ROAD DEATH

Owning Department: Specialist Crime and Capabilities Command

Department SPOC: Det Insp Serious Collision Investigation Unit (JMIT)

Risk Rating: Low

Legal Sign Off: 08.09.2023

JNCC: 05.06.2023

Published Date: 16.04.2025 (V3.1)

Review Date: 05.06.2027

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Legal Basis

Legislation specific to the subject of this policy document:

- Road Traffic Act 1988
- College of Policing APP – Investigating Road Death
- Charging (The Directors Guidance) – Sixth Addition
- Joint Emergency Services Interoperability Procedures
- Sudden Death in Children Protocols (Norfolk)

- Sudden Death in Children Protocols (Suffolk)
- Victims Code of Practice
- Forensic Regulation Standards ISO 17020
- NPCC (2018) Policing our Roads Together – 3 Year Strategy 2018 -2021
- Police and Criminal Evidence Act 1984
- Human Tissue Act 1984

Other relevant legislation which you must check this document against (required by law)

- Human Rights Act 1998 (in particular A.14 – Prohibition of discrimination)
- Equality Act 2010
- Crime and Disorder Act 1998
- Health and Safety at Work etc. Act 1974 and associated Regulations
- General Data Protection Regulation (GDPR) and Data Protection Act 2018
- Freedom of Information Act 2000
- The Civil Contingencies Act 2004

Other documentation which you must check this document against:

- College of Policing – Code of Ethics
- Norfolk and Suffolk Constabularies' Standards of Professional Behaviour
- College of Policing – Authorised Professional Practice

Other Relevant Documents

- Family Liaison Policy
- Vehicle Recovery and Examination Policy

1. Introduction

1.1 This policy aims to ensure Norfolk and Suffolk Constabularies professionally investigate all deaths on the roads.

Our responsibilities are to:

- Act on behalf of HM coroner and present evidence to enable the coroner to hold an inquest into the death.
- Provide the family and friends of the deceased with an explanation of what happened.
- Prepare a report for the Crown Prosecution Service (CPS), as appropriate and.
- Learn lessons which may assist in preventing further deaths or serious injuries.

2. Policy Aims

2.1 The aims of this policy are to:

- Have a standard way in which the Constabularies fully and compassionately investigates road deaths.
- Ensure that we personally inform the family about the death.
- Ensure a Family Liaison Officer is appointed at the earliest opportunity.
- Detail the responsibilities of all those involved in the investigation.
- Ensure we interview relevant witnesses, have continuity of evidence and examine, recover, seize, retain and dispose or release involved vehicles.
- Ensure all Coroner or CPS case files are submitted within reasonable timescales.
- Ensure we personally inform the family about the progress and result of the investigation and any decisions made by the Crown Prosecution service where practical to do so.
- Refer those involved to suitable organisations that can provide support.

3. Statement of Policy

3.1 This policy has been formally agreed via the approved policy development/review process. It will be maintained by the Specialist Crime and Capabilities Command in conjunction with the Central Policy Unit.

3.2 The policy is intended to promote equality, eliminate unlawful discrimination and actively promote good relations regardless of age, disability, gender reassignment, marriage or civil partnership, pregnancy and maternity, race, religion or belief, sex, sexual orientation, economic or family status.

3.3 Managers have a responsibility to ensure this policy is applied fairly, and unless otherwise stated, all policies and procedures are non-contractual.

4. Applicability

4.1 Unless otherwise stated, this policy applies to all police officers (including officers of the Special Constabulary) and all members of police staff (including police support volunteers).

5. Fatal or Potentially Fatal Collision

5.1 A fatal collision (FRTC) is one where any person has died as a result of injuries caused in a road traffic collision.

5.2 A '*recordable'* fatal collision is one where a person has died within 28 days of a road traffic collision and the collision is a cause of death.

5.3 A collision may be deemed to be potentially fatal if there is evidence from a senior medical practitioner or it appears there is an obvious and imminent likelihood of a casualty dying from their injuries. This decision can be made by any officer but must be ratified by a RAPT or SCIU supervisor as soon as practicable.

5.4 Any collision where a significant injury, including severe shock to a frail or other vulnerable person is caused, will initially be regarded as a potentially fatal collision. The casualty's age should be considered, but that in itself should not automatically result in a collision being identified as potentially fatal.

5.5 It may appear that a fatal collision is in fact a '*medical episode'*. Where it is clear this is the probable cause, a proportionate response can be considered. However if there are any doubts, the incident must be treated as a fatal or potentially fatal collision.

6. Constabulary Commitment

6.1 All road deaths will be investigated as unlawful killings (APP Roads Policing).

6.2 All locations of fatal or potentially fatal collisions will be treated as serious crime scenes.

6.3 The Lead Investigating Officer (RDLI) will notify the coroner of the death to allow an inquest to be opened. This will take place within one working day of the collision.

6.4 Any offences that are subject to statutory time limits (STL) will be identified and progressed with sufficient time to enable prosecution. Where it is likely that the investigation will exceed the STL the information must be laid before the court to allow future prosecution.

6.5 The investigation will provide a report to the coroner for inquest and provide updates to allow management of the coronial process.

6.6 Families, and those affected, will be updated and supported and offered the opportunity to speak to investigators to aid their understanding as to the reasons and causes of a collision.

7. Attendance

7.1 All fatal, and potentially fatal collisions will initially be notified to the duty Roads and Armed Policing Supervisor who must be, as a minimum, Lead Investigator trained.

7.2 The Lead investigator will assess the collision and categories using the College of Policing guidance:

Category A+	Assessed as likely homicide investigation or where complexity requires the deployment of a nationally registered SIO.
Category A	Confirmed fatality – one or more vehicles failed to stop and/or drivers decamped or other factors are present that significantly increase the complexity of the investigation.
Category B	Confirmed fatality – all drivers/riders are known or can be immediately identified.
Category C	Confirmed fatality – driver/rider only killed, no third party involvement – inquest only.
Category D	Confirmed fatality – driver/rider only killed, death due to natural causes, may involve a third party – no inquest necessary.

