can put the Agency in contact with the SIO or act as a liaison.

¹⁴ Continuity statements are a form of witness statement and cover the moving or removal of any item of evidence including the body of the deceased for essential reasons, such as to enable treatment of any other injured parties, etc.

- The Agency and service provider should keep in contact to ensure awareness as to how the Police are proceeding with the investigation. **Agency staff should remain mindful that if not being interviewed 'Under Caution', any 'casual' opinion given concerning highways issues may still be recorded and can be used in a court of law.**
- The Agency and service provider should also ensure that any conversation with the Police is noted and the discussion content kept on file.

Section E: Where highway issues are not considered to be a contributory factor



Where the Police indicate that they do not consider that any highways issues are involved at this stage the asset delivery team and service provider should keep all the initial paperwork and any additional reports/information on a central RDI file pending any further information requests.

It is important that the Agency considers the findings of a RDI, even where it is apparent that highway issues are not a factor, for the following reasons:

- it ensures there are no other potential issues regarding the highway which may lead to future incidents;
- it may help to identify trends so the Agency can devise and develop appropriate safety measures. The Agency may, for example, use Variable Message Signs to warn of the dangers of driving when tired at locations where a number of collisions have occurred due to motorists falling asleep at the wheel; and
- if the Agency only reviews those incidents where highways issues could be a contributory factor, it could undermine the credibility of the Agency in future RDIs.

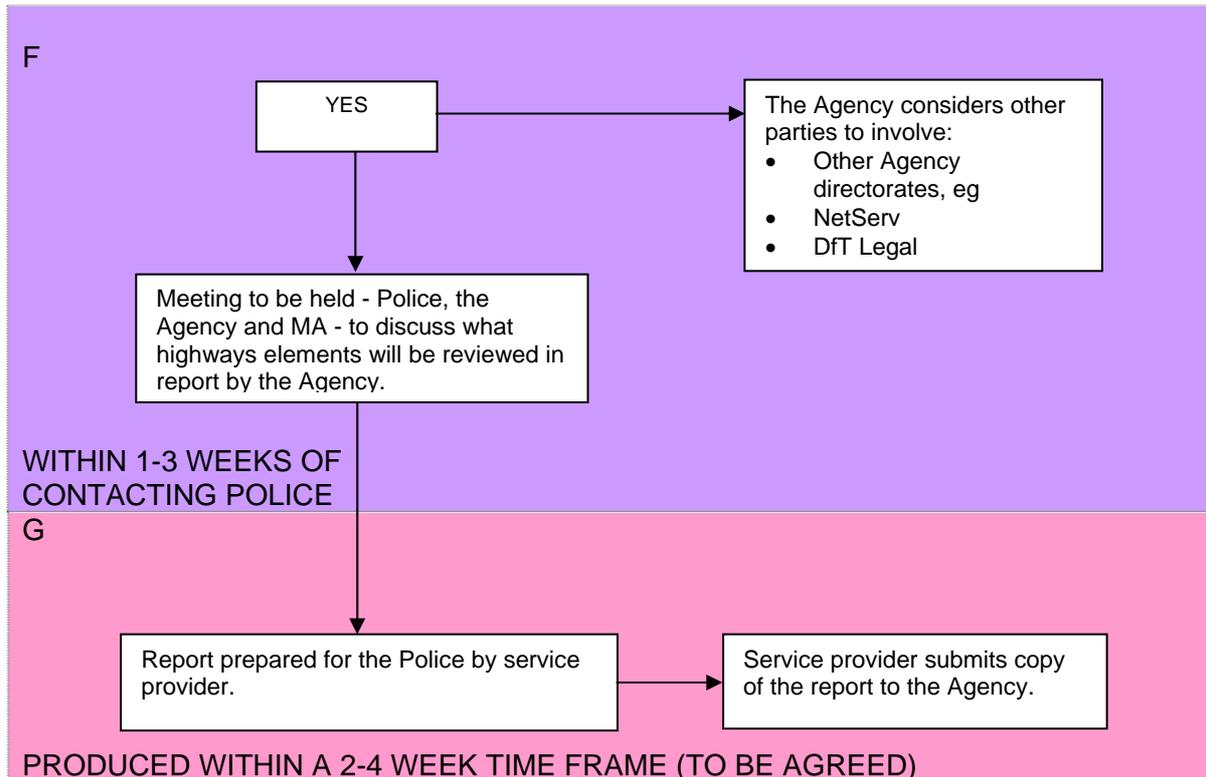
The RDI itself may not be closed for the following reasons:

- in some cases the Police/Coroner may want to clarify specific aspects regarding highways issues; and
- as previously suggested, the Agency may wish to use the report to identify trends which may result in the need for future improvement works.

Important Actions

- The Agency asset delivery team should track the process of the investigation to ensure that the Agency is best positioned to become involved if/as necessary. For example the Police or Coroner may, later on in the investigation, decide to return to specific highways-related issues.

Section F & G: Where highways issues could be a contributory factor



Where the Police consider at this stage that certain highways issues could be a contributory factor they will investigate further. It is likely that the Police will ask the Agency to prepare a report containing relevant information in regard to highways issues. A list of the information they can request and which is often covered in a report is attached in the 3 example scenarios at annexes 1-3. The Police may also ask for a specific focus on certain highways issues, for example, drainage systems, design of the road or road markings.

It is important to stress that further investigation by the Police may only be required to rule out highway issues as a contributory factor.

At this stage the Agency needs to consider if other internal or external persons need to be involved or contacted. For example if the particular focus is on the Agency's infrastructure, such as a bridge, it may be that NetServ specialist staff are best to be placed to provide factual information for the report. If the required expertise cannot be found in the Agency, then consideration should be given as to whether external experts should be consulted.

Please note that given the Police may, in certain cases, employ their own experts. It would not be expected that the same consultants be used by both parties. The consultants employed by the Police will have a list of documentation they would wish to view. An example list is available at annex 3.1.

The Agency asset delivery teams should consider if they require formal advice and/or support from the Department for Transport Legal Division. At present a 24/7 facility is provided by DfT Legal, to provide staff with a solicitor and legal advice. It is advised that if there is a concern regarding the highways issues involved then Legal

should be contacted at the earliest opportunity. This will enable the Division to consider if there are any liability issues and also assess if legal representation is required should staff be interviewed in the report stage, or the Agency be called to give evidence at inquest.

The DfT 'Out of Hours' telephone number is **020 7944 5999** through which the DfT Legal 'Out of Hours' contact can be accessed. On calling this number the DfT Legal number should be requested. During normal office hours (9.00-17.30) you should call the DfT switchboard number (0300 330 3000) and ask for the Highways Agency legal contact and you will be connected to their office.

With regard to the formal report, the Agency should work with the service provider in the document's collation and preparation.

The Agency asset delivery team should arrange a meeting with the Police SIO and service provider to discuss what is required in the report and to agree a date on which it will be submitted to the Police. If other specialists are required such as NetServ specialists, they should also attend the meeting.

A RDI and report can, on average, take approximately 3 months to prepare and deliver; as such the Agency should be responsive to any such requests for information. If the report is likely to be very technical in nature an extended time frame may be more realistic and this would need to be discussed and agreed with the Police. At all times the Agency must provide a timely response to any information request so as not to delay the investigation.

In preparing the report it is very important that the document:

- focuses on factual information in regard to highways issues;
- does not express any opinions; and
- must not provide any 'hearsay' or anecdotal evidence.

It is unlikely that asset delivery staff, supported by service provider staff, preparing the report will have actually witnessed the incident 'first hand'. Therefore, information concerning areas such as weather conditions eg how heavily rain was falling at the time of the incident, would have to be sought from other sources such as an Incident Data Capture Sheet or the TO Incident Report Form¹⁵.

