REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** 1. The Rt. Hon Mark Harper MP, Secretary of State for Transport, The Department of Transport (DfT) Great Minster House, 33 Horseferry Road, London SW1P 4DR 2. [redacted], Chief Executive, Network Rail, Waterloo General Office, London SE1 8SW
1	**CORONER** I am Dr Julian Morris, senior coroner for the coroner area of London Inner South.
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 4 May 2020 an investigation into the death of Fraser William Moore, aged 25, was opened. The investigation concluded at the end of the inquest on 15 December 2022. The conclusion of the inquest, heard before a jury was the "inappropriate handcuffing, his unnecessary arrest, inadequate supervision of his arrest and the failing to prevent his escape." He escaped firstly onto the station concourse and then onto the railway lines at London Bridge Station. The medical cause of death was 1a. Electrocution, 1b. Contact with live rail.
4	**CIRCUMSTANCES OF THE DEATH** On 25 March 2020 Mr Moore had been arrested, handcuffed and was present in a carriage. He managed to exit one of the carriage doors, which was unattended and fled onto the platform. After running for a short period of time firstly up and then down the platform by moving down one side of the concourse to the other, he was running towards the country end at London Bridge Hospital. He proceeded to jump onto the track whilst still within the platform area before continuing out of the platform area towards the country. He was followed by a BTP officer. The rails were still live. The calling for the lines to be isolated occurring about the same time that maters were picked up by the signalman. Sadly, he made contact with the live rail before power could be severed. Subsequently, after the power switched off and assistance to move to his location, some distance from the platforms, he was pronounced dead at the scene.
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. – The CCTV coverage/ footage ends at the end of the station concourse on both the city and country ends. Station footage does not get sent to Route Control. On a risk-based review, the chances of incidents happening in a busy cosmopolitan station must, by footfall and surrounding populations alone, increase the risk of an event. An event that should then be looked at. In order to look at an event, I accept that current CCTV is in place within the station confines but for these stations, I do not consider that I have received sufficient evidence to persuade me that the footages should not be available immediately to the Route Control Rooms or that the coverage should not extend up or down line beyond the end of the platforms.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to look into both the extension of CCTV in busy cosmopolitan station and its passage to Route Control to help prevent future deaths and I believe 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 Monday, January 29th 2024. 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 [redacted] of Taylor-Rose UK for the family [redacted] of Kennedys Law for Network Rail [redacted] of Kennedys Law for Network Rail [redacted] of Weightmans for British Transport Police [redacted], IOPC [redacted] for MPS [redacted] for MPS [redacted], Lead Investigator for Police Conduct 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	**[DATE]** **[SIGNED BY CORONER]** 4th December, 2023 Julian Morris, Senior Coroner