7.3 Once an assessment is made the deployment plan (as below) will be followed.

7.4 The deployment plan is the minimum standard to be achieved. Higher trained officers can attend where it is assessed there would be a benefit to the investigation.

7.5 The Senior Investigator on scene will retain the responsibility for any incident until a handover has taken place and an agreement on the transfer of responsibility for the investigation is made.

8. Deployment Plan

	Fatal Cat A+	Fatal Cat A	Fatal Other
Duty RAPT Sgt (RDLIO)	Yes (first response)	Yes (first response)	Yes (first response)
SCIU Investigator	Yes	Yes	Yes
SCIU LI	Yes	Yes	No (Unless requested)
SCIU DI	Yes	Yes	No (Advice on Request)
FCIU	Yes	Yes	Yes
CSI	Yes (Following consultation with SIO)	Yes (Following consultation with DI)	No, (Unless requested by LI)
JMIT SIO	Yes	No (PIP3 advice on request)	No (PIP3 advice on request)
Duty DI	Where deployment indicates SCIU DI is required but is not available (out of hours) the Force Duty DI will provide response/advice as per SCIU DI deployment line.		
Force Duty SIO	Where deployment plan indicates JMIT SIO is required but is not available (out of hours) the Force Duty SIO will provide response/advice as per the JMIT SIO deployment line		

9. Road Death Initial Response

9.1 Initial response to any fatal or potentially fatal collision must be overseen by a competent supervisor, trained as a Road Death Lead Investigator (RDLI).

9.2 RDLI's must have completed a relevant training qualification which must include assessment, continuing professional development and competence in the role.

9.3 Staff with the PIP 2 Detective qualification and additional management of serious and volume crime training or experience are considered to be relevantly trained to provide initial investigative advice and will support RDLI's where required.

9.4 Roads Policing Road Death Lead Investigator (RP RDLI) will:

- Attend the scene, secure it, open scene logs and assume overall control subject to JESIP principles and agreements.
- Assess the collision using the college of policing APP Collision categories and ensure the appropriate investigating officer is informed.
- Account for all injured or deceased parties.
- Establish a dedicated control vehicle / RVP and provide an early METHANE briefing.
- Request FCIU attendance via both Constabulary CCR's (FCIU staff use RF callsigns).
- Request on duty SCIU attendance via both Constabulary CCR's (SCIU staff use RE callsigns).
- Review the actions that have been taken before your arrival.
- Ensure enough resources are available to provide an effective investigation into the collision, preserve the scene, gather evidence, and maintain a secure and safe working environment.
- Request specialist resources such as CSI or Drone or Search Units to carry out their duties.
- Appoint an Exhibits Officer.
- Provide a briefing in compliance with forensic accreditation standards to any Crime Scene or Forensic Collision Investigators attending.
- Where any deceased is under the age of 18 years to inform the Force Safeguarding D/Insp or Duty D/Insp to manage SUDIC procedures.
- Ensure continuity is maintained in respect of any deceased persons.
- Initiate any Golden Hour and Fast Track actions, e.g., Scene searches, obtaining witness account, gathering evidence, identifying digital evidence, locating and arresting suspects;
- Ensure the victim's family is made aware of the death and appoint an FLC and FLO at the earliest opportunity.
- Maintain a decision/policy log.
- Where a person is a suspect in a criminal offence but is not arrested, conduct a person-based risk assessment to manage any risks of self-harm Appendix A: Serious or Fatal Collision - Suspect Risk Assessment.
- Ensure all witnesses are referred to on line resources for support see Appendix B
- Submit fatal notification form Appendix C
- Arrange for those staff involved in the initial response, including control staff, to be debriefed Appendix D
- Assess if any work-related management failures may have contributed to the collision and inform the Health and Safety Executive.

- Conduct a final scene walkthrough prior to re-opening the road to check for evidence, belongings of the deceased or suspect, items that may cause the public distress or damage to the road or infrastructure.
- Using a Current Situation Report which documents all enquiries completed to date, provide a handover to the SCIU RDLI.

10. Serious Collision Unit Lead Investigator (SCIU RDLI)

10.1 The SCIU RDLI will be lead investigator trained and will supervise the investigation of the road death following handover from a Road Policing RDLI.

10.2 Where the SCIU RDLI attends a collision scene they will work with the Roads Policing RDLI.

10.3 Additionally, the SCIU RDLI will:

- Arrange a handover either on scene or post collision with the attending RP RDLI.
- Review the collision category.
- Allocate a Road Death Investigating Officer (RDIO) and where required form an enquiry team.
- Update the Athena investigation and provide a detailed investigation plan with a review date.
- Brief the Family Liaison Coordinator and Family Liaison Officers. Key objectives should be agreed.
- Work with the Forensic Collision Investigator, working through the FCIU / SCIU Service Level Agreement.
- Notify, the coroner within 1 working day, of the death, the investigation type and the recommended Post-mortem type Appendix E
- Maintain a decision and enquiry log for all cases.
- The RDLI will be responsible for reviewing and setting the post custody investigation. Suspects released on bail or under investigation for extended periods should now be updated with the progress of the case every 30 days.
- Set a 14-day management review date.
- Add the case to the SCIU demand tracker.
- Consider if CPS early investigative advice is required.
- Ensure all staff meet their obligations under the Victims Code of Practice.
- Provide the RDIO with enough time and opportunity to complete the investigation.
- Complete regular meaningful reviews of the investigation every 20 days.
- Review cases within other departments providing guidance and advice.

10.4 Where a case meets the relevant tests for charging advice, the SCIU RDLI must;

- Quality assess the case file.
- Complete an evidential review of the case.
- Ensure disclosure obligations have been met.
- Ensure next of kin are informed at the point of submission of the case to CPS and the receipt of charging advice.
- Update press office in relation to any agreed charges.

10.5 Where an investigation is submitted to the coroner they must:

- Ensure a coroners officers report has been completed. Review the documents being sent to the coroner to ensure sufficient evidence is being provided for the coroner to inquire into the cause and circumstances of the death.
- Ensure any digital media has been redacted and sent to the coroner with appropriate warnings.
- Add any comments and recommendations to the coroner's officers report.
- Ensure the documents being served to the coroner are recorded on the Athena Investigation.
- In agreement by the coroner arrange a family meeting with relevant staff and coroners' officer to explain the evidence.
- Review the FLO objectives and arrange exit strategies, handing the family over to the coroners officer.
- Review and close the Athena Record.

