Regulation 28: Prevention of Future Deaths report

Liam Floyd SEAGER (died 01.01.19)

THIS REPORT IS BEING SENT TO:

1. Mr Mike Brown
Commisioner
Transport for London
5 Endeavour Square
London E20 1JN

2. Mr Will Tuckley
Chief Executive
Tower Hamlets Council
Mulberry Place
Town Hall
5 Clove Crescent
London E14 2BG

1 CORONER

I am: Coroner ME Hassell

Senior Coroner Inner North London

St Pancras Coroner's Court

Camley Street London N1C 4PP

2 CORONER'S LEGAL POWERS

I make this report under the Coroners and Justice Act 2009, paragraph 7, Schedule 5, and The Coroners (Investigations) Regulations 2013, regulations 28 and 29.

3 INVESTIGATION and INQUEST

On 4 January 2019, I commenced an investigation into the death of Liam Floyd Seager, aged 24 years. The investigation concluded at the end of the inquest on 14 February 2020. I made a determination at inquest that death arose from a road traffic collision.

4 | CIRCUMSTANCES OF THE DEATH

Liam was knocked over and killed by a transit van at approximately 3am on New Year's Day 2019, when he was crossing the A12 southbound underpass between Old Ford Junction and Bow Interchange. His judgement was impaired by alcohol and drugs, and the driver was travelling in excess of 20mph above the speed limit of 40mph.

The medical cause of death was:

- 1a multiple injuries
- 1b blunt force trauma
- 2 ethanol and MDMA intoxication

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.

I heard at inquest that there is no pedestrian crossing on the A12 near the location of the collision.

- Transport for London has indicated that it hopes to have a traffic management order in place by June 2020, which will prohibit pedestrians from crossing at this point. I am concerned that we are still four months away from this.
- Once the traffic management order is in place, a pedestrian crossing is needed to make it easier for pedestrians to cross the top of the A12 at Wick Lane. Even before this, Tower Hamlets could undertake useful preparatory work to enable the build to proceed quickly following the TMO.

6 ACTION SHOULD BE TAKEN

In my opinion, action should be taken to prevent future deaths and I believe that 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 20 April 2020. 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 following. • HHJ Mark Lucraft QC, the Chief Coroner of England & Wales , parents of Liam Seager 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 Senior Coroner, at the time of your response, about the release or the publication of your response by the Chief Coroner. 9 DATE SIGNED BY SENIOR CORONER 17 February 2020