

Road Death Investigation Manual – Implications for Highway Engineers Thursday 29 July 2010

The loss of a life resulting from a road traffic collision is a traumatic situation especially for relatives who will be, understandably, seeking the facts of the incident and where appropriate apportioning responsibility to achieve a sense of justice for the victim(s). This is regardless of whether the only occupant of a vehicle is the driver of a single vehicle or it is carrying others. As is all too well known, many such incidents are avoidable and the role of the investigators is to establish the truth surrounding the incident and to determine the primary cause to establish any culpability and where possible to propose measures that may avoid repetition.

The Road Death Investigation Manual (RDIM) was adopted throughout the UK Police Service to standardise investigative methods into fatal and potential fatal road collisions that occur on the network. This document has adopted the 'best practices' of individual Police forces augmented by comprehensive processes to ensure conformity.

The Branch's recent afternoon seminar was delivered to nearly 50 delegates by representatives from Sussex Police Roads Policing Unit who explained the principals of the RDIM and the affect it could have on Highway Engineers. This was followed by a complex 'stroll' through the consequences of any culpability by a public authority in terms of negligence which is covered by The Health & Safety at Work Act 1974 and the Corporate Manslaughter & Homicide Act 2007 ('Manslaughter' in England – 'Homicide' in Scotland, allowing for different legal systems)

In the first instance, the RDIM requires that any collision involving a loss of life shall be treated as a possible homicide/manslaughter/unlawful killing and every incident shall be treated as such until the contrary is proved. The Manual sets out the role of the Senior Investigating Officer, Family Liaison Officer and expert technical investigators – all of whom play an essential role in the process of the investigation. Police Sergeant Gary Pearson produced the relevant volume explaining in some detail the role of each in the build up to presentation of a file to the Crown Prosecution Service (CPS) or, as necessary HM Coroner for the purposes of an inquest.

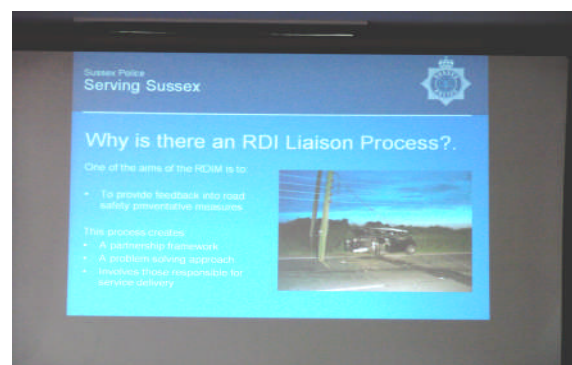


Gary Pearson introduces the RDIM

It was stressed that the main feature was to establish facts and then apportion responsibility based upon those facts. Pre-judgement in any circumstances was, at times, understandable but an undesirable path to follow. Time didn't permit a more detailed look at the RDIM but it is worth noting that delegates can download the current edition (in pdf format) from the Association of Chief Police Officers (ACPO) web site (www.acpo.police.uk/asp/policies/Data/road_death_investigation_manual_18x12x07.pdf).

The presentation then moved on to implications, in law, for corporate bodies, regardless of whether they are public or private. It would be true to say that this aspect was quite involved. The Health & Safety at Work Act had been around for some 30 plus years but it had been agreed that in many cases higher levels of (corporate) management were avoiding prosecution even though their levels of negligence were contributory to the incident. The Corporate Manslaughter & Homicide Act, though new and yet to be fully tested, was intended to address this issue. There were questions from the floor which indicated the level of concern that some delegates had and Gary endeavoured to respond; not necessarily reassuring people but simply explaining the intricacies of 'negligence' being involved in the investigative process. Members wishing to do more research should go to www.cps.gov.uk/legal.a_to_c/corporate_manslaughter where more useful and detailed information can be found.

Ian Jeffrey, who assisted in writing the second edition of the RDIM, explained the process of liaison with highway authorities, as prescribed in the RDIM. As with the primary investigation, the purpose of this was fact finding and establishing any preventive measures that could have been in place at the material time or installed for the future. Given the right attitude this was a valuable part of the process to bring justice and closure to relatives. Delegates confirmed that such liaison took place with their authorities in the south which was ready confirmation that the principals of the RDIM were followed.



The afternoon session concluded with a brief case study of a fatal incident when a motor cyclist lost his life after losing control when passing a slower vehicle. A detailed investigation revealed that centre white line marking, having been over painted and renewed over the years, had exceeded the vertical height standard. Though technically incorrect, this situation had not presented a problem until the victim rode his machine over the lines to make the overtake and, due to the excessive height of the marking, the machine 'tripped' over the line causing an extreme loss of control with tragic consequences. What measures should have been taken to avoid this? Was there negligence and to what degree and by whom? Regardless of criminal liability someone, somewhere should have the death of this innocent road user on their conscience.

A sobering conclusion to an excellent presentation and it is certain that this subject will be covered again in the future.

We are grateful to Ian Jeffrey, Gary Pearson and their colleague Stuart Watson for the presentation and to the Chief Constable, Sussex Police for kindly allowing this to take place.