11. Road Death Investigator (RDIO)

11.1 All staff involved with the investigation of Road death will either be PIP2 qualified or be working towards meeting this qualification and have completed the Road Death College of Policing Module.

11.2 All investigations will be recorded using ATHENA.

11.3 The case officer will be assigned by the SCIU RDLI, and will:

- Complete allocated actions and all reasonable lines of enquiry, recording investigative updates on the investigation log.
- Send the condolence letter to the next of kin Appendix F: Condolence Letter;
- Identify, Manage and search scenes
- Seize and examine evidence relating to the case and effectively manage seized property and exhibits.
- Trace, Identify and Interview relevant witnesses in a manner deemed best to record their evidence and agreeing a contract to provide timely updates.
- Collating and exploring information and intelligence from a range of sources including partner agencies.

- Work with expert witnesses and forensic professionals gathering and reviewing relevant reports.
- Work with The Coroners Service and family liaison professionals providing updates in adherence to VCOP.
- Identify, interview and manage suspects.
- Effectively manage STL issues and highlight any such matters to the LI at the earliest opportunity.
- Present case material and evidence to the Crown Prosecution Service and the Coroners Service.
- Manage the disclosure of material as per CPIA 1996 and Directors Guidance.
- Attend all criminal court hearings (unless otherwise authorised by the Lead Investigator).

12. Forensic Collision Investigators (FCI)

12.1 Forensic Collision Investigators are trained in methods and procedures to ensure the collection of the best evidence at road death scenes. All staff within the Forensic Collision Investigation Unit work towards, or in adherence to, ISO 17020 Forensic Quality standards.

12.2 Forensic Collision Investigators are employed by the Constabularies but are impartial and provide evidence as a recognised expert in the Courts.

12.3 FCI's must avoid information or exposure to evidence which may bias them towards a particular hypothesis, all briefings or information passed to the FCI's will be recorded.

12.4 All staff have a responsibility to assist in the compliance with forensic accreditation standards, this includes considering the information passed to an FCI and its impact in influencing the FCI's decisions and actions.

12.5 FCI's will:

- Identify the extent of the scene and in consultation with the RDLI adjust scene guards and road closures.
- Examine the collision scene and ensure that all evidence is captured according to SOPs.
- Provide expert advice to the RDLI regarding the forensic strategy.
- Seize and examine evidence in relation to the scene (where not seized by others).
- Consider if other specialist resources are required for matters outside the FCI capabilities (CSI, DVSA or other experts).
- Identify where external / other expert analysis is required.
- Provide any key updates to the lead investigator which may impact on the incident, risks or decision making.

- Examine and analyse all evidence that may assist with identifying not only what happened but also why.
- Provide unbiased and impartial opinion by means of a report, or other suitable means to the investigation and for use in criminal and coronial courts within the parameters of service level agreements.
- Participate in CPS pre and post charge meetings.
- Present evidence and give technical explanation(s) at any trial and at the inquest.
- Identify issues relating to road safety and liaise with relevant local and national highways departments to resolve.

13. Family Liaison Officers (FLO)

13.1 The joint Family Liaison policy should be consulted prior to the deployment of a Family Liaison Officer.

13.2 The primary purpose of a FLO is to be an investigator and to secure the confidence and trust of families of victims of murder or manslaughter, road fatality, mass disaster, rail fatality or another critical incident. A FLO's role is to gather evidence and information from the family, to contribute to the investigation and preserve its integrity. The FLO also provides support in a sensitive and compassionate manner, ensuring that family members are given timely information in accordance with the needs of the investigation, including timely referrals to relevant support agencies

13.3 The lead investigator in all Road Death incidents, where a FLO is appointed, will be known as the SIO or RDLI. The SIO RDLI will have overarching responsibility for the management of the FLO deployment

13.4 In relation to road fatalities, it is only necessary to deploy a single FLO to the next of kin, however the FLC will need to consider the most effective and appropriate FLO deployment to meet the needs of the family / families involved and the investigation. Consideration must be given for the deployment of additional FLO(s) for each identified family group.

13.5 Officers who are deployed as a FLO must have completed a relevant FLO course, which meets the requirements set out in the College of Policing National Policing Curriculum.

13.6 FLO's will:

- Complete an initial contract covering the contact frequency, method and contingencies for contact at short notice where the FLO may not be available.
- To provide a timely and documented two-way communication channel, between the family and police, which is fully recorded using the family liaison log. The log should be sent to the SIO / RDLI and FLC.
- To manage families' understanding and expectations with regards to the investigation, the criminal justice and / or H.M. Coronial processes.

- To gather evidence and information from the family in a sensitive manner which will contribute to, and preserve the integrity of, the police investigation.
- To provide timely and up-to-date information and practical support for the family throughout the investigation.
- To sensitively meet the needs of the family through the provision of information about support agencies and deliver a copy of the current bereavement pack to the relatives, or those caring for them.
- To assist in providing an understanding of media management and response whilst supporting the needs and wishes of the family
- To provide safeguarding options and assist with the management of any operational risk assessment process throughout the deployment.
- To ensure that the family are briefed and have their wishes considered and acted upon regarding retention, disposal and / or reunification of body tissue.
- To work with H.M. Coroner and ensure compliance with the Human Tissue Act.
- Will be present at meetings between the family and the investigation team or CPS.
- Will provide support at any court proceedings which the family wish to be present for and notify the FLC where they are unable to meet any court or other meeting commitments.

14. Family Liaison Officers Coordination's (FLC)

14.1 The role and responsibilities for the Family Liaison Coordinator are documented within the Family Liaison policy.

14.2 The FLC will be responsible for deploying FLOs and will report to an SIO or LI.

14.3 Where a FLO is deployed to an incident, an "investigative" FLC will be nominated to act as a tactical advisor to the SIO / RDLI and take responsibility for the development and continued management of the FLO strategy and objectives.

