



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

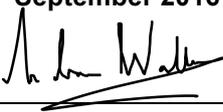
North London Coroners Court,  
29 Wood Street,  
Barnet EN5 4BE

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	<p><b>REGULATION 28 REPORT TO PREVENT FUTURE DEATHS</b></p> <p><b>THIS REPORT IS BEING SENT TO:</b> RSSB, Enquiry Desk, 1 Torrens Street, London EC1V 1NY</p>
1	<p><b>CORONER</b></p> <p>I am Andrew Walker, senior coroner, for the coroner area of Northern District of Greater London</p>
2	<p><b>CORONER'S LEGAL POWERS</b></p> <p>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.</p>
3	<p><b>INVESTIGATION and INQUEST</b></p> <p>On the 13 day of April 2016 I opened an investigation into the death of Lauris Kodors , 32 years old. I opened an inquest on the 6<sup>th</sup> day of May 2016. The inquest concluded on the 29<sup>th</sup> June 2016. The conclusion of the inquest was "Rail Collision", the medical case of death was 1a Multiple Injuries</p>
4	<p><b>CIRCUMSTANCES OF THE DEATH</b></p> <p>Lauris Kodors was struck and suffered fatal injuries in the Harrow Tunnel at about 10.10 am on the 11<sup>th</sup> April 2016 on the Southbound railway line. Mr Kodors was not discovered until later on the 12<sup>th</sup> April 2016 and confirmed as having died on the 13<sup>th</sup> April 2016.</p>
5	<p><b>CORONER'S CONCERNS</b></p> <p>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.</p> <p>The <b>MATTERS OF CONCERN</b> are as follows. –</p> <p>That the RSSB Rule Book allows trains to be stopped only in circumstances where that person may cause damage to a train, but does not allow for trains to be stopped where the person may be in danger form a train.</p>
6	<p><b>ACTION SHOULD BE TAKEN</b></p> <p>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.</p>



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7	<p><b>YOUR RESPONSE</b></p> <p>You are under a duty to respond to this report within 56 days of the date of this report, namely by Thursday 8<sup>th</sup> December 2016 I, the coroner, may extend the period.</p> <p>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.</p>
8	<p><b>COPIES and PUBLICATION</b></p> <p>I have sent a copy of my report to the Chief Coroner and to the following Interested Persons;-</p> <p>I am also under a duty to send the Chief Coroner a copy of your response.</p> <p>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.</p>
9	<p><b>13<sup>th</sup> September 2016</b></p> <p></p>