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. Rt. Hon Chris Grayling MP, Secretary of State for Transport, Great Minster House, 33 Horseferry Road, London SW1P 4DR** **2. His Honour Judge Mark Lucraft QC, The Chief Coroner for England and Wales, Chief Coroner's Office,11th Floor, Thomas More, Royal Courts of Justice, Strand, London, WC2A 2LL**
1	**CORONER** I am Christopher Williams an assistant coroner, for the coroner area of Inner London South (Southwark Coroners Court).
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. http://www.legislation.gov.uk/uksi/2013/1629/regulation/28/made and http://www.legislation.gov.uk/uksi/2013/1629/regulation/29/made
3	**INVESTIGATION and INQUEST** An investigation into the death of **Julia Luxmore Peto** commenced on the 22 October 2018. The investigation concluded at the end of the inquest on **27 March 2019**. The conclusion of the inquest was that the medical cause of death was 1(a) Head Injury. The conclusion was "Road Traffic Accident".
4	**CIRCUMSTANCES OF THE DEATH** On Sunday 16 September 2018, at about 16:53 pm., Julia was using a pedestrian crossing over the Eastbound carriageway of Deptford Broadway, SE8 (A2), when a bus collided with her causing a catastrophic head injury. She died in hospital the following day. She was aged 27 years and did not have significant health problems or disabilities. She was crossing from the Northside of Deptford Broadway to the Southside. The three lanes of the Eastbound carriageway had split phasing of traffic light signals. When crossing the first two lanes of the Eastbound carriageway the traffic had stopped at red traffic light signals. When she entered the third lane of the Eastbound carriageway, which was a filter lane for vehicles turning right, the traffic light was green in favour of the approaching bus when the collision occurred. At the time she crossed the three lanes of the Eastbound carriageway the pedestrian signal was red. There was a pedestrian island between the second and third lanes. CCTV footage, from inside the bus, showed that she was looking to her left and when she stepped into the road she did not see the bus which was approaching from her right hand side. The Eastbound carriageway consisting of three lanes was the first part of a 'two stage' crossing, the Westbound carriageway being the second stage. At the time she was crossing the Eastbound carriageway a green pedestrian light was displayed on the far side of the Westbound carriageway. Based on the available evidence it was not possible to establish, on the balance of probabilities, that Julia had been confused by this particular green pedestrian signal.

	The CCTV footage from the bus showed Julia moving at a pace, which was faster than walking, but not running, across the first and second lanes and continuing into the third lane where the collision occurred. The driver of the bus passed eyesight breath and drug tests at the scene. He was travelling well below the speed limit of 30 mph through a green light, in his favour, and had applied the brakes before the collision occurred. The estimated speed of impact was below 4 mph. There were no mechanical problems with the bus.
5	**CORONER'S CONCERNS** From the evidence I received, at the inquest, there are matters giving rise to concern. In my opinion there is a risk that future deaths could occur unless action is taken. In the circumstances it is my statutory duty to report to you. The **MATTERS OF CONCERN** are as follows. – I recorded in section 3 of the Record of Inquest that it was not possible to establish, on the balance of probabilities, that Julia had been confused by a green pedestrian signal on the other side of the Westbound carriageway of a 'two stage' crossing. Nonetheless I remain concerned that there is a strong possibility that she was distracted or confused by the green pedestrian light for the Westbound carriageway. Transport for London (TfL) who are responsible for the signals, on the junction in question, have subsequently taken remedial measures to minimise the possibility of a recurrence of the accident by modifying the green pedestrian signals with louvres to reduce the risk of 'see-through' for pedestrians on the staggered pedestrian crossing. TfL informed me, at the inquest, that they are putting in place "Look Left" and "Look Right" markings on the road to inform pedestrians on the direction of approaching traffic (A copy of the TfL report to me is appended for ease of reference. This contains a useful plan and photographs). From the evidence I heard I am satisfied that these particular changes would not have a wider impact on traffic flow but would improve the safety of pedestrians. I was pleased to hear that TfL had taken proactive practical measures to reduce the risk at this particular junction but I remain concerned that there are likely be other "two stage" pedestrian crossings throughout England and Wales which also do not currently have louvres to prevent pedestrian 'see-through' and road markings to warn pedestrians of traffic direction. I am therefore of the view that I am under a duty to report this wider concern to the Department of Transport to take appropriate action to reduce the risk of fatalities and serious injuries at two stage crossings throughout England and Wales.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe your organisations have the power to take the following action: - **The Department of Transport:** Should use its available legal powers to introduce appropriate measures to reduce the above-identified risk at two stage pedestrian crossings throughout England and Wales.
7	**YOUR RESPONSE**

	You are under a duty to respond to this report within 56 days of the date of this report, namely by the **29 June 2019.** I, the coroner, may extend the period. Your responses 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 who may find it useful or of interest: 1. [redacted] (mother of Julia Peto) 2. Transport for London 3. Go Ahead London (Bus company) 4. Metropolitan Police 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	**4th April 2019** **Christopher Williams – Assistant Coroner**