14.4 It is the responsibility of the nominated investigative FLC to identify and deploy a suitable FLO for the investigation, based upon the rationale for FLO deployment provided by the SIO / RDLI.

14.5 The FLC will:

- Meet with the SIO / RDLI to devise a FLO strategy and objectives.
- Identify FLO's according to the FLO deployment spreadsheet and liaise with the officer's command to advise them of their deployment.
- Arrange a briefing with the SIO / RDLI and FLO.
- Review all FLO deployments to ensure the officer is suitable and can provide a long-term commitment and service to the family.

- Complete the initial FLO deployment form, personal risk assessment, and operational risk assessment and initial briefing form, prior to deploying the FLO.
- Provide pastoral support to FLOs monitoring their welfare, availability and CPD.
- The FLC will continue to provide tactical advice to the SIO, maintain the FLO strategy and ensure the continued welfare of the FLO, but will not prevent the direct line of communication between SIO and FLO.
- Supervise FLO logs in to the investigation team.
- Implement the exit strategy agreed with the SIO / RDLI.
- Conducting a debrief with the FLO following exit from deployment.

15. SCIU DI Deployment

15.1 The SCIU DI is responsible for the management of SCIU RDLIs and RDIO's. They may also be qualified as a PIP3 SIO.

15.2 If the collision amounts to one of the circumstances below the SCIU DI or DCI must be informed. This will be the SCIU DI or DCI during core hours and the duty DI out of office hours.

15.3 The relevant circumstances are:

- Category A+ and A collisions
- Collisions involving significant complexities
- Death or serious injury caused where police activity was a contributing factor (e.g., pursuit, surveillance operation or unit responding to an emergency call).

16. SIO Deployment

16.1 If the collision amounts to one of the offences listed below, then a Senior Investigating Officer (PIP3) must be informed. This will be a JMIT SIO during core hours and the force on call SIO out of hours.

16.2 The relevant offences are:

- Murder.
- Manslaughter.
- GBH with Intent.

16.3 The Deployment Plan should act as a guide to when an SIO should be deployed for fatal and potentially fatal collisions outside of those listed above.

17. Police Vehicle Involvement

17.1 Any fatal or potentially fatal collision involving a police vehicle will be a critical incident as the effectiveness of the police response is likely to have significant impact on the confidence of the victim, their family and/or community.

17.2 The following persons should be notified where such a collision occurs

- SCIU DI or DCI.
- Force Duty Supt.
- Professional Standards Department.
- Area Commander for the area the collision occurred.
- Department commander for the officers involved.
- Post Incident Procedure Manager (PIM).
- Police Federation and Staff associations for any members involved.
- For collisions occurring in Norfolk, Norfolk Legal Services legalservices@norfolk.police.uk. For incidents occurring in Suffolk, Suffolk Legal Services legalservices@suffolk.police.uk

17.3 Consideration must be given to the impartiality of staff and that staff deployed do not have a connection to those involved. This is for their welfare and to protect the integrity of the investigation.

17.4 The Serious Collision Investigation Unit and Forensic Collision Investigation Unit are joint force units and can deploy cross border where required. Consideration must still be given to the impartiality of staff in any mutual aid deployments.

17.5 Norfolk and Suffolk Constabulary have a regional agreement where support can be obtained from either Essex or Bed/Cambs/Herts. The preferred partner is Essex police. Where staff who are independent are required, contact can be made with the Essex Operations Room Manager who will notify the duty RDLI to consider deployment.

17.6 All deployments of staff to police involved incidents of this nature must be considered with PSD and if required the Independent Office for Police Conduct.

18. Evidence Gathering

18.1 All staff must avoid cross contamination of exhibits and suspects and ensure continuity of evidence for all cases where items are seized.

18.2 Body Worn Video (BWV) should be activated:

- Whilst travelling to the scene.
- On arrival.
- When interacting with witnesses and suspects.
- When within the scene itself.

18.3 Due to battery life, it may not be possible to continually use BWV. When working in pairs this can be alternated to maximise recording time. Where BWV is not available, or not functioning, every effort should be made to ensure witness and suspect contact is recorded visually and audibility on approved force issued devices, or if not, noted by the officer.

18.4 Dashcam is an important feature of investigations and care must be taken when dealing with private and commercial dashcam systems.

18.5 Where Dashcam is identified it must not be interfered with, adjusted, or removed unless:

- There is an immediate risk to the public and the removal and viewing is required to mitigate the risk.
- There is likely to be loss of evidence unless action is taken.
- The contents are required to make a key operational decision with regard to safety of staff.

18.6 Where a decision to remove dashcam is made by untrained staff the decision maker and actions taken must be recorded and justified.

18.7 In all other cases the opinion an expert in CCTV/Dashcams should be sought. Staff within the Technical Support Unit are suitably trained to remove and copy material for review.

19. Crime Scene Investigators

19.1 When developing a forensic strategy, human, vehicle and environmental factors should be considered. The Forensic Collision Investigator can recover evidence relating to the physical collision but cannot recover traditional forensic evidence (crime scene marks, body fluids).

19.2 The Forensic Collision Investigator and CSI will work together to maximise evidence recovery and meet the objectives of any strategy agreed by the RDLI or SIO.

19.3 Not all scenes will require a CSI. Best practice is for the RDLI / SIO to seek advice from both the on-scene FCI or FCIU manager and CSI or Crime Scene Manager. This will avoid confusion as to the FCI and CSI roles and capabilities.

20. Scene Imagery

20.1 Forensic Collision Investigators at collision scenes, will take a series of digital photographs. This also includes a 3D scan of the scene using the approved scanning technology.

20.2 Best evidence is achieved where the scene is disturbed as little as possible. This may not be achievable where lifesaving activity has taken place. It is important not to ‘stage’ a scene by replacing moved items after the fact. Where an item or evidence is moved it must be documented as to the reasons why and left in situ unless recovery is required immediately.

20.3 The use of drones is valuable in collision investigation. Where possible aerial imagery should be obtained. Further to this, use of a drone to travel the approach routes to any scene at driver’s eye level, can provide important visual evidence.