Wherever possible the report should adhere to 'Plain English' guidelines. The purpose of the report is to ensure enough clear information is provided so that the Coroner has no further questions which they may wish to ask at an inquest. If the report is too technical and does not provide clear evidence, the Coroner may call the Agency to the inquest to explain further.

The report should have an explanatory statement containing the Agency management structure and service provider involvement. Where appropriate the report must contain recommendations if it is determined that any remedial or safety work should be carried out on the particular stretch of road concerned.

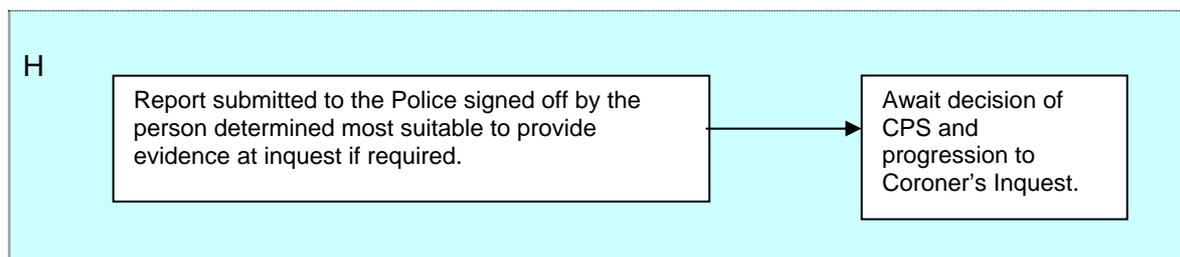
¹⁵ <http://jhpn33/hawwww/www/TO/processes/APTR/documents/P080027-TOIncidentReportFormAll4pages.pdf>

A copy of any report, if drafted by the service provider, must be sent to the Agency for endorsement prior to final submission.

Important actions

- If in any doubt or uncertainty, DfT Legal advice should be requested at the earliest opportunity.
- The report produced should not be too technical in nature unless such technical content is directly relevant to the investigation.
- The report must focus on factual information.

Section H: Submission of Report



The report will be viewed as evidence by the Police and Coroner and will therefore, once submitted, be treated as a witness statement. The report cannot be edited by the Agency or service provider once submitted, and must be submitted in its entirety. It must therefore be submitted with an accompanying statement from the Agency asset delivery team leader (or delegated asset manager) which introduces the report and states the origin of the report; why it has been prepared and by whom.

The report must be signed off by the person determined most suitable to provide evidence at inquest. The person should be knowledgeable regarding the highways issues and in most cases the most appropriate person will be the asset delivery team leader, but can be an AM or in exceptional cases, an assistant asset manager.

Once the report has been provided to the Police it will be included in the file/report the Police present to the Coroner. The Agency must then wait to hear from the Police as to whether any further information is required.

The Agency must also wait to be advised if the Coroner requires Agency attendance at the inquest. The report may be sufficient and the Coroner may consider Agency attendance is not required. Likewise, the Coroner may feel it appropriate for the Agency, and/or service provider, to attend so that further questions can be asked.

If the Agency is not summoned, consideration should be given as to whether an Agency representative should attend the inquest to observe proceedings to enable the Agency to hear all evidence and the verdict.

The Agency should keep in regular contact with the Police who will be able provide the inquest date if the Agency is not summoned.

It is considered beneficial for Agency staff who may be involved with Coroners investigations to attend an inquest to obtain an understanding of the processes and procedures.

Important Actions

- The report must be submitted in its entirety. The Agency cannot produce a statement derived from this report as this could suggest to the Police and Coroner that the Agency was being selective in the information it was providing to the investigation.

- The Agency asset delivery team should maintain contact with the Police to determine whether the Agency will be required to provide evidence at the inquest.
- The Agency should consider a representative attending the inquest as an observer where the Agency is not requested to give evidence at inquest¹⁶.

¹⁶ If this should occur, as the Agency representative is attending as an observer for training purposes only, it is essential that they do not identify themselves as attending on behalf of the Agency to ensure that they are not asked to address the inquest in a professional capacity.

PART 3: THE CORONERS INQUEST

3.1 What is a Coroner's Inquest?

The inquest is not a trial, even though it might appear like one in some respects, if there is a jury present. The purpose of the inquest is not to apportion blame for the death. The inquest's function is that of an inquiry to find out:

- The name of the deceased.
- The injury or disease that caused the death.
- The time, place and circumstances at or in which the injury or disease was sustained.
- Conclusions as to how the deceased came by their death.

The inquest helps the family of the deceased to find out what happened and the information obtained during the inquiry could help to avoid similar deaths occurring in the future.

3.2 Who gets summoned?

At the inquest the Coroner will hear evidence from a number of witnesses to help determine the cause of death¹⁷. A 'witness' will be a person who may have actually witnessed the event, eg a Traffic Officer, or a person who can provide other relevant information to the court, eg an asset manager for general route maintenance issues; or a specialist from NetServ for Agency technical standards.

Any person who believes they can be of help to the inquest should contact the Coroner or Police who will assess the relevance and/or use of evidence that the person might provide. As a result of this, a witness may either be asked or summoned to attend. At the inquest the Coroner will decide the order in which the witnesses are heard.

3.3 What happens during the Inquest?

Each witness is questioned under oath and will normally read from the statement they have provided prior to the inquest. It can be a very daunting experience giving evidence under such circumstances. A member of staff will read from a statement, but they can still be asked further questions by the Coroner, the family of the deceased or by legal representation and anyone who has a 'proper interest' that includes the following:

- a parent, spouse, child or anyone acting for the deceased;
- anyone who gains from a life insurance policy on the deceased;
- any person appointed by a Government Department to attend the inquest;
- anyone whose actions the Coroner believed may have contributed to the death, accidentally or otherwise;

¹⁷ *In cases where the M25 is part of Greater London "and it is alleged the accident was due to –*

- (a) *the nature or character of a road or road surface; or*
- (b) *a defect in the design or construction of a vehicle or in the materials used in the construction of a road or vehicle",*

the presiding Coroner shall send in writing to the Secretary of State (SoS), or to any officer of the SoS as s/he directs the time and place of the inquest and notification of any adjourned inquest. (The Coroners Act 1988).

- the Chief Police Officer (only through a lawyer) ;
- any insurer having issued such a policy; and/or
- anyone else who the Coroner may decide also has a 'proper interest'.

If it becomes apparent during the inquest that criminal proceedings are to be brought, or a person has been charged before a Magistrate's Court in connection with the death, or informed by the Director of Public Prosecutions (DPP) that a person has been charged before Examining Justices, then the Coroner can adjourn the inquest until conclusion of the criminal case or at the direction of the DPP. If the inquest re-adjourns it will do so as a fresh inquest.

3.3.1 Coroners Inquest with a jury

In certain circumstances a Coroner may hold an Inquest with a jury. The jury would consist of no less than 7 people, but no more than 11. The reasons why a jury would be present in relation to a road fatality are if the death:

- (a) is reportable under separate legislation to a government department, officer or to the HSE; or
- (b) it occurred in circumstances where the continuance or possible recurrence of which endangers the health or safety of the public or any section of the public.

If an Inquest commences without a jury and one of the above factors becomes evident, then the Coroner can summon a jury to the Inquest.

3.4 The verdict and the Coroner's Report

After all the evidence has been heard and the Coroner is satisfied that no further information is required the Coroner will close the inquest. On doing so, the Coroner will give the verdict which will be one of the following:

- accidental death;
- suicide;
- lawful killing;
- unlawful killing;
- natural causes; or
- open verdict

Having delivered the verdict the Coroner may, depending on the case in question, write a report if they feel there is a continued or future risk of more fatalities at the location concerned. During the inquest the Coroner may announce an intention to write a report, but the Coroner is not legally obliged to announce their reporting intentions.

