Her Majesty's Coroner for the Northern District of Greater London
(Harrow, Brent, Barnet, Haringey and Enfield)

North London Coroners Court,
29 Wood Street,
Barnet EN5 4BE

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	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** 1.RSSB, Enquiry Desk, 1 Torrens Street, London EC1V 1NY
1	**CORONER** I am Andrew Walker, senior coroner, for the coroner area of Northern District of Greater 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 22nd April 2015 I opened an inquest touching the death of Michael Anthony Bovell , 22 years old. The inquest concluded on the 26th June 2015. The conclusion of the inquest was "open", the medical case of death was 1a Multiple Brain Injuries
4	**CIRCUMSTANCES OF THE DEATH** On the 12th April 2014 Michael Bovell at about 8.45pm was in a car with two other people when he phoned the police to report a suicide initially telling the operator he was at Enfield Lock but was corrected by persons with him that he was at Brimsdown Rail Station. Mr Bovell left the car and scaled the fence and made his way onto the railway line. The train driver was contacted by the signaller at Brimsdown Work Station telling him of a suicidal man in the Brimsdown area. The driver was instructed to proceed at caution and slowed his train to 15 mph. The train driver failed to see Mr Bovell who was struck and run over by the train. Had the train been stopped by the signaller, (which is not permitted by the RSSB Rule book in these circumstances), rather that the train driver being instructed to proceed on "caution", the collision would not have occurred.

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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. – That the RSSB Rule Book allows trains to be stopped only in circumstances where a person who has trespassed onto the line person may cause damage to a train, but does not allow for trains to be stopped where the person may be in danger from a train other than to stop the train to place the train on caution. That the train travelling having been cautioned and reduced its speed still struck Mr Bovell
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.
7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of the date of this report, namely by Thursday 20th August 2015 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;- Members of the family. London Underground Transport for London 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	**29th June 2015**