21. Scene Security

21.1 The preservation of a scene must be total, the smallest mark may be critical to the investigation. Evidence can easily be lost by allowing vehicles to drive over debris or adjacent road surfaces. All persons on scenes must

- Treat it as a serious crime scene.
- Secure it immediately and open a scene log.
- Document who is within the scene and those entering
- Ensure all movement is through a sterile route.

RDLI's will request additional resources for road closures or diversions via the CCR.

Scenes will remain secured until the RDLI or SIO agrees it can be released.

21.2 Where other agencies are employed to close roads and provide security, the responsibility for the safety of all staff remains with the scene manager. They must ensure that where unstaffed road closures are in place, that persons cannot drive towards or enter the scene. If there are any doubts or concerns regarding scene safety or integrity further staffing must be requested.

22. Witness Accounts

22.1 Many witnesses remain on scene for a short period of time. Every person on the scene must be spoken to and the following obtained:

- Their full identify and contact details.
- An initial account of what they have seen and their movements in the area.
- Their vehicle details and position in the vehicle where there are multiple occupants.

22.2 Accounts can be formally documented in the CR1 record or CRASH; however, consideration must be given to if this is the best way to capture the best evidence from the witness.

22.3 All accounts recorded must be consistent and accurate. Where BWV records the interaction, and the account is subsequently written down it is important to maintain the integrity of the evidence.

22.4 All witnesses must be assessed for Significance, vulnerability and intimidation factors to determine how best to gather their evidence. Where there are concerns a specialist witness interview advisor should be contacted.

22.5 A significant witness is one who has witnessed an indicatable offence, part of such an offence or events closely connected to it and/or have a particular relationship to the victim or central position in an investigation into an indicatable offence.

22.6 Persons who have witnessed a fatal collision or the events immediately after will be presumed to be a significant witness unless otherwise determined. Their

evidence must be obtained by a specialist witness interviewer by video recorded interview. If there is an operational or personal reason which prevents this method, it should be brought to the attention of the RDLI / SIO.

22.7 Where any person has difficulty in speaking or understanding English their evidence should be recorded in their chosen language using an interpreter.

23. Suspect Management

23.1 At the earliest opportunity, the identify of those involved in the collision must be confirmed.

23.2 Unless it is impractical to do so due to medical treatment or condition, any person suspected of involvement may be asked to confirm their identity and any vehicle they were driving at the time of the collision

23.3 Persons suspected of a criminal act involving the collision must not be questioned without the authority of the SIO/RDLI.

23.4 Where circumstances dictate that questions must be put to a suspect prior to seeking advice they should not be questioned regarding the circumstances of the collision, except after caution. Any questioning may be considered to be an interview and as such PACE must be complied with.

23.5 If an individual volunteers an explanation, they should be placed under caution and any subsequent responses treated as a significant statement.

23.6 Witness statements should not be taken from any person unless the evidence clearly indicates that there are no reasonable grounds to suspect them of an offence.

23.7 Where a suspect is identified and there are reasonable grounds to suspect they have committed an offence then arrest must be considered. The relevant tests as set out in PACE must be met.

23.8 Where a decision is made not to arrest a suspect or potential suspect Appendix A: Serious or Fatal Collision - Suspect Risk Assessment must be undertaken prior to their leaving the scene. Mitigating action must be taken for any risk identified.

23.9 Formal interviews should only take place at a Police Investigation Centre (PIC) and conducted by appropriately trained staff. The decision on location of interview will rest with the SIO/RDLI with a presumption it will take place at a PIC unless there are strong and justifiable reasons to the contrary.

24. Blood Tests, Blood and Samples

24.1 Unless the relevant doctor in charge at hospital instructs otherwise, all drivers/riders must be breathalysed and tested for the presence of drugs, utilising the approved drug wipe test devices.

24.2 Where appropriate, consideration should also be given to Field Impairment Testing drivers suspected of being unfit to drive. This must be conducted by a relevantly trained and competent officer.

24.3 Roads and Armed Policing Supervisors and some staff can provide practical advice, support and direction on obtaining samples in a hospital and custody.

24.4 Intimate samples can only be used to confirm or disprove a person's involvement in an offence and is not a substitute for obtaining samples under the Road Traffic Act.

25. Casualties and Post-mortems

25.1 Coroners have a statutory duty to hold an inquest into all road deaths. Where appropriate, the area Coroner for the location should be informed immediately, or if not on the next working day.

25.2 If a casualty dies in hospital, the coroners' officer can be requested to take possession of the admission blood samples for use in later analysis.

25.3 Hospital pathologists are independent of the police and provide evidence as to the cause of death. In the majority of investigations this will be sufficient to prove the link between the collision and death.

25.4 Where there are complicating factors a forensic post-mortem should be considered, particularly if:

- Interpretation of injures are required.
- There is a forensic necessity
- There is a doubt between collision and death.

25.5 Where a Forensic Post-mortem (also known as Home Office PM) is required, the following process is to be followed:

- The coroner is to be informed of the reasons why a HOPM is suggested, and that advice is being sought from a PIP3 or PIP4 trained SIO.
- The relevant Crime Scene Manager can provide advice on the capability of the pathologist and the achievability of the evidence sought in the PM process.
- The JMIT Duty SIO, or if unavailable the Force Duty SIO, will consider the request and authorise if appropriate.
- Where the SIO agrees to a HOPM, a formal request for authority must then be made to the coroner who is the final decision maker.
- The Crime Scene Manager will arrange the PM with the pathologist, Mortuary and CSI staff.
- The Lead Investigator will ensure they are present at the PM with an Exhibits Officer and provide a briefing to the Pathologist.

25.6 The offer of a second post-mortem following a HOPM can be made to the suspect and their defence team:

- The Interviewing or Investigating Officer should inform the suspect or their legal representative of the Post-mortem and ask if they wish to be present (Legal Advisor or defence expert only).
- The coroner will consider if a second post-mortem is required. The coroners' officer will communicate any information and further requirements to the suspect/legal team.

25.7 There is no legal requirement to offer a second post-mortem in none HOPM cases, as such a standard PM does not require any further action or notification to the suspect or defence.