Under Rule 43 of the Coroners Rules¹⁸ (2008 revision) the Coroner will write a report on the findings to prevent **any type** of fatality at a location if they feel there is a future potential issue. The recommendations in such a report do not have to relate specifically to the type of fatality heard at the inquest.

3.5 Responding to a Coroner's Report

Under Rule 43, it is now a **Statutory Duty** to respond to a Coroner's report. This rule has been amended to improve future public health and safety, and is ultimately intended to help save lives.

3.6 What to do on receipt of a Coroner's Report

On receipt of a Coroner's Report, the Agency must:

1. Acknowledge receipt of the report **immediately** in writing.
2. Respond in full **within 56 days** in writing to the Coroner¹⁹, including details of what action is to be taken or not taken and the reasons why.
3. If it is not possible to reply in full within 56 days, then the Agency must request in writing an extension from the Coroner at the earliest opportunity. The Agency must include in their request full details of why a full reply is not possible at this stage. The length of extension is at the Coroner's discretion.

If the Agency does not reply the Coroner is duty bound to make all reasonable attempts to pursue the matter with the Agency. If a response is still not provided by the Agency after all reasonable attempts have been made the Coroner at this stage is legally obliged under Rule 43 to inform the Lord Chancellor of our failure to respond.

Any reported failure to respond may be recorded in **any** document the Lord Chancellor publishes about Rule 43 reports in general²⁰.

¹⁸ Taken from [Summary of Reports and Responses under Rule 43 of the Coroners Rules...](http://www.justice.gov.uk/search?collection=moj-matrix-dev-web&form=simple&profile=default&query=Coroner%27s+Rules)

¹⁹ A copy of the Coroners report and our response will be sent to the Lord Chancellor and the DfT Road User Safety Division, by the Coroner or the Ministry of Justice.

²⁰ A reporting measure at present.

3.7 Other proceedings

Other proceedings that could occur following a RDI report are under:

- Corporate Manslaughter Act 2007
- Gross Negligence Manslaughter; and/or
- prosecution under the Health & Safety at Work Act; or
- civil action for claims²¹.

Manslaughter cases may occur before the inquest or during the inquest. If they occur during the inquest then the inquest will be adjourned until the manslaughter case has been heard and a verdict delivered.

A manslaughter case will affect the timing and length of any inquest. After the inquest it is possible for civil action to be pursued for the claiming of damages. The information obtained and considered at the inquest may lead to potential claims, particularly by the deceased's family.

The Corporate Manslaughter Act 2007 and Gross Negligence Manslaughter are considered at 3.8 and 3.9.

Where a civil claim arises against the Agency from a road fatality, the claim must be sent immediately for receipting, acknowledgement and response to the Red Claims team. The team must also be advised that the claim is en-route to them. Once the Red Claims team has receipted the letter this starts the 21 day response time and 90 days for the case decision.

The Red Claims team can be contacted by telephone GTN 6189 5934 or via email REDCLAIMS_HAIL@highways.gsi.gov.uk.

3.8 The Corporate Manslaughter Act 2007

The Corporate Manslaughter and Corporate Homicide Act 2007 came into force on the 6 April 2008 (full details are available on the Ministry of Justice website), with the 'Corporate Homicide' term applicable to Scotland only. The Act sets out a new offence for convicting an organisation, rather than an individual, where gross failure in the way activities were managed or organised results in a person's death. Courts will look at management systems and practices across the organisation involved, allowing for prosecution of the worst corporate failures to manage health and safety properly. **If a gross breach of a duty of care within the managing or organising of an activity results in a person's death, the organisation will be considered guilty of Corporate Manslaughter.**

The Act recognises that a substantial part of the failure will lie at a senior level that will include employees who make significant decisions about the organisation or substantial parts of it; including centralised/headquarters functions as well as those in operation management roles.

²¹ Civil action for claims must commence within three years of the date of the fatality (taken from the Home Office advice leaflet 'When Sudden Death Occurs' (2002).
http://www.dca.gov.uk/corbur/sudden_death.pdf

Sentencing guidelines for the Act have been produced by the Ministry of Justice's Sentencing Guidelines Council.

Individual employees cannot be prosecuted under the Act as it is aimed at cases where management failures lie across an organisation, and it is the organisation itself that will face prosecution. Individuals can, however, be prosecuted for the already established offence of Gross Negligence Manslaughter (see 3.9) which is not affected by the introduction of the Corporate Manslaughter and Corporate Homicide Act.

Due to the nature of the Agency's business, and associated duties of care, the Corporate Manslaughter Act could pose a tangible risk to the Agency via the RDI process. Notwithstanding, the Ministry of Justice has stated that organisations currently adhering to the present Health and Safety laws are not considered as being likely to breach the Act.

3.9 Gross Negligence Manslaughter

Gross Negligence Manslaughter comes under involuntary manslaughter in law (full details are available on the Crown Prosecution Service website). This is where a death occurs as a result of a grossly negligent (though otherwise lawful) act or omission. The **maximum** penalty for this is life imprisonment and individuals can be prosecuted.

There is a 4 stage test to identify Gross Negligence Manslaughter. This is known as the 'Adomako Test' and involves;

- i) the existence of a duty of care to the deceased;
- ii) a breach of that duty of care which;
- iii) causes (or significantly contributes) to the death of the victim; and
- iv) the breach should be characterised as gross negligence, and therefore a crime.

Those with an established duty of care, that would include Agency staff towards the Agency's customers, must act as a 'reasonable person would do in their position'. Failure to do so would breach the required duty of care. It is no defence if the defendant did not appreciate the risk - only that the risk would have been obvious to a reasonable person in the defendant's position.

Due to the nature of the Agency's business, and associated duties of care, Gross Negligence Manslaughter could pose a tangible risk to Agency staff through association with the RDI process. Employees who act in a reasonable manner toward their work, however, are not considered likely to be exposed.

PART 4: HIGHWAYS AGENCY RDI SUPPORT

This section provides information and contact details for Agency staff that become involved with a RDI. Each of the following elements is covered within this section:

- **Training** please see Section 4.1
- **Highways Agency Staff Handbook** please see Section 4.2

In **exceptional** circumstances, staff should also be aware of the following:

- **24/7 Support (Legal and Media)**, please see Section 4.3
- **Counselling Services** please see Section 4.4

4.1 Training – evidence and witness statements

A DVD titled 'Evidence & Witness Statements' has been developed by the Traffic Learning Centre (TLC) for the benefit of Agency Traffic Officer and Regional Office staff. Copies of the DVD have been distributed to Training Lead Operations Managers in all TOS regions.

The DVD's purpose is to inform and support staff, should they be asked to supply evidence and/or witness statements. It provides information and advice regarding Agency policy and process associated with giving evidence related, for example, to Traffic Officer duties. The DVD addresses why the Agency supports courts in dealing with cases related to the work of TOS. It explains the steps involved for Traffic Officers in giving witness statements to the Police and/or evidence to various types of court.

The information is designed to be of particularly relevance and value to staff if, for example, issued with a Summons to appear before a court or if asked by the police to provide a witness statement.

For further information please contact the TLC directly.

TLC@highways.gsi.gov.uk

4.2 Highways Agency Staff Handbook

For regional office based staff, please consult 6.3, and supporting annex, in Chapter 6 of the Staff Handbook.

For Traffic Officer Service staff, please consult Chapter 14 of the Staff Handbook.

4.3 24/7 support (Legal & media)

Under the current arrangements the DfT Duty Officer will provide contact details for DfT Legal in order that the services of a solicitor can be procured any time of night and day if the need arises.

DfT 'Out of Hours' telephone number: **020 7944 5999**

4.3.1 Basic RDI advice for TOS:

TOS staff may be requested by the Police, third party solicitors and/or other Agencies associated with the RDI process to provide a statement or information in relation to an incident that has occurred on the network. This guidance is for all occasions when in connection with their official duties; a claim is made upon or proceedings are taken against, TOS staff including;

- any request received, in connection with legal proceedings, to make a statement, produce a document or give evidence;
- any document in court proceedings, including a witness summons, is served;
- involvement in or becoming aware of any incident which may constitute a criminal offence or give rise to civil legal proceedings against themselves or any other member of the agency.

