	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. The Rt Hon Grant Shapps MP, Secretary of State for Transport** (A separate Regulation 28 Report arising from this same case has been sent to Oxfordshire County Council and a copy is enclosed for information purposes).
1	**CORONER** I am Mr D M Salter, HM Senior Coroner for Oxfordshire.
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 02 August 2022 I concluded the inquest into the death of Jennifer Wong with a hearing at Oxford Coroners Court. Ms Wong was 32 years old when she died at the scene of a road traffic accident on 26 September 2021 on Headington Road, Oxford at the junction with Headley Way. The conclusion was Road Traffic Collision with the following factual findings: *At approximately 09:55 hours on 26th September 2021 Jennifer Wong cycled along Headington Road towards traffic lights at the junction with Headley Way and cycled on the nearside of a stationery mobile crane. She was positioned on the nearside in a cycle lane intending to cycle straight on. The mobile crane was positioned in the nearside lane for vehicles turning left. On the lights changing Jennifer Wong and the mobile crane moved forwards and when the crane began to turn left into Headley Way it caused Jennifer Wong to be knocked to the ground and be run over, resulting in her instant death due to crush injuries.* I heard evidence from a number of witnesses at inquest along with other written statements and reports. I enclose the following documents for your information: 1. Police Report – 02/07/2022 2. Collision Investigators Report ([redacted]) - 19/04/2022 3. Report of [redacted] (Traffic Management Post Collision Report) – 22/10/2021 4. Statement of [redacted] of Oxfordshire County Council 01/08/2022 5. Record of Inquest I heard oral evidence from the driver of the mobile crane and from [redacted]

4	**CIRCUMSTANCES OF THE DEATH** Ms Wong was riding her pedal cycle on the morning of Sunday 26 September 2021 along Headington Road in Oxford and was intending to cycle straight across the junction. She was on the near side of a mobile crane intending to turn left into Headley Way. She was knocked off her pedal cycle by the crane and run over. There were significant blind spots for the crane driver to the nearside. This is apparent from the report of [redacted] and the photographs therein. In addition to the issue of the blind spots, [redacted] also stated that an overarching issue is the cycle lane and the left turn at the traffic light junction which results in vulnerable road users coming into direct conflict with vehicles intending to turn left into Headley Way.
5	**CORONER'S CONCERNS** It was apparent at inquest that the regulations concerning vehicles of this type are difficult to understand and to determine which regulations apply. The mobile crane in question was a Kato City Crane with a capacity of 22 tonnes, registration number P477 YHT. The odometer recorded 65,917 kilometres. According to the police Vehicle Examiner, it is classed as a mobile crane and operates outside of the Construction and Use regulations which governs HGV's. It is said that it is governed by The Road Vehicles (Authorisation of Special Types) (General) Order 2003, otherwise known as STGO. I am further advised that under STGO it is likely to be classed a Cat B mobile crane. I understand it can also be regarded as a motor tractor/light locomotive/heavy locomotive under some regulations but at the same time it can also be classed as a road vehicle as it is intended for use on the road to get to site for example. Despite this, if I understand the position correctly, it is subject to reg 33 of the Construction and Use Regs and, for a vehicle first used after 1978 as this one was, it only requires a single offside mirror to be fitted. According to paragraph 9.8 of the Collision Investigator's report, it is categorised as 'Engineering Plant' (Department of Transport 2010) and does not fall within the requirements for close proximity mirrors (EU 2007, UN 2013). **During the course of the Inquest the evidence revealed matters giving rise to concerns. In my opinion there is a risk that future deaths will occur unless action is taken.** **In the circumstances it is my statutory duty to make this report to you.** The **MATTER OF CONCERN** is as follows: 1. It is immediately striking that the driver has virtually no view of the nearside of his vehicle or immediately in front of it. The crane is designed in such a way so that the boom/jib extends along the near side of the cab obliterating most of the view. It had one side mirror on each side but there were very significant blinds pots. These appear to be worse than what one might have with a HGV or bus for example which, very often, have more mirrors and perhaps camera's and audible warnings. It is also noteworthy that the crane did not have indicators which could be seen by someone alongside the crane as opposed to being behind or in front of it.