26. Body Recovery

26.1 Where a body is recovered from a scene and is properly placed into a body bag and documented in the correct way to provide full continuity, there is no requirement to accompany the deceased to the mortuary.

26.2 Where a HOPM is likely or possible consideration to accompanying the body should be made, however where the body is in a sealed body bag and properly recorded this is not an absolute requirement.

26.3 Where there are multiple fatalities, each body must be uniquely tagged to ensure there is no confusion as to who they are.

26.4 Where a body or multiple bodies are dismembered, damaged or fragmented, or where there are or likely to be issues with removal of remains from a vehicle or scene, advice must be sought from a relevantly trained Disaster Victim Identification Senior Identification Manager (DVI SIM).

26.5 Where a body is left on the scene during examination both RAPT and FCIU have body tents to allow the deceased to be covered. This provides a level of protection to the remains, is reassuring to families and reduces staff exposure to further trauma. These will be available from the on scene FCI and at RAPT bases.

27. Vehicle Recovery

27.1 Vehicles will be seized and retained in accordance with the Vehicle Recovery and Examination policy relating to this activity.

28. Post Incident Actions

28.1 Following any incident covered within this policy the SIO/RDLI must arrange an immediate debrief. The aims of this will be.

- Understanding and clarification of officers' actions and the evidence gathered.
- Identification of fast track enquires.
- Review of the incident, what went well and any points of learning and improvement.
- Ensure all staff are identified for trauma support and welfare.

28.2 All staff deployed must be referred to the Trauma Risk Management process. Additionally, all staff line managers must be informed of their staff attendance at a scene.

28.3 Where immediate welfare issues are identified these must be managed and brought to the attention of the relevant supervisors and managers.

28.4 Managers and Supervisors should take into account staff attendance at incidents and their exposure to multiple incidents in a short timescale. The welfare of staff should be paramount, and officers should be provided the time and space to decompress and process the incident whilst seeking any relevant support they require.

29. National Highways and Local Authority

29.1 National Highways are responsible for the strategic road network, in Norfolk and Suffolk this is currently:

- The A14
- The A12 from Copdock Interchange to Essex
- The A11
- The A47

29.2 National Highways must report the following major road collisions through to the Department of Transport:

- Serious multiple collisions involving at least 5 fatalities or 20 serious injuries or 30 or more vehicles.
- Fatal or serious injury collisions on motorways or dual carriageways where the vehicles cross over from one carriageway to another.
- A fatal or serious collision involving a coach or PSV (public service vehicle).
- Any serious collisions involving a vehicle carrying dangerous substances.
- Collisions causing serious structural damage to a bridge or similar which requires a road closure.
- Multiple fatal collisions where death results from a fire.

29.3 The Local Authority is responsible for all other adopted roads within the Counties.

29.4 Where a road requires cleaning or repairs prior to reopening, the relevant agency must be informed and will take responsibility for the activity.

29.5 Where staff identify a road defect which is serious and presents a danger to the safety of others, they must take mitigating action and, if required, maintain a road closure until the relevant authority attends.

29.6 Where staff identify a road defect which may be contributory but does not post a real and immediate threat, but consider a change may improve safety, they should notify the Constabulary Traffic Management Officer to highlight the issue.

29.7 The Traffic Management Officer will conduct a safety audit of all fatal collision sites, either independently or with partners.

30. Investigation Recording

30.1 Athena will be the default system of recording fatal and serious injury collision investigation unless HOLMES is used.

30.2 Offences will be recorded as a 'non-crime investigation – RTC' The classification will only change on positive charging advice from the Crown Prosecution Service (Home Office Counting Rules).

31. Prosecution Case File Submissions

31.1 In order to achieve a timely, appropriate and supportive prosecution and best service to both victims and families, **the following rules will be adhered to**:

1) Fatal Collision Investigators must aim to complete all investigations in a timely manner with the full involvement of CPS. The CPS provide specialist supervision of fatal investigations and an enhanced level of service to bereaved families. In order for these to be triggered and operate effectively, all files must be submitted to the CPS. Early guidance can be obtained where necessary.
2) No early charging decisions must be taken without the explicit approval of a CPS prosecutor. Ordinarily, a full advice file must be submitted in all cases other than those where the suspect is remanded in custody.
3) A full collision file will be submitted within a reasonable timeframe. This will be dependent on the nature and complexity of the offences, any technical considerations and demand within both the SCIU and FCIU. The management of SCIU file submissions and the provision of FCIU technical reports will be managed within the FCIU / SCIU Service Level Agreement.
4) In complex or protracted investigations which are likely to exceed 6 months, the CPS prosecutor must be engaged through the agreed processes for early evidence advice and any STL issues managed through local processes.
5) A FLO will be appointed in all fatal collision cases.

32. Coroner Case File Submissions

32.1 Coroners case files must be submitted within the agreed timescales, both Norfolk and Suffolk Coroners agree that this will be as soon as possible or within 6 months from the time of death.

32.2 Where cases will exceed this time period the Coroner must be informed. This includes where a person is under criminal investigation or necessary enquiries with SCIU or FCIU will exceed this timescale.

32.3 Where dashcam or other visual evidence exists, CJS image technicians can supply this in a viewable format on submission of an MG0. .

32.4 The investigation will provide one unedited case file complying with the information sharing agreement between Norfolk and Suffolk Constabularies and

Norfolk and Suffolk County Council. The Coroners officer is responsible for the disclosure of information to families and other interested parties, once the Coroners file is submitted the investigating officer will not be involved in further disclosure. If there is any doubt about material to be disclosed to the Coroner, you should contact Legal Services.

32.5 The investigation team will offer all families a formal meeting to discuss the evidence provided to the Coroner. The purpose of this meeting is to explain the evidence and the opinions of the investigators as to the causes and responsibility of the collision and answer any questions the family or interested party might have. An invite will be extended to the Coroners Officer and will form part of the FLO exit strategy.

32.6 Where the fatal collision/incident involves a police vehicle, the Coroner's case file will also be sent to Legal Services. For collisions occurring in Norfolk, the file will be sent to Norfolk Legal Services legalservices@norfolk.police.uk. For incidents occurring in Suffolk, Suffolk Legal Services legalservices@suffolk.police.uk.

