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 Russell A Caller, HM Assistant Coroner, for the Coroner Area of Inner London West
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 17th February 2017 Dr. Fiona Wilcox, HM Senior Coroner, for the Coroner Area Inner London West submitted a report under paragraph 7, Schedule 5, of the Coroners and Justice Act 2009 and regulations 28 and 29 of the Coroners (Investigations) Regulations 2013 which was sent subsequent to preliminary evidence taken by the Senior Coroner at a Pre-inquest Review touching the death of Milan Dokic on 14th February 2017 Subsequent to the aforementioned Pre Inquest Review the Inquest took place on 11th July 2017 **Medical Cause of Death** 1 (a) Multiple Traumatic Injuries **How, when and where and in what circumstances the deceased came by his death:** The 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.

	At the Inquest I stated in my summing up, that the death was caused by a combination of factors including the manoeuvre Mr.Dokic made from the main highway into Cycle Super Highway 8 ("CSH8") and the speed he was travelling at the time and the lack of grip on the blue area on the CSH8 set at 56.5 being below the recommended level of 60 set for the blue area on CSH8 **Conclusion as to the death:** Accidental death contributed by Neglect
4	**CIRCUMSTANCES OF THE DEATH** The evidence was that the blue cycle lane of the CSH8 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 56.5 compared to the road surface of 77.05 and the CSH8 before the pedestrian crossing an even higher skid resistance value of 89.85. I understand that some cyclists have raised concerns that the CSH8 appears in places to have lower grip than other areas of road surface. 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 an 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 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. There is an inadequate system of determining grip levels on CSH8 and on other Cycle Super Highways and on other roads in London.. 2. There has been a failure to monitor grip values on Cycle Super Highways in London. 3. Urgent research needs to carried out on having a clear scientific way of determining grip values which can be applied to roadways in London. 4. Urgent research should be carried out into the adverse effects of having adjacent areas of road with very different grip values and , subject to such research, remedial response is needed once that research has been carried out.
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 Assistant 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] [redacted] [redacted] [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 Assistant Coroner, at the time of your response, about the release or the publication of your response by the Chief Coroner.
9	**11th August 2017** **Russell Caller** **HM Assistant Coroner** **Inner West London** **Westminster Coroner's Court**

	65, Horseferry Road **London** **SW1P 2ED**