



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

Telephone 0208 447 7680  
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|   | <p><b>REGULATION 28 REPORT TO PREVENT FUTURE DEATHS</b></p> <p><b>THIS REPORT IS BEING SENT TO:</b><br/>1.RSSB,<br/>Enquiry Desk,<br/>1 Torrens Street,<br/>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 10<sup>th</sup> May 2016 I opened an inquest touching the death of George Henry Dicker , 26 years old. The inquest concluded on the 8<sup>th</sup> November 2016. The conclusion of the inquest was "Accident", the medical case of death was 1a Electrical injury</p>  |
| 4 | <p><b>CIRCUMSTANCES OF THE DEATH</b></p> <p>On the 9<sup>th</sup> May 2016 George Henry Dicker made his way onto an area with railway tracks and electrical lines having walked to the end of, and through a gate, onto the tracks at Woodside Park Underground Station. Mrs Dicker is likely to have died following contact with the live rail and was then struck by a train.</p>   |
| 5 | <p><b><u>CORONER'S CONCERNS</u></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 there is no alarm or warning to the signaller that a person has passed through the gate to the tracks at the end of the platform.</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 Monday 8<sup>th</sup> May 2017 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;-<br/>RSSB</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> March 2017</b></p>  |