33. Review Process

33.1 The review process is implemented to identify key learning, good practice and record action taken regarding lessons learnt. The process is focussed on learning and improvement and is not an arbitrary process.

33.2 All fatal collision investigations will be reviewed at the following times:

- Following scene closure through the debrief process (On scene RP RDLI).
- Within 4 days of SCIU receiving handover from the RP RDLI.
- Within 14 days by a PIP3 for all Category A collisions and SCIU DI for all others.
- At point of submission to the CPS or Coroner (SCIU Supervisor).
- At any point no further action is taken against a suspect (SCIU DI).
- At point of closure utilising the principles of major crime reviews (SCIU DI).

33.3 A record of all action take from reviews will be maintained by the Joint Major Investigation Team.

Appendix A: Serious or Fatal Collision - Suspect Risk Assessment

Serious or Fatal Collision Investigation - Suspect Risk Prevention Assessment

A suspect RA is required where:

- A suspect is identified and aware of the police investigation but not arrested.
- Following a voluntary interview (and not subject to a release RA whilst in a custody environment)
- Following any contact with the investigation which may have an impact on the wellbeing of the subject (charge/summons decision)
- Where any officer determines, an RA is required to identify and mitigate any risks e.g. Lengthy periods under investigation, awaiting arrest or interview.

Decisions not to arrest / interview, and / or to release on bail / under investigation, should be fully documented with a rationale.

Suicide Risk Factors – the following may increase risk

- Previous self-harming or suicide attempts
- Thoughts of self-harming or suicide
- Unemployment
- Physical health problems such as a debilitating or painful illness or chronic pain.
- Living alone with no local family or friends.
- Alcohol and/or drug use or dependence
- Mental Health Problems or engagements with mental health services.
- Experiencing particular difficulties in life or struggling with past events

Positive Factors – Evidence is weak but protective factors may include

- Strong religious faith
- Family support
- Having children at home
- Sense of responsibility for others
- Problem solving skills
- Plan for the future.

Mitigation

- Establish rapport
- Explain the process and timescales
- Obtain a contact method and address, Contact them again within 24-48hrs.
- Signpost them to support from GP, NHS and online police website information
- Ascertain if they have family or friends to support them. Encourage disclosure of the incident.
- Consider submitting an Adult Protection Investigation to the MASH.

Following speaking with the suspect the risk can be assessed:

- High – Risk of serious harm to the suspect or public is assessed as very likely.
- Medium – Risk of harm is assessed as likely but not serious

- Low – Risk is minimal or does not exist.

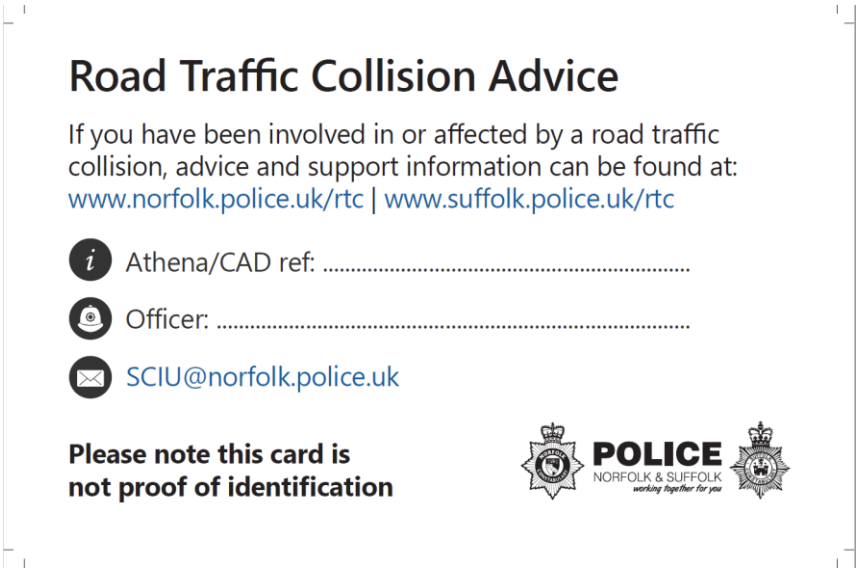
Where a risk exists, mitigating action must be taken and adult PVP completed. The assessment level must be recorded on Athena or any handover document. The assessing officer is responsible for providing any rationale.

Appendix B: Road Collision Support

The following cards are available to provide to those involved in fatal or serious road traffic collisions.

www.suffolk.police.uk/rtc and www.norfolk.police.uk/rtc contains up to date support and FAQ's

All RAPT and JMIT SCIU staff have the website included within any email signatures.



NORFOLK CONSTABULARY *Our Priority is You*

SUFFOLK CONSTABULARY *Taking pride in keeping Suffolk safe*

FATAL COLLISION NOTIFICATION

STORM/CAD No.
.....

The information contained in this email message is intended only for the person or organisation to whom it is addressed.

Unauthorised disclosure or use of such information may be a breach of legalisation or confidentiality.

Day	Date	Time

Parish	Road No.	Road Name

Exact Location	W3W:
	Map Ref:

Weather conditions	Road condition

O I C	Name	Rank/No.	Station
F L O	Name	Rank/No.	Station
Supervisor attending	Name	Rank/No	Station
FCI	Name	Rank/No	Station

Brief circumstances (including direction of travel)

Appendix C: Fatal & Serious Collision Notification Forms

FATAL COLLISION NOTIFICATION

Vehicles

No.	Make/model/Reg/Colour	Driver's Name & Address	Age	Vehicle taken to:
1				
2				
3				
4				
5				

Deceased 1

Name			Address		
Sex	D.O.B.	Veh No.	Position in Vehicle	Positively Identified	Next of kin informed

Deceased 2

Name			Address		
Sex	D.O.B.	Veh No.	Position in Vehicle	Positively Identified	Next of kin informed

Deceased 3

Name			Address		
Sex	D.O.B.	Veh No.	Position in Vehicle	Positively Identified	Next of kin informed

Coroner (Officer) informed	Location of body/bodies
yes	

FATAL COLLISION NOTIFICATION Continued

Casualties

Name		Address	Veh	Injuries
1.				
2.				
3.				
4.				
5.				
6.				
7.				