In all incidences staff must refer to Chapter 6 in the Staff Handbook. The main guidance from the Chapter is listed below:

1. It is the responsibility of all staff to immediately or as soon as is practicable to do so, report to their line manager. Their line manager will refer the matter to HR immediately or as soon as practicable to do so. Upon being advised the HR will facilitate as necessary the provision of advice from the Department's Legal Advisors.
2. It is not appropriate for staff to make a response that could prejudice their own or the Agency's defence until they have received advice from the Agency. Therefore staff should try to resist giving an immediate response and instead should discuss the matter with their line manager who will arrange for the appropriate support.
3. The Agency will in general provide legal support to a member of staff where in the course of their employment legal proceedings are brought against them. This support will be subject to conditions.
4. The Agency will provide staff with legal representation if they are involved in an inquest or fatal accident inquiry as a result of their official duty provided there is not a conflict of interest between them and the Agency. Where conflict does occur it is at the Agency's discretion as to whether it provides legal representation.
5. The Agency will provide legal advice to staff that are assaulted in the course of their official duty and will consider whether to give assistance with any subsequent proceedings.

6. Staff have the right to appeal if they are denied the right to legal advice provided for by the Agency.
7. If statements etc. are required out of the normal working hours the Duty Operations Manager should be consulted to determine the appropriate course of action. If, exceptionally, legal advice is required outside the normal office hours the Department for Transport Duty Officer should be contacted with the consent of the Regional Operations Manager or Duty Operations Manager. Contact details for can be obtained from the RCC under the supervision of the RCC Team Manager. The Duty Officer will have available to them contact numbers of divisional managers in Legal Group including Head of Employment and Corporate Service Division, Legal.
8. If in the unlikely event a member of staff is arrested, staff should in the first instance seek advice from the Duty Solicitor.

Aide Memoire for Traffic Officers and Traffic Officer Managers

An aide memoire has been devised for Traffic Officers and their Managers to use as a quick but comprehensive guide to what procedures to follow when an incident occurs on the network, including counselling and a checklist. The Aide Memoires can be found at Annex 6.

4.3.2 Basic RDI advice for asset delivery teams:

Asset delivery team staff may be requested by the Police, third party solicitors and/or other Agencies associated with the RDI process to provide a statement or information in relation to an incident that has occurred on the network. This guidance is for all occasions when in connection with official duties; a claim is made upon or proceedings are taken against;

- any request is received, in connection with legal proceedings, to make a statement, produce a document or give evidence;
- any document in court proceedings, including a witness summons, is served;
- involvement in or becoming aware of any incident which may constitute a criminal offence or give rise to civil legal proceedings

In all incidences staff must refer to Chapter 6 in the Staff Handbook. The main guidance however is listed below:

1. It is the responsibility of all staff to immediately or as soon as is practicable to do so, report to their line manager or when the line manager is a PB5 or below it is essential a PB6 or above is also informed. For avoidance of doubt the more senior manager (PB6 or above) will assume overall responsibility for the request and any associated support that may be required. **No information or statement should be given at this stage.**
2. The manager must try to establish if there is any legal basis for the request and confirm the source.
3. Where it is apparent that potential proceedings could be brought against the Agency or an employee, or where a previous request has lead to legal

proceedings, the manager **must** contact HR immediately or as soon as practicable before responding to the request.

4. The manager should then consider carefully how best to provide the information being requested.
5. HRS must remain fully informed on proceedings.
6. HRS will in return provide support to the manager and staff as appropriate, this may include liaising with the Department's legal advisors.
7. If in the unlikely event a member of staff is arrested the manager must inform the HR and Divisional Director immediately.
8. If in the unlikely event a member of staff is arrested, staff should in the first instance seek advice from the Duty Solicitor.
9. The Agency will in general provide legal support to a member of staff where in the course of their employment legal proceedings are brought against them. This support will be subject to conditions (eg there is not a conflict of interest between them and the Agency.- where conflict does occur it is at the Agency's discretion as to whether it provides legal representation).

4.3.3 Media – Highways Agency duty press officer

In the event that media advice is required at any point, the number for the Agency's Duty Press Officer is 020 7081 7443.

4.4 Counselling Services

As set out within the Personal Incident debriefing in the Service Provider Contingency Plan (AMM 86/07):

“If any member of staff from the Agency or Service provider requires a personal incident debriefing for stress or trauma reasons, then they should contact their line manager or confidential counselling services supplied by their employer”.²²

For Traffic Officers the provision of counselling services is set out in providing initial, middle and final stage support under the trauma process²³.

The Agency has an Employee Assistance Programme (EAP) in place which can be contacted 24/7. The EAP is provided by Workplace Options (formerly Employee Advisory Resource Services).

²² See 12.2 of Annex C in AMM 86/07 – Service Provider Contingency Plan Model Document.

²³ See [Trauma Process](#) flow diagram in the Traffic Officer Manual.

http://portal/portal/server.pt?open=space&name=CommunityPage&id=13&psname=Opener&psid=0&cached=true&in_hi_userid=17507&control=SetCommunity&PageID=0&CommunityID=747&WG_link=http://rp_po_weboprod/minisite/hawww/dreamwww/TO/processes/Manage_Traffic_On_The_Network/./APTR/trauma/index.htm

The EAP is a completely **free of charge, confidential service** provided by the Agency for its employees and includes:

- **Available 24 hours a day, 7 days a week, 365 days a year.** At any time of the day or night, at weekends and over bank holidays, staff are able to speak with one of EAP's professional advisors.
- **Unlimited support.** EAP can be used as often as required.
- **Confidential.** Although the Agency receives utilisation statistics on the number of people using the EAP service and the types of issues raised, no personal, identifying information is disclosed. The EAP usage reports to the Agency are strictly depersonalised / anonymous in accordance with the Data Protection Act 1998.
- **Independent, impartial source of support.**

Legal matters to do with the RDI should not go through EAP, but follow the legal process at section 4.1.

The EAP confidential service can be accessed either by telephone (0800 243458) or e-mail assistance@workplaceoptions.com.

EAP access for Agency regional office staff

Regional Office (ie non-Traffic Officer Service) staff need to state the organisation name and Directorate.

EAP access for Traffic Officer staff

Traffic Officer staff need to state the name of the organisation, Traffic Officer Service and RCC region.

PLEASE NOTE: No personal details are required to use the EAP service and any questions regarding the service should be directed through the respective HR Business Partner.

GLOSSARY

ACPO	Association of Chief Police Officers
AM	Asset Manager
CPS	Crown Prosecution Service
DBFO	Design, Build, Finance and Operate
DfT	Department for Transport
DPP	Director of Public Prosecutions
EAP	Employee Assistance Programme
ESL	Emergency Services Liaison Team (Highways Agency)
HR	Human resources
HSE	Health and Safety Executive
HSWA	Health and Safety at Work Act (1974)
LM	Line Manager
MA	Managing Agent
MAC	Managing Agent Contract
Met office	Meteorological office
NCC	Network control centre
NDD	Network delivery and development
NetServ	Network services
NPIA	National Policing Improvement Agency
NTIS	National traffic information services
PSA	Public Service Agreement
RCC	Regional control centre
RDI	Road death investigation
RDIM	Road death investigation manual
SGC	Sentencing guidelines council
SIO	Senior investigating officer
SoS	Secretary of state
SP	Service provider
TMC	Term Maintenance Contractor
TO	Traffic Officer
TOS	Traffic Officer service
TRL	Transport Research Laboratory
VMS	Variable messaging sign
VOSA	Vehicle and Operator Services Agency

REFERENCES

Area Management Memo No. 86/07 (Highways Agency) – Service Provider
Contingency Planning Template and Guidance

Highways Agency NW - Road Death Collision/Coroners Courts Interim Guidance on
Submitting Expert Reports and Witness Statements
(<http://share/Share/livelink.exe/overview/11423251>)

Police RDIM Advice Note (Highways Agency ESL team)

Road Death Investigation Manual 2007

The CPS: Corporate manslaughter (information page)

The Coroners (Amendment) Rules (S.I. 2008/1652)

The Coroners (Amendment) Rules (S.I. 1999/3325)

The Corporate Manslaughter and Corporate Homicide Act 2007 (c. 19)

The Coroners Rules (S.I.1984/552)

The Network Management Manual Part 7a

When Sudden Death Occurs: Coroners & Inquests (2002), Home Office Leaflet

ANNEXES

Annexes 1 - 4: Documentation required by the police - example scenarios.