	I refer you to the photographs in the report of the police collision investigator, [redacted] and particularly from paragraph 9.10 and the figures which give a representation of the driver's view. Notwithstanding the above, it appears that the vehicle is only required by regulations to have one offside mirror and no close proximity mirrors which are designed to reduce the driver's blind spots. The regulations are confusing but regardless of whether the vehicle is classed as engineering plant or some form of locomotive, the reality is that such vehicles are permitted to drive on the roads through towns and cities with next to no near side view. It is the second such case I have dealt with this year in Oxford. I understand there may be some separate and safer regulations that apply in London called the Transport for London Direct Vision Standard which would classify this vehicle with a star rating of zero and require the fitting of safe system measures. I am aware that the Government launched the Road Safety Investigation Branch (RSIB) this year and it appears that this is a matter which could be considered by this new organisation in addition to your department and other stakeholders.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you 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. I may extend the period on request. 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 confirm that a copy of this report and your response will be sent to Ms Wong's family. The Chief Coroner may publish this report and your response in a complete or redacted form on the Chief Coroner's website. 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.
9	**Signed** **Date**  02 September 2022 **Mr Darren Michael Salter** **HM Senior Coroner for Oxfordshire**

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. Mr Stephen Chandler, Chief Executive, Oxfordshire County Council** (A separate Regulation 28 Report arising from this same case has been sent to the Secretary of State for Transport and a copy is enclosed for information purposes).
1	**CORONER** I am Mr D M Salter, HM Senior Coroner for Oxfordshire.
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5	**CORONER'S CONCERNS** I note there have been audits both pre and post accident and, as outlined, I had the benefit of a statement and oral evidence from [redacted] of OCC, Group Manager Traffic and Road Safety. I understand there are planned mitigation measures, to include amending the traffic signal timings to give advanced cycle priority on green. Further, there is the plan to drop the kerb to enable cyclists to join Headley Way off carriageway. I understood that the signal change and dropped kerb were due to take place in late August/September and I would be grateful if you could provide an update. I also understand that OCC have committed to undertake a Stage 4 RSA Safety Audit after the works have been completed and it will be helpful if I could be provided with the result of this in due course. I also heard about a Vulnerable Road User's Audit and enquire if there is a place for this at the location. **During the course of the Inquest the evidence revealed matters giving rise to concerns. In my opinion there is a risk that future deaths will occur unless action is taken.** **In the circumstances it is my statutory duty to make this report to you.** The **MATTERS OF CONCERN** are as follows: 1. The first and main concern is in relation to the nearside cycle lane and what appeared to be an element of confusion or perhaps a dilemma for cyclists at this location intending to cycle straight across the junction. The cycle lane puts cyclists on the nearside of a lane that is specifically for vehicles turning right into Headley Way. There is the box/advanced stop line in front of the line of traffic in the lane but this requires the cyclist to decide to use it and, importantly, to have time to make it pass the nearside of the vehicles and into the box before the vehicles in the lane commence their right turn. If there was no cycle lane, it appears more likely that a cyclist heading straight across would position themselves in lane 2 for vehicles also

	heading straight on. I believe that further consideration should be given to this issue and if improved signage has a part to play to mitigate the risks. I appreciate of course that it is not possible to remove risk completely and cyclists will make different choices about where to position themselves at a junction such as this one. I anticipate that the junction is not dissimilar to many others in Oxford. The issue of cyclists in nearside blind spots, particularly involving large commercial vehicles with limited visibility, therefore presents a significant and ongoing risk. 2. The second concern relates to the width of the cycle lane. It is believed to be 0.95 metres wide at this location but the recommended width is 1.2m or perhaps 1.5m. I understand this is an issue which has already been raised following a site meeting. There may be valid reasons why the lane is the width it is but I would be grateful if this could be considered.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you 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. I may extend the period on request. 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 confirm that a copy of this report and your response will be sent to Ms Wong's family. The Chief Coroner may publish this report and your response in a complete or redacted form on the Chief Coroner's website. 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.
9	**Signed** **Date**  02 September 2022 **Mr Darren Michael Salter** **HM Senior Coroner for Oxfordshire**