Can details of the COLLISION be released?	If NO give reason: No.		Case referred to Victim Support Scheme

Can details of DECEASED/INJURED be released?	If NO give reason and estimate of time/date when they can:

Details of Press Appeal.

SERIOUS COLLISION NOTIFICATION

STORM/CAD No.

To be emailed to:

Road Policing-Fatal/Serious Collision Notification

The information contained in this email message is intended only for the person or organisation to whom it is addressed.

Unauthorised disclosure or use of such information may be a breach of legalisation or confidentiality.

Day	Date	Time

Parish	Road No.	Road Name

Exact Location	Map Ref.

Weather conditions	Road condition

O I C	Name	Rank/No.	Station
F L O	Name	Rank/No.	Station
Supervisor attending	Name	Rank/No.	Station
Collision Inv. attending	Name	Rank/No.	Station

Brief circumstances (including direction of travel)

SERIOUS COLLISION NOTIFICATION

Vehicles

No.	Make/model/Reg/Colour	Driver's Name & Address	Age	Vehicle taken to:
1				
2				
3				
4				
5				
6				

Casualties

Name	Address	Veh	Injuries
1.			
2.			
3.			
4.			
5.			
6.			
7.			

SERIOUS COLLISION NOTIFICATION

Can details of the COLLISION be released?	If NO give reason:		Case referred to Victim Support Scheme

Can details of INJURED be released?	If NO give reason and estimate of time/date when they can:

Details of Press Appeal:

Appendix D: Fatal / Serious Debrief Form

POLICE
NORFOLK & SUFFOLK
working together for you
RAPT
ROADS ARMED POLICING TEAM

FATAL/SERIOUS DEBRIEF FORM

CAD Number & Location	
Officers in attendance: LI: SCIU: Attending officers:	
Brief Circumstances: (Can be from the Serious/fatal notification)	
Victim/Deceased suffered major physical trauma?	Y/N (if Y brief details)
TRiM e-mail sent to relevant officers?	Y/N By whom?
Officer/staff welfare - Open discussion - You may feel worse over the coming days - Don't bottle it up - Check in on each other even after today	
Handover welfare issues to be considered by next duty Sgt/Insp:	

Discussion Topics: Scene Management – Safe? Manageable? Team happy with their roles and responsibilities? Handover & admin post-scene – allocated fairly? Amb/Fire/Air Amb/Highways interoperability - Any issues or learning points? Victim/Witness management issues? Availability of Lead Investigator and/or SCIU? Availability of FLO? Any other points.	

Please email: Road – Supervisors, Road – Inspectors, Sally Mack, Joint SCIU.

Appendix E: Coroner Notification of New Enquiry

Coroner Notification of New Enquiry	
Name of deceased: **Deceased D.O.B:**	
Circs of Incident:	
Investigation TEAM	
LIO:	
OIC:	
FCI:	
FLO:	
FLC:	
SCIU Classification:	Choose an item.
Collison Category:	Choose an item.
Post Mortem:	Choose an item.
Family can be contacted direct by Coroner's office: Choose an item	
Any other information (including location of deceased):	

Appendix F: Condolence Letter

Dear

I am writing to express my deepest condolences and those of my team following your tragic loss and to explain at an early stage the next steps for the investigation and what you can expect.

The Serious Collision Investigation Unit will be investigating the circumstances surrounding the collision. This is a joint unit who work in both Norfolk and Suffolk and deal solely with serious and fatal collision investigations.

A Lead Investigator (LI) is appointed in all fatal collision investigations. This is the person who oversees and directs the inquiry. A number of other staff will also be involved in trying to establish how and why the collision occurred.

If you would like to know more about who is involved, or support available to you, please look on the Norfolk or Suffolk Police websites at https://www.suffolk.police.uk/rtc

(This has a Suffolk address, but the content is the same for both Norfolk and Suffolk).

A Family Liaison Officer (FLO) will be provided to deal with any questions or issues and to help communication between the investigation team and yourself. They will agree when and how to contact you and provide you with any information they can surrounding the circumstances of the collision and the progress being made. If you have any questions, then please discuss them with your FLO.

There may be times when your FLO are unavailable to contact you, if this is the case and an event happens which is significant to the investigation either myself or one of the investigating officers will contact you.

It is important to explain generally what happens next in the investigation, how long it might take and what you might expect at Court.

All collisions are approached and dealt with as a serious crime. This is to make sure all the physical evidence is considered to determine how the collision may have happened and to meet the requirements of both the Criminal and Coroners Courts.

A prosecution is considered in all collisions where any living person is suspected of committing a criminal offence and causing the death of another. Investigations can take some time. There may be a requirement for the Forensic Collision Investigation Unit to produce a report and this can only be completed after all the relevant documents, interviews and other evidence is obtained by the investigation team.

If there is a criminal prosecution you will be informed of the key dates and will be supported through the process.

Some cases do not involve a prosecution. This may be where there is a single vehicle collision with no evidence of any other vehicles having been involved or where the person deceased has unfortunately been the cause of the collision. These cases are sent directly to the Coroner for the relevant County. You will be contacted by a Coroners officer at an early stage who can explain their processes and provide you with relevant information.

The coroner is required to determine the answer to 4 key questions:

- Who is the deceased?
- Where the person died?
- When the person died?
- How the person died?

The investigation team can explain the sequence of events, generally discuss the evidence that has been collated and show you CCTV or dashcam footage if it is available and you want to see it.

Only the Coroner can decide the facts of the case and decide how the death occurred, the police will explain their opinions, but the coroner is the person who decides in law the cause and manner of the death.

Whilst the team strive to deal with all investigations in a timely manner to allow you some closure some cases take longer than others, especially where expert technical advice is sought. We will always consider your needs and our wish to provide you with an answer to how the collision occurred and provide you with some guidance around the timescales involved.

If you should have any queries or concerns, please do not hesitate in bringing them to my attention through your Family Liaison Officer.

Yours sincerely

Detective Inspector

Head of Collision Investigations – Norfolk and Suffolk Constabularies