Annexes 1-3 relate to potential road fatality scenarios and detail the different examples of documentation that could be requested as evidence by the Police in their investigation. Annex 4 gives brief information headings of what should be included in a short report after an on-site assessment. These annexes are based on material from the Police Road Death Investigation Manual and have been adapted to cover Agency documentation.

Annex 1 – New surface, structure and/or road furniture

A new road surface, structure or 'furniture' installation is considered to have possibly contributed to the fatality.

Annex 2 – Road profile

A fatality occurs on a section of carriageway and the profile of the road, eg bend in the road, potential camber or grade separated junction, might be considered a contributing factor.

Annex 3 – Winter maintenance

A vehicle has skidded on frost or ice and the condition of the road needs to be checked.

Annex 3.1 – Winter Maintenance (Police Employed Contractor)

In certain cases the Police may wish to employ an external contractor to assist with the investigation. The material contained in this annex covers what a Police-employed Contractor could request.

Annex 4 – Short Report Template

Please note:

1. These lists are not conclusive, but are intended to give a general idea to the potential wealth of information the Agency might have to provide.
- 2 Unless stated by the Police, all the documents that could be requested are ones that were current at the time of the fatality.
3. The investigation will be in-depth and not just concerned with finding out what happened at the time of the collision, but the relevant period leading up to it. As such, the Police will want to know about the development of relevant Agency policies which could have had an effect upon the collision, how the Agency decides the priority of work, as well as the work itself and actions taken, and assess their effect on the collision.

Annex 5: Ministry of Justice's Sentencing Guidance Council - Corporate Manslaughter Act Sentencing Guidelines

Annex 6: Aide Memoires for Traffic Officers and Traffic Officer Managers including checklists

ANNEX 1 – NEW SURFACE, STRUCTURE AND/OR ROAD FURNITURE

In this scenario a fatality occurs on a stretch of road at a bridge. It is suspected that one of the following may have contributed:

1. the road surface (this could be a stretch of new road or existing road that has been repaired recently);
2. the bridge;
3. the safety barrier; and/or
4. any mounted signage or equipment, eg safety cameras, VMS, etc.

As a result, the Police may ask for some or all of the following documents for their investigation:

- reason/s for works - is it a trial site, part of the business plan or emergency works?
- Initial design - design plans.
- Scheme background - Priority of the scheme and inclusion on the works programme.

Other information required here could be a full list of the works programme, copies of minutes of asset delivery/DBFO meetings with Agents to decide/approve works programme, and criteria for prioritising sites.

- Contractor and equipment details.
- Supervisory details - who was working at the time, what was the management chain and who occupied those roles. Contactability as well.
- Tender documents/Works Specification - includes materials used, specification adopted (national or local), layer thicknesses, quality of materials (any national/international standards), etc.
- Work log - detailing any problems experienced during the works and/or deviations from specification, eg substitute materials for non-availability of original material.
- Works Orders.
- Preparation works - Details of work at the location. Can include patching, haunching, deep-recycling, laying of services.
- Special/Site Specific information - any communication given from the Agency to the Contractor regarding methods/equipment to be adopted, operational restrictions, timings of works, laying seasons for certain materials, etc.

- Date/s of laying for road surfaces/concrete safety barriers - extent of “rips” if laid on more than one day.
- Any additional/ad hoc notes made during the works by the Contractor or Supervisor.
- Weather conditions - details of weather conditions during the works and any effect they may have had, eg delays to work or work having to be redone.
- Monitoring/Performance checks - includes delivery and rolling temperatures, nuclear density meter checks, grading and binder content laboratory checks, rates of spread of pre-coated chippings, layer thicknesses, sand patch or texture depth measurements, surface regularity checks.
- Media material - Photographs or video footage taken at the site prior, during or after the works.
- Complaints Log - details of any complaints from any of our customers during the works or regarding the quality of the job done following the works.
- Complaints and Correspondence received from any of our internal/external customers relating to:
 - the condition of the road,
 - number of accidents,
 - number of near misses,
 - suitability of the route and driver perception at location,
 - requests for reduction in speed limit, vehicle restrictions, carriageway re-profiling, installation of noise barriers, and/or
 - incidences of surface contamination, eg chemical leaks, lorries shedding liquid loads, etc.
- Any liaison or dialogue between the client and the contractor concerning the “quality” of the repairs, non-conformance and ongoing maintenance.
- Copy of our Inspection Manual at the time.
- Last 3 years of routine/special inspections records for the location, prior to the accident and 1 year after the accident.

This should also cover the time since the last repairs.

- Modifications/Remedial/Maintenance works - Details of any Statutory Undertaker works, repairs to defects, etc.
- Performance checks - Details of any checks/tests done following completion of repairs and any checks/tests that occurred before the accident.
- Road markings/Signage provision - Details of the site at the time of the accident. Had the road markings and/or signs improved, enhanced or updated, or reduced/remove at the time.

- Personal Injury Accident Location and Route Record - This is any documentation/statistics relating to fatalities/accidents at the specific location and for the route in question.

Please note that with this request, the Police will want the last 10 years prior to the accident and the period after it. Also, if available, any records relating to damage-only accidents.

- Met Office data on weather conditions at the time of the accident. If the accident is considered weather related then drainage maintenance and adverse weather response plans will be required.
- Adverse weather related problems - periods of extreme temperature have caused the road surface to fatten up.
- Surface contamination - Details of any surface contaminate found at the time/location of the accident. This includes exact location, extent and any prior knowledge of contaminates at the site.
- Routine/Special skidding resistance measurements/test - details of the results undertaken by us at the location in the 3 year period prior to the repair works, the period between the repair work and the accident and any subsequent actions, eg erection of information warning signs, further remedial work.
- Investigation data relating to ANY previous accidents at the site. It should include the results of any tests done and any remedial action taken.
- Surface water records - is the location prone to flooding/ponding?
- Traffic count and speed data for the site.
- Contact/liaison correspondence with local authorities regarding their experiences with the use/performance of the materials used.

ANNEX 2 – ROAD PROFILE

In this scenario a fatality occurs on a stretch of road and on investigation it is suspected that one of the following may have contributed:

1. the bend/s in the road;
2. adverse camber; and/or
3. the profile of the junction.

As a result, the Police may ask for some or all of the following documents for their investigation:

- National Codes of Practice for Highway Maintenance, Traffic Sign, Road Markings that were in effect at the time of the accident.
- Copy of maintenance plan. If the following details are not in the maintenance plan, then they may have to be provided:
 - Inspection frequencies,
 - Verge maintenance/rutting,
 - Sign maintenance,
 - Rural grass cutting.

The information should include relevant details relating to the plan's development and approval.

