Regulation 28: Prevention of Future Deaths report

Francis Nelson GOLDING (died 08.11.13)

	THIS REPORT IS BEING SENT TO: **1. [redacted]** **Director** **Culture and Environment** **Camden Council** **Town Hall Extension** **Argyle Street** **London WC1H 8NJ**
1	**CORONER** I am: Coroner ME Hassell Senior Coroner Inner North London St Pancras Coroner's Court Camley Street London N1C 4PP
2	**CORONER'S LEGAL POWERS** I make this report under the Coroners and Justice Act 2009, paragraph 7, Schedule 5, and The Coroners (Investigations) Regulations 2013, regulations 28 and 29.
3	**INVESTIGATION and INQUEST** On 21 November 2013, I commenced an investigation into the death of Francis Nelson Golding, aged 59. The investigation finished at the end of the inquest on 7 April 2014. I concluded that Mr Golding died as a result of a road traffic collision.
4	**CIRCUMSTANCES OF THE DEATH** The road traffic collision occurred when the pedal cycle Mr Golding was riding collided with a left turning coach on Vernon Place, at the junction with Southampton Row in London, at about 6.40pm on Tuesday, 5 November 2013.

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 will occur unless action is taken. In the circumstances, it is my statutory duty to report to you. The **MATTERS OF CONCERN** are as follows. During the course of the inquest, I heard evidence of three fatalities at this junction in the last ten years, each involving a cyclist colliding with a left turning vehicle. Whilst of course every road user has a responsibility to take care at junctions, it does seem that this junction leaves cyclists particularly vulnerable. There is also, I heard, an issue with the oncoming bus lane not leaving any additional space for cycles. I was told by a Camden Council design team manager, that the whole corridor including this junction would be considered for improvement, but she was not able to describe a great deal of progress with this. She thought that traffic modelling would take place within the next couple of months, but she was a little vague on the point. Mr Golding died five months ago. I appreciate that the planning of road layout consists of much more than simply reacting to adverse events but, given the circumstances of the collision in which Mr Golding lost his life, and bearing in mind the other collisions that have occurred at this junction, it seems that Vernon Place/ Southampton Row would benefit from early consideration by your team.
6	**ACTION SHOULD BE TAKEN** In my opinion, action should be taken to prevent future deaths and I believe that you and your organisation, having responsibility for the road layout at this junction, 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 10 June 2014. 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 following. • HHJ Peter Thornton QC, the Chief Coroner of England & Wales • [redacted] Francis Golding's civil partner • [redacted] bus driver • [redacted] design team manager, Camden Council • [redacted] MPS traffic management unit • [redacted] TfL legal department 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 Senior Coroner, at the time of your response, about the release or the publication of your response by the Chief Coroner.
9	**DATE** **SIGNED BY SENIOR CORONER** 14.04.14