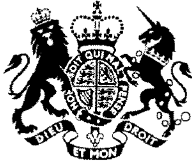

Her Majesty's Coroner for the
Northern District of Greater London
(Harrow, Brent, Barnet, Haringey and Enfield)
North London Coroners Court,29 Wood Street, Barnet EN5 4BE
Telephone 0208 447 7680 Fax 0208 447 7689

TO: [redacted]
Traffic and Highway Network Management Department
Civic Centre
Harrow Council
POX 39
Station Road
Harrow HA1 2XA

This report is sent to you under Rule 43 of The Coroners Rules 1984 (as amended by The Coroners (Amendment) Rules 2008).

Rule 43 findings at the inquest

At the inquest touching the death of Joseph Burrell heard before H.M. Deputy Coroner John Taylor at North London Coroners Court sitting at 29 Wood Street, Barnet EN5 4BE on 22 July 2013, the Deputy Coroner found that (a) the evidence at the inquest gave rise to a concern that circumstances creating a risk of other deaths would occur, or would continue to exist, in the future, and (b) in the Deputy Coroner's opinion, action should be taken to prevent the occurrence or continuation of such circumstances, or to eliminate or reduce the risk of death created by such circumstances.

This report is sent to you as a person who the Deputy Coroner believes may have power to take such action.

The fatal collision

At 7:15 pm on Saturday 28 July 2012, Mr. Burrell attempted (as a pedestrian) to cross the two-lane southern carriageway of The Broadway, in Stanmore, at its junction with Church Road and Stanmore Hill. He was seen on the central reservation, next to the traffic lights, waiting to cross to the south side. At the moment when he began to cross, the traffic in the right-hand lane of The Broadway (from where it would turn into Stanmore Hill) was held on a red light, and the traffic in the left-hand lane (from where it would bear left into Church Road) was permitted to proceed through the lights, by virtue of a green filter light. As Mr. Burrell attempted to make his way across the left-hand lane, he was struck by a car proceeding through the green filter light. He died from the multiple injuries which he sustained in that collision.

The circumstances

The evidence before the Deputy Coroner was:

1. a pedestrian on the central reservation has no clear view of the green filter light (particularly if there is a high-sided vehicle held stationary in the right-hand lane)
2. there is no "second set" of lights beyond the lights (as there is at many junctions) - which would be easier for a pedestrian to see
3. there is no "red man/green man" pedestrian light, or warning sound (which would indicate when it was safe to cross)
4. there are no control buttons for pedestrians to use (in order to bring the lights in both lanes to red)
5. for each and all of the above reasons, and when deciding his moment to cross, a pedestrian on the reservation cannot easily be certain whether the lights for both lanes are on red (and hence whether it is safe to cross)

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6. the speed limit at the lights was (and is) 30mph
7. a pedestrian waiting to cross may thus expose himself to risk of injury, or death, if he mistakenly believes that both lights are on red, and so chooses to cross at the time when the light for the left-hand lane is not on red, but instead on the green filter; and
8. there were references in the documentary evidence to "near misses" on earlier occasions

The Deputy Coroner accordingly invites you to consider these circumstances, and whether to take action in relation to them.

Your response to this report

Your attention is drawn to the following provisions of Rule 43:

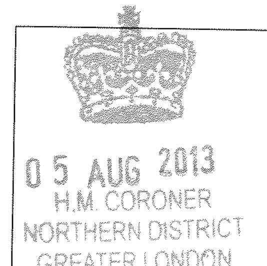
"43A. (1) A person to whom a coroner sends a report under rule 43(1) must give the coroner a written response to the report containing—

(a) details of any action that has been taken or which it is proposed will be taken whether in response to the report or otherwise; or

(b) an explanation as to why no action is proposed

within the period of 56 days beginning with the day on which the report is sent.

43B. A coroner may extend the period of 56 days mentioned in rule 43A (1) (even if an application for extension is made after the time for compliance has expired)."



Assistant Coroner John Taylor
(formerly, H. M. Deputy Coroner)

5 August 2013