- Highways Agency policy and guidance concerning:
 - Advance bend warning signs,
 - Chevrons,
 - Edge line markings,
 - Reflective road studs,
 - Kerbing.
- Inspection manual. This should contain inspection methodology, definition of defects to be detected during routine inspections and guidance on the prioritisation of defects.
- Routine/Special inspection records. Last 3 years prior to the accident and 1 year post accident at the location of the accident.
- Original design details of the road/junction. Any modifications to the alignment or crossfall made at any time to the accident.
- Personal Injury Accident Location and Route Record -> This is any documentation/statistics relating to fatalities/accidents at the specific location and for the route in question.

- Full records of **ANY** maintenance/safety engineering works at the site done prior to the accident, eg resurfacing, installation of signs.

Any records should include works orders from the Agency to works units/contractor (and confirmation of receipt); any additional/ad hoc notes made during the works; works supervisor logs; works record sheets; and details of monitoring/performance checks done on the works, etc.

- Full details of any remedial maintenance/safety engineering works done at the location after the accident. This includes the installation/provision of any additional road markings, road signs, street lights, etc.
- Details of road markings/signage provision, etc at “*similar*” bends on the route or in the locality.
- Traffic count and speed data for the site.
- Surface contamination -> Details of any surface contaminate found at the time/location of the accident. This includes exact location, extent and any prior knowledge of contaminates at the site.
- Routine/Special skidding resistance measurements/test -> details of the results undertaken by us at the location in the 3 year period prior to the repair works, the period between the repair work and the accident and any subsequent actions, eg erection of information warning signs, further remedial work.
- Complaints and Correspondence received from any of our internal/external customers relating to:
 - Condition of the road at the location.
 - Number of accidents.
 - Number of near misses.
 - Suitability of the route/perception of the severity of the bend.
 - Poor edge delineation in poor visibility and/or dark conditions.
 - Requests for speed limit reduction, vehicle restrictions, bend re-alignment, reprofiling.
 - Surface contamination.
- Met Office data on weather conditions at the time of the accident. If the accident is considered weather related then drainage maintenance and adverse weather response plans will be required.

ANNEX 3 – WINTER MAINTENANCE SCENARIO

In this scenario a fatality occurs on a stretch of road and on investigation it is suspected that one of the following may have contributed:

1. surface not cleared appropriately or not at all;
2. problem with the drainage; and/or
3. inappropriate or lack of winter maintenance response.

As a result, the Police may ask for some or all of the following documents for their investigation¹:

- Generic Agency Winter Maintenance Policy/Plan.
- Winter maintenance plan for the relevant period. This should include all relevant details including its development and approval (eg minutes of meetings).
- Winter maintenance salting routes -> information required would be any document relating to the development/decision and issue of final routes.
- Staff training -> City and Guilds certificates showing staff training in areas such as driving and decision making (as appropriate).
- Specification of salt ordered, including results of quality assurance checks.
- Weather Forecast Provider (Name of Company and Contact details).
- Record and details of weather forecasts received.
- Weather Station. Type of weather station and Certificate of Conformity.
- Details regarding climatic domains within the accident area and the provision, siting and maintenance of automatic weather stations.
- Thermal mapping.
- Ice detection system data.
- Drainage design (as built drawings) and maintenance details, if the accident is ice related.
- Listings and maintenance records for salting vehicle fleet.
- Instructions from the Agency to service provider (and confirmation of receipt).

¹ Much of the information listed in Annex 3 can be freely obtained by registered users of the Agency's weather information service (HAWIS) website or the winter reporting system (WRF1) website. For access to HAWIS, please visit <https://hawcs.dft.gov.uk> or for WRF1, please visit <http://winter.atkinsglobal.com/winter>. Further assistance can be sought from the Agency's National Winter and Severe Weather team.

- Any additional/ad hoc notes made by the Agency and/or service provider regarding salting decisions.
- Works supervisor logs and works record sheets from the Agency and service provider.
- Tachograph records from the salting vehicle.
- Data logger/black box information if available.
- Calibration records of salt spreading equipment.
- Staff rotas. Including changeovers, decision makers, supervisors, drivers, etc).
- Monitoring/performance checks made.
- Collision reports for the last 6 years at the site.
- Collision reports in the surrounding authority area in the 24 hours prior to the accident.
- Records of liaison with Emergency Services and the general public, etc around the time of the accident, relating to adverse conditions at the location.
- Records of all media coverage and advice given at the start of the winter maintenance season as to provision of winter maintenance services across the network.
- Records of liaison with adjoining authorities/bodies regarding winter maintenance decision making.

ANNEX 3.1 – WINTER MAINTENANCE (Police Employed Contractor Requirements)

The list of documents below is an example list of the types of questions and documents (including time period) that a Contractor employed by the Police could request from the Agency and its Service providers.

Under the area of gritting, the contractor would be looking at 5 points, these being: the salt; the vehicles; the gritting routes; reporting and staff rotas/qualifications.

INSPECTIONS

- Details of daily safety inspection patrol logs (previous 7 days to the collision).
- Details of weekly safety inspection patrol logs (last 12 months).
- Details of repairs made to the carriageway or furniture (barrier or fence damage) since the date of initial construction.
- Copy of data from traffic loops in the carriageway (raw data in minute slots from a specific time period defined by the Contractor).
- Reasons for any repairs at the collision location, and time that they were identified and completed.

DECISION PROCESS

- Details of decision making practice (statement).
- Details of factors that affect the decision.
- Details of parameters set within the process.
- Decision records.
- Frequency of review of decisions and factors affecting frequency.
- 'Traffic Light' status – record of policy.
- Any agreements with the weather forecaster re: notification of changing conditions.

WEATHER

- Contact details (name and address) of weather forecast provider.
- Details of contract with the forecaster.
- Details of Service Level Agreement made with the forecast provider and any updates.
- Copy of communication logs (provider).
- Copy of communication logs (customer) including notification of gritting actions to the forecast provider.
- Copy of telephone account (person obtaining forecast or updates), ie itemised bill.
- Complete copy of records forecast provided for previous 7 days (including transmission method and any updates).
- How many weather stations does the service provider have access to and how are many are used in relation to the collision site?
- Geographical location and type of weather stations.
- Timings of forecasts.
- Notification of weather updates. What is the communication method from forecast provider to the Agency.
- Are site specific graphs available.
- What data is used to provide the forecast (information required from provider).
- Copy of graphs from ice detection sites (7 days prior to collision).

GRITTING

SALT

- Salt sample (10mm sample from the store).
- Detail on how the salt is stored (including photo of stockpile).
- Origin of the salt (a copy of the sales invoice).
- How is the salt loaded?
- Copy of contract with the salt provider.

VEHICLES

- Calibration certificates for the gritting fleet.
- Service records for the gritting fleet (fitter maintenance record).
- Service record for gritting equipment.
- How are maintenance checks conducted?
- What are the servicing intervals?
- Check of vehicle systems, eg warning devices.
- Do the drivers know when to change settings?
- Installation and functionality of tacographs.
- What is the salt holding capacity of the vehicle?
- Are the gritters belt driven?
- What is the number of salt sensors on the vehicle?
- What is the cleaning rota for the vehicle?

ROUTES

- Gritting routes.
- How many gritting vehicles patrol the route in question?
- Are gritting vehicles set up for a specific route?
- The lane position of the gritting vehicle.
- Are route cards kept in each cab?
- Gritting action sheets for the 7 days prior to the collision and salting tickets.
- Gritting logs.
- Information provided to the driver/operator.
- Spread rate quantity. Do the drivers know how much to spread?

REPORTING

- Method of reporting any faults on the run.
- Method for recording the run and settings.
- How is the salt usage monitored?

STAFF

- Staff rota.
- Staff training records and qualifications.
- Qualifications of the decision maker.

ANNEX 4 – INFORMATION REQUIRED IN A BASIC FACTS REPORT

General information

- Location of accident – marked on a map – marker posts? – must be agreed with Police.
- Time and date of accident.
- Number and type of vehicles involved.
- Number of casualties.
- Initial understanding of what happened.
- Weather conditions.
- Photographs of site.
- Photographs of approach to the site.
- Damage to infrastructure (photographs if necessary).
- Retention of damaged components (Police or agent).

