REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** TFL [redacted] Principal Lawyer Tf L Legal, Windsor House, 42-50 Victoria Street, London. SW1H 0TL
1	**CORONER** I am Dr Fiona J Wilcox, HM Senior Coroner, for the Coroner Area of Inner West 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.
3	**INVESTIGATION and INQUEST** On the 14th February 2017 I took preliminary evidence at a Pre-inquest Review touching the death of Milan Dokic. **Medical Cause of Death** 1 (a) Multiple Traumatic Injuries **How, when and where and in what circumstances the deceased came by her death:** The preliminary view of the evidence based upon CCTV recordings and the view of the collision investigator was that Mr Dokic was travelling east on a motorcycle and overtaking a van from the inside on Battersea Park Road on the 1st March 2016 in wet conditions, when he lost control of his vehicle when he drove onto the blue cycle lane just past the pedestrian crossing opposite the junction with Forfar Road. The CCTV clearly shows the motorcycle losing grip and sliding along the road. Sadly, Mr Dokic came off, and hit a bollard sustaining injuries that led to his death at the scene. **Conclusion as to the death** No Conclusions have yet been reached as the Inquest has not been heard.
4	**CIRCUMSTANCES OF THE DEATH**

	The preliminary evidence was that the blue cycle lane of the cycle super-highway (CSH) at the point where he come off when later tested by the collision investigator offers a much lower grip than the conventional road surface with a skid resistance value of 56.3 compared to the road surface of 77.05 and the CSH before the pedestrian crossing an even higher skid resistance value of 89.85. I understood that some cyclists have raised concerns that the CSH appears in places to have lower grip than other areas of road surface. I am also due to hear evidence in another death in slightly different circumstances than this of Mr Dokic where low grip on the CSH may also have played a part. This death also occurred in Battersea. The Collision Investigator was also concerned that Battersea Park Road at the junction with Forfar Road is an area in which turning maneuverers are frequent and so it may be area of particular danger to vulnerable road users prone to slip such as motorcyclists and cyclists.
5	**CORONER'S CONCERNS** During the course of the pre-inquest review the preliminary 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. That the use of the road surface with reduced grip on the CSH compared to the usual road surface represents a hazard to road users making it more likely that they will lose control of their vehicles. 2. That the surface of the CSH with reduced grip may be widespread and as such other dangerous areas may exist. 3. That TfL should therefore undertake an urgent review of all areas treated with such road surface and replace it with the higher grip surface 4. That the CSH should all have increased rather than reduced grip compared to the ordinary road surface since cyclists are vulnerable road users. 5. That areas of road at junctions such as this junction between Battersea Park Road and Forfar Road are of particular concern from a risk perspective. 6. That these concerns are too urgent to wait until the full hearing of the evidence to be addressed. It may well that further matters of concern for example in relation to guidance, standards and testing will arise after the inquest has been heard, but evidence has yet been received in relation to these issues.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you [AND/OR your organisation] have the power to take such action. It is for each addressee to respond to matters relevant to them.
7	**YOUR RESPONSE**

	You are under a duty to respond to this report within 56 days of the date of this report. 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 following Interested Persons : [redacted] [redacted] SCIU TDV Merton Traffic Unit, 15 Deer Park Road, Merton. SW19 3 YX [redacted] Serious Collision Investigation Unit, 15, Deer Park Road, Merton, London. SW19 3YX 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	**17th February 2017**  **Dr Fiona J Wilcox** **HM Senior Coroner** **Inner West London** **Westminster Coroner's Court** **65, Horseferry Road** **London** **SW1P 2ED**