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

[redacted]

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** 1. Thames Water, Clearwater Court, Vastern Road, Reading RG1 8DB 2. Alexandra Palace, Alexandra Palace Way, London N22 7AY 3. Network Rail, One Eversholt Street, London, NW1 2DN
1	**CORONER** I am Mr Andrew Walker, H M Coroner and 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 4th January 2022 I opened an investigation touching the death of Connor Peter Marron, aged 19 years old. I opened and inquest on the 31st January 2022. The inquest concluded on the 7th June 2021, having been adjourned part-heard from the 21st April 2022. The conclusion of the inquest was "Open", the medical case of death was 1a Multiple compound injuries, 1b Train collision.
4	**CIRCUMSTANCES OF THE DEATH** On the Second of January 2022 at about 42 minutes past midnight Connor Peter Marron was struck and fatally injured by a train 300 meters north of Hornsey Railway Station. Mr Marron left the Victoria Stakes Public House to return to Alexander Palace, where he had earlier attended an event, with the intention of recovering his phone. Towards the edge of the grounds a stream runs alongside a railway line. There is a path then a fence before the railway track itself. It was not possible, from the evidence heard at the inquest, to be clear about what happened in the journey Mr Marron took until the point at which Mr Marron is seen on CCTV train footage just before being struck by a train. Mr Marron was soaked from his waist down and not wearing shoes at the time of the collision and was seen on the train's camera moving across the path of the train appearing to be unaware that the train was approaching him.
5	**CORONER'S CONCERNS**
	The **MATTERS OF CONCERN** are as follows. – 1. There was no lighting beside the stream or the railway fence, nor any signs identifying the stream, its depth and any warning of danger. 2. There were no signs in that area to assist with locating a way out from that part of the venue's grounds. 3. The fence separating the venue grounds from the railway track was not adequate to prevent ingress to the railway track.
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 Wednesday the 17th August 2022 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;- The Family. .
9	**22nd June 2022**