Road surface

- Is road wet/dry/icy?
- Had the road been gritted/salted (if appropriate)
- Is there any surface water?
- Type and condition of drainage.
- Type of surfacing.
- Condition of road lining?

Aids to movement and safety

- Road Signs. Inventory of signage in the vicinity of the incident:
 - Location of Matrix/VMS signs, and
 - Messages Displayed.
- White line provisions.
- Reflective studs (cats eyes?)
- Lighting – is it switched on?
- Road markings.
- Any defects of the above?

Containment – safety fences, guardrails & barriers

- Type and condition.
- Any damage or defects?

Visibility at junctions and bends

- Is visibility at junction good/poor?
- Is the vegetation appropriately maintained?

Road works and street works

- Systems of traffic management in place eg signing, lighting and safety barriers.
- Take photographic evidence if necessary.

ANNEX 5 – Corporate Manslaughter & Health and Safety Offences Causing Death

Below is a pdf version of the above guidance from the Ministry of Justice's Sentencing Guidelines Council on Corporate Manslaughter as mentioned in the RDI guidance.



Sentencing Guidelines Council

Corporate Manslaughter & Health and Safety Offences Causing Death

Definitive Guideline

http://sentencingcouncil.judiciary.gov.uk/docs/web_guideline_on_corporate_manslaughter_accessible.pdf

ANNEX 6 – Aide Memoires for Traffic Officers and Traffic Officer managers including checklists

CORONERS COURT – A BASIC GUIDE FOR TRAFFIC OFFICERS

Actions prior to Officer attending Coroners Court

Welfare

Managers should in the first instance ensure that all staff that has attended any incident resulting in serious injury or fatality is offered trauma diffusion. If you require further support the details of the Employee Advisory Programme are: - telephone number 0800 243458 or e-mail assistance@workplaceoptions.com. It is good practice for the duty manager to arrange a welfare call with you, at a time agreed by both parties. This is to confirm you have arrived home safely and ensure you are still okay.

Incident De-Brief

A hot de-brief should be carried out by the duty manager with you on an individual basis, so as to avoid any chance of coercion and also to ensure the integrity of the information. This should be carried out in a way that suits your individual needs and if at any stage you feel uncomfortable or upset, ask to take a break. If after a break you still feel uncomfortable by the manner in which the manager is conducting the debrief; inform him/her immediately. The manager should then adapt their style of questioning to suit your individual needs. The manager should flag up and follow up any issues that are identified, ie stakeholder, partners, communications, etc. Once you have read and agreed the debrief, you and the manager should sign and date the document. Only sign a document if you agree with the content. The manager should then store the document in a secure location and referred to at a later date if required.

Pocket Note Book (PNB)

At the start of every shift you should enter the day and date in your pocket book. An entry should be made to state which Outstation you are working out of that day, time on duty, patrol call sign and vehicle registration. All entries are to be made in pen and any incorrect entries are to be crossed out with a single line. Correction fluid is not to be used. Pages are not to be removed from your pocket book. All blank spaces within the entry need to be struck through with a single line. All entries are to be referenced by time, date, incident log number and location. The time of observation and entry are to be recorded. Your PNB should be updated as soon as is practicably possible after the time of the observation and signed by the manager on duty.

Police Statements

The relevant Police force may wish to take a formal statement from you. The police will normally ask to come to your Outstation or ask you to visit the police station, but will try to meet your needs.

The police realise that talking about what has been witnessed can be a difficult experience. If you find making a statement distressing, you can ask for a break at any time.

Managers should support you if you are required to give a formal police statement and are apprehensive about doing so. In addition, ensure that a suitable time is chosen to attend and give a statement ie the next day if after a night shift or during shift time.

Once the statement has been written, the police officer will ask you to read through it to check that it is correct. If you prefer, you can ask the police officer to read your statement to you.

You will be asked to sign the statement to say that it is an accurate account of what you did and/or what you think happened. If something is not correct, you must tell the police officer so it can be changed. It is very important to do this, even if you feel nervous about doing it, as it could affect the investigation. A formal statement given to the Police cannot be changed at a later date once agreed, so it is imperative that the information you give is correct and complete. You can request that the statement be added to at a later date if you feel that full information was not taken at the time. The Police Officer in question will review your request and provide a rationale for a yes or no response to this request.

It is imperative that you do not discuss your statement with anyone in the interim, as this could be seen as collusion. It is also important to note that any additions to your original statement/s can be challenged within the Court proceedings.

Although it is not an obligatory requirement that a statement be made, it is in your best interest to make a statement. This will ensure that the evidence given is fresh and therefore more likely to be accurate. Also there should be no reason why anyone would want to refuse to give a formal statement as this may be seen as you have something to hide.

A witness statement is different from a statement given by a suspect. If you are required to give a statement as a suspect, the Police will inform you and also caution you beforehand. You should inform your of any witness statements that you have given and also those given under caution.

It is very difficult to predict when managing incidents if a Coroner's inquest will follow, so it is advisable that you make a formal police statement if requested.

Some Coroner's may not permit the use of PNBs, however, this is unusual and as long as permission is gained prior to referring to a PNB there should be no problem.

Interim Period

There may be periods of inactivity between the incident and giving evidence, hence the reason for the hot de-briefs to be carried out and PNB updated as soon as is practicable to avoid any important details being forgotten. It is reasonable for you or your manager to ask the relevant Police force for any updates if there are long periods of inactivity.

Should you be notified that you are required to attend Coroner's Court, you are encouraged to arrange attendance at a Coroner's Court inquest prior to your date. If possible, attendance at an inquest which involves a road related incident would be most suitable. You are encouraged to enquire if a guide or information service is available for the Coroner's Court you will be attending, to allow you to digest what the process is likely to entail.

Additional Support

Your manager should offer you support throughout the process. If you feel this is not being done, then you should ask for support. Any assistance you request should be treated as strictly confidential.

You should ask for and be given time to research the Coroners Court you are to attend, with a view to raising your awareness of what to expect and what will be required of you at Court. You should be given the opportunity to attend a Coroner's Inquest, prior to giving evidence. If it would be of benefit for you to be accompanied then you should make this request. Details of the Court Clerk should be obtained and utilised as most are extremely helpful and

willing to assist where they can. In addition the Coroners' Court Support Service (CCSS) can be a great help to anyone that is attending coroner's court for the first time. The CCSS can be contacted on telephone number 0207 802 4763.

The Employee Assistance Programme (EAP) is also available to offer support. The EAP is a programme that offers practical information, advice and counselling.

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A guide to giving evidence has been produced by the Highways Agency and you should request this is made available to you. This guide explains what your role will be in Court eg what you should be commenting on, ensuring you keep to facts and not make personal opinions, assumptions and/or comments.

A register is to be compiled within regions with details of those who have attended Coroner's Court. It should indicate on the register those who would be willing to offer a support network which could be utilised for advice and offer guidance to those in the future who find themselves in similar situations.

Actions after Officer has attended Coroners Court

Going to Court can be a stressful and traumatic experience for many people. The stress that is often felt can be compounded if the Court does not give the result that was hoped for. It is imperative that you continue to receive support from your manager throughout the whole period and after your attendance at Court, until such time you feel support is no longer required.

