ANNEX A

REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

REGULATION 28 REPORT TO PREVENT FUTURE DEATHS THIS REPORT IS BEING SENT TO: 1. The Chief Executive, Royal Borough of Greenwich, John Comber, Town Hall, Wellington Street, Woolwich, London SE18 6PW 2. Managing Director Surface Transport, Transport for London, Floor 11 R4, Palestra, 197 Blackfriars Road, London SE1 8NJ Senior Manager, Lands, Estates and Property, Housing and Land Directorate, Greater London Authority, City Hall, London SE1 2AA CORONER I am Philip Barlow, assistant coroner, for the coroner area of Inner South London 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. [HYPERLINKS] 3 **INVESTIGATION and INQUEST** On 8 January 2016 I commenced an investigation into the death of Amanda Coppen, age 44. The investigation concluded at the end of the inquest on 12 August 2016. The conclusion of the inquest was that Ms Coppen died of multiple injuries caused as a result of a road traffic collision. CIRCUMSTANCES OF THE DEATH At approximately 0704 on 4 January 2016 Ms Coppen suffered fatal injuries when she was struck by a bus as she was crossing Pilot Busway on the south side of the junction with John Harrison Way. 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. -(1) The evidence at the inquest was that Ms Coppen was crossing the busway on a signal controlled pedestrian crossing while the signal was red to pedestrians and green to traffic. However, the evidence also suggested that the layout of Pilot Busway and the neighbouring road (West Parkside) is unusual: they run side by side; West Parkside consists of a single carriageway in each direction; Pilot Busway consists of a single dedicated bus lane in each direction. The evidence was that this layout could mislead road users (pedestrians and motorists) into believing that this is a standard dual carriageway. Ordinary traffic has been seen in the dedicated busway, and pedestrians could be misled into looking the wrong way when crossing the road. (2) I understand that a new school is shortly to be built close to this junction. This may

	increase the numbers of pedestrians using the junction and there is a potential risk to schoolchildren. (3) I understand that some discussion about the junction may already be underway
	between London Borough of Greenwich, Transport for London and the Greater London Authority.
	(4) I enclose copies of the reports of dated 15 February 2016 and dated 13 June 2016 which set out the circumstances in more detail.
6	ACTION SHOULD BE TAKEN
	In my opinion action should be taken to prevent future deaths and I believe you or your organisations 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 October 2016. 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 family as Interested Persons. I have also sent it to who may find it useful or of interest.
1	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	[DATE] [SIGNED BY CORONER]
77 77 848	19" August 2016 Ph. A. R.