H.M. Coroner, City of London

City of London Coroner's Office
Walbrook Wharf, 78-83 Upper Thames Street, London EC4R 3TD

Coroners & Justice Act 2009; The Coroners (Investigations) Regulations 2013 No. 1629
REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

*NOTE: This form is to be used **after** an inquest.*

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. The Commissioner for Transport for London (TFL)** **2. C.c. Corporation of the City of London (Roads, for information)**
1	**CORONER** I am Dr Roy Palmer, assistant coroner for the City of London coroner area
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, No. 1629.
3	**INVESTIGATION and INQUEST** On 02 August 2014 we commenced an investigation into the death of Christopher Tandy (CT) born 05 November 1985. The investigation concluded at the end of the inquest on 04 June 2015. The conclusion of the inquest was death by misadventure. The medical cause of death was multiple injuries due to a road traffic collision. Alcohol intoxication was a contributory, but not a direct, cause.
4	**CIRCUMSTANCES OF THE DEATH** At about 19.30h on 2nd August 2014 CT was cycling north over London Bridge. The carriageway was clear of traffic on his side of the road, as shown on CCTV. For unexplained reasons his cycle veered across the northbound carriageway, struck the kerb and precipitated him off the cycle, his body then straddling the central reservation but with his head and upper thorax thrown into the offside of the southbound carriageway where he was struck by a motor car travelling south over London Bridge. The car had travelled southwards from north London and entered the northern end of London Bridge, behind a London bus. As soon as he was able to overtake the bus, which moved nearside towards the bus stop, the driver accelerated past. The City of London collision investigator calculated the speed of the vehicle to have been 38 mph. At the time the speed limit on the road had then recently been reduced from 30 mph to 20 mph. The driver of the car, a foreign national unfamiliar with roads in London, believed the speed limit to have been 30 mph at the time. Even had he been correct in his belief, the evidence of the collision investigator was that at 30 mph he would probably have been able to avoid the collision. Had he been travelling at or below 20 mph he would assuredly have avoided 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 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. – A review of the signage and road layout suggest that there is opportunity to take steps to try to prevent a recurrence of deaths in comparable circumstances. A driver unfamiliar with City roads, having been stuck in slow-moving traffic through the city, and on seeing the road over London Bridge open out from, first, one lane, to two lanes then to three lanes, is tempted to accelerate to a speed above the new statutory limit. I suggest that some improved signage is desirable, to remind drivers that the speed limit on the bridge remains 20 mph. I was informed in evidence that there is no prominent speed limit signage at the commencement of the bridge and that in other places in the City only the smaller 20 mph repeater signs are displayed. A driver travelling from south to north over Southwark Bridge will see a large 30mph speed limit sign at the north end. If the driver turns right onto Upper Thames Street and then goes under London Bridge and turns left into Fish Street Hill, then left onto Monument Street and then left onto London Bridge there is no prominent signage to make clear that the speed limit reduces from 30 to 20mph. Ideally, a separate lane for cyclists (e.g. as on Southwark Bridge) would separate them from vehicular and pedestrian traffic. Please will you give consideration to the issues raised by this case and arrange to assess whether it is feasible to introduce additional safety measures and improved signage.
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, namely by 17 August 2015. I, the coroner, may extend the period if you so 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 have sent a copy of my report to the Chief Coroner and to the following Interested Persons: Slater & Gordon, solicitors to the family of the late Mr Tandy The driver of the vehicle involved 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.
9	**19th June 2015**

[redacted]

Coroner