Useful Contacts

- Employee Advisory Program - 0800 243458 or e-mail assistance@workplaceoptions.com
- Coroner's Court Support Service - 0207 802 4763

TRAFFIC OFFICER CHECKLIST	COMPLETED	COMPLETED	COMPLETED
	YES	NO	NOT REQUIRED
On Day of Incident			
Check PNB			
De-brief			
Trauma Diffusion			
Police Statement			
Employee Advisory Program details			
Manager conducted welfare check			
Other			
Interim Period	COMPLETED	COMPLETED	COMPLETED
	YES	NO	NOT REQUIRED
Court Letter Received			
Court Location Known			
Visit Coroners Court prior to attendance			
Coroners Court Support Service details			
Support/advice requested before inquest			
From Manager			
Employee Advisory Program			
Coroners Court Support Service details known			
Other			
Coroners Court Inquest	COMPLETED	COMPLETED	COMPLETED
	YES	NO	NOT REQUIRED
Support/advice requested for inquest			
From Manager			
From Colleague			
Other			

CORONERS COURT – A BASIC GUIDE FOR MANAGERS

Actions Prior to Officer Attending Coroners Court

Officer's Welfare

Managers should in the first instance ensure that Officer/s who attended an incident resulting in serious injury or fatality, are offered trauma diffusion. Officers should also be given details of the Employee Advisory Programme telephone number 0800 243458 or e-mail assistance@workplaceoptions.com. It is also good practice to check on the Officer/s welfare once they have left work ie will someone be at home, etc. If the Officer/s lives alone, the manager should agree a time that they can contact them to ensure they have arrived home safely and that they are okay.

Incident De-Brief

A hot de-brief should be carried out with the Officer/s involved in the incident on an individual basis, so as to avoid any chance of coercion and also to ensure the integrity of the information. Again, the Officer's welfare should be taken into consideration and the Manager should adapt their style of questioning to suit the Officers individual needs. If any issues are identified, ie stakeholder, partners, communications, etc. these should be flagged up and followed up in the usual way. All learning points should be recorded and discussed at the cold de-briefs to ensure best practice. The aforementioned de-briefs should be signed by the Officer/s and the Line Manager as an accurate reflection of what has been discussed. The document should then be stored in a secure location and referred to at a later date if required.

Pocket Note Book (PNB)

At the start of every shift the TO should enter the day and date in their pocket book. An entry should be made to state which Outstation they are working out of that day, time on duty, patrol call sign and vehicle registration. All entries are to be made in pen and any incorrect entries are to be crossed out with a single line. Correction fluid is not to be used. Pages are not to be removed from the pocket book. All blank spaces within the entry will be struck through with a single line. All entries are to be referenced by time, date, incident log number and location. The time of observation and entry are to be recorded. The Officer/s PNB should be updated as soon as is practicably possible after the time of the observation and signed by the manager on duty.

Police Statements

The relevant Police force may wish to take a formal statement from the Officer/s involved in the incident. The police will normally ask to come to the Officers Outstation or ask the Officer/s to visit the police station, but will try to meet their needs.

The police realise that talking about what has been witnessed can be a difficult experience. If the Officer/s finds making a statement distressing, they can ask for a break at any time.

Managers should support staff that are required to give formal police statements and are apprehensive about doing so. In addition, ensure that a suitable time is chosen to attend and give statements ie the next day if after a night shift or during shift time.

Once the statement has been written, the police officer will ask the Officer/s to read through it to check that it is correct. If the Officer/s prefer they can ask the police officer to read their statement to them.

The Officer/s will be asked to sign the statement to say that it is an accurate account of what they did and/or what they think happened. If something is not correct, they must tell the police officer so it can be changed. It is very important to do this, even if they feel nervous about doing it, as it could affect the investigation. A formal statement given to the Police cannot be changed at a later date once agreed, so it is imperative that the information is correct and complete. The Officer/s can request that the statement be added to at a later date if they feel that full information was not taken at the time. The Police Officer in question will review the request and provide a rationale for a yes or no response to this request.

It is imperative that the Officer/s do not discuss their statements in the interim, as this could be seen as collusion. It is also important to note that any additions to the original statement/s can be challenged within the Court proceedings.

Although it is not an obligatory requirement that a statement be made, you should encourage the Officer/s to make a statement. This will ensure that the evidence given is fresh and therefore more likely to be accurate and also there should be no reason why anyone would want to refuse to give a formal statement.

A witness statement is different from a statement given by a suspect. If the Officer/s is required to give a statement as a suspect, the Police will inform them and also caution them beforehand. As a manager you should be made aware of any witness statements that have been given and also those given under caution.

It is very difficult to predict when managing incidents if a Coroner's inquest will follow, so it is advisable that all managers encourage their Officer/s to make a formal police statement if requested.

Some Coroner's may not permit the use of PNBs, however, this is unusual and as long as permission is gained prior to referring to a PNB there should be no problem.

Interim Period

There may be periods of inactivity between the incidents and giving evidence, hence the reason for the hot de-briefs to be carried out and PNB updated as soon as is practicable to avoid any important details being forgotten. It is reasonable for you or the Officer/s to ask the relevant Police force for any updates if there are long periods of inactivity.

Where Officers are notified they are required to attend Coroner's Court, they should be encouraged to attend a Coroner's Court inquest prior to their date. If possible, attendance at an inquest which involves a road related incident would be most suitable. All staff required at Court, should be encouraged to enquire if a guide or information service is available for the Coroner's Court they will be attending, to allow them to digest what the process is likely to entail.

Additional Support

Managers should understand that Officers attending Coroner's Court will have different needs which may require differing levels of support. However, it is better to assume a high level of support will be required, than not offer enough. Any assistance that is requested by the Officer/s should be treated as strictly confidential.

Officers should be given time to research the Coroners Court to be attended, with a view to raising their awareness of what to expect and what will be required of them at Court.

Officer/s should be given the opportunity to attend a Coroner's Inquest, prior to giving evidence. If it would be of benefit to the Officer/s concerned, they should be accompanied to offer additional support. Details of the Court Clerk should be obtained and utilised as most are extremely helpful and willing to assist where they can. In addition the Coroners' Court Support Service (CCSS) can be a great help to anyone that is attending coroner's court for the first time. The CCSS can be contacted on telephone number 0207 802 4763.

Managers should also assist their Officers in securing agency legal representation (if necessary eg suspect).

The Employee Assistance Programme (EAP) is also available to offer support. The EAP is a programme that offers practical information, advice and counselling.

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A guide to giving evidence has been produced by the Highways Agency and this should be made available to those individuals attending Court. This guide explains what their role will be in Court e.g. what they should be commenting on, ensuring they keep to facts and not make personal opinions, assumptions and/or comments.

A register is to be compiled within regions with details of those who have attended Coroner's Court. It should indicate on the register those who would be willing to offer a support network which could be utilised for advice and offer guidance to those in the future who find themselves in similar situations.

Actions after Officer has attended Coroners Court

Going to Court can be a stressful and traumatic experience for many people. The stress that is often felt can be compounded if the Court does not give the result that was hoped for. It is imperative that managers continue to support staff, throughout the whole period and after their attendance at Court, until such time support is no longer required.

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- Coroner's Court Support Service - 0207 802 4763

MANAGERS CHECK LIST	COMPLETED	COMPLETED	COMPLETED
	YES	NO	NOT REQUIRED
On Day of Incident			
Inform the Duty OM			
Check PNB			
Conduct Hot De-Brief			
Offer Trauma Diffusion			
Police Statement (Witness or Suspect)			
Employee Advisory Service details given			
Contact Officer at home to check on welfare same day			
Monitor Welfare			
Other			
Interim Period	COMPLETED	COMPLETED	COMPLETED
	YES	NO	NOT REQUIRED
Copy of Coroners Court Letter seen			
Officer attended Coroners Court prior to the inquest date			
Coroners Court Support Service details given			
Advice/support offered before inquest			
Monitor Welfare			
Secure Agency Legal Representation (if necessary e.g. suspect)			
Other			
Coroners Court Inquest	COMPLETED	COMPLETED	COMPLETED
	YES	NO	NOT REQUIRED
Advice/support offered after inquest			
Monitor Welfare			
Other			