

REGULATION 28 REPORT TO PREVENT FUTURE DEATHS

	THIS REPORT IS BEING SENT TO:
	Transport for London
1	CORONER
	I am: Assistant Coroner Sarah Bourke Inner North London Poplar Coroner's Court 127 Poplar High Street London E14 OAE
2	CORONER'S LEGAL POWERS I make this report under paragraph 7, Schedule 5, of the Coroners and Justice Act 2009 and Regulations 28 and 29 of the Coroners (Investigations) Regulations 2013.
3	INVESTIGATION and INQUEST On 20 August 2018 I commenced an investigation into the death of Ozan Allen (aged 40 years). The investigation concluded at the end of the inquest on 28 March 2019.
	The conclusion of the inquest was that: Mr Allen was hit by a car on 16 August 2018 as he was crossing the road at the junction between Mile End Road and Burdett Road. He died in hospital on 20 August 2018.
	The medical cause of his death was: 1a traumatic brain injury

I recorded a short-form conclusion that Mr Allen's death was due to a road

1b road traffic collision

traffic collision.

4 CIRCUMSTANCES OF THE DEATH

Mr Allen was walking along the north side of Mile End Road from Stepney Green Underground Station to Thames Magistrates' Court. At the junction with Burdett Road, he walked across Mile End Road to the central traffic island. He then ran diagonally in the direction of the central traffic island in Burdett Road. Whilst he was crossing the junction, he was hit by a red Suzuki car that was travelling north up Burdett Road. Mr Allen sustained head injuries in the collision and died in hospital a few days later.

The witness evidence, investigation report and CCTV established that there were a number of vehicles seeking to turn into the westbound section of Mile End Road at the time. In addition, the evidence established that the driver of the Suzuki would not have been able to prevent the collision.

5 CORONER'S CONCERNS

During the course of the inquest the evidence revealed matters giving rise to concern. In my opinion there is a risk that future deaths could occur unless action is taken. In the circumstances it is my statutory duty to report to you.

The **MATTERS OF CONCERN** are as follows. –

- (1) The junction is a busy crossroads involving multiple traffic lanes with filters, segregated cycle lanes and multiple pedestrian and cycle crossings
- (2) There is no pedestrian guard railing at the junction
- (3) Visibility of the junction can be impaired by vehicles waiting to turn.
- (4) There are staggered two-stage crossings in place to enable pedestrians to cross the road. The investigator from the Metropolitan Police's Road Engineering Unit, observed that pedestrians often do not use the crossings as intended.
- evidence was that in the three years to the end of 2017, there have been 36 reported personal injury collisions within 50 metres of the junction 17 of which involved pedestrians.
- (6) In addition, informed me that a collision study undertaken by TfL has identified that whilst collisions involving cyclists had decreased since the introduction of Cycle Superhighway 2, the proportion of collisions involving pedestrians had increased.

6 ACTION SHOULD BE TAKEN

In my opinion action should be taken to prevent future deaths and I believe you and your organisation have the power to take such action.

7 YOUR RESPONSE

You are under a duty to respond to this report within 56 days of the date of this report, namely by 27 May 2019. I, the coroner, may extend the period.

Your response must contain details of action taken or proposed to be taken, setting out the timetable for action. Otherwise you must explain why no action is proposed.

8 COPIES and PUBLICATION

I have sent a copy of my report to the Chief Coroner and to the following Interested Persons: (mother), (driver). I have also sent it to the Metropolitan Police's Serious Collision Investigation Unit.

I am also under a duty to send the Chief Coroner a copy of your response.

The Chief Coroner may publish either or both in a complete or redacted or summary form. He may send a copy of this report to any person who he believes may find it useful or of interest. You may make representations to me, the coroner, at the time of your response, about the release or the publication of your response by the Chief Coroner.

Sarah Bourke Assistant Coroner 1 April 2019