Regulation 28: Prevention of Future Deaths report

Vanessa FORD (died on 23 September 2023)

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. [redacted], Group Safety & Engineering Director, Network Rail – [redacted]** **2. [redacted], Interim Chief Executive, London Borough of Hackney, 1 Hillman Street, London, E8 1DY**
1	**CORONER** I am Ian Potter, assistant coroner for the coroner area of Inner North 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 2 October 2023, an investigation was commenced into the death of VANESSA FORD, then aged 47 years. The investigation concluded at the end of an inquest, heard by me, on Monday 26 February 2024. The conclusion of the inquest was a short narrative conclusion, the medical cause of death being: 1a multiple traumatic injuries
4	**CIRCUMSTANCES OF THE DEATH** On 23 September 2023, Vanessa Ford consumed a significant amount of alcohol while undergoing an acute mental health crisis. She accessed [redacted] and allowed herself to drop onto the railway tracks below, where she was later struck by a train. There is insufficient evidence to suggest that she intended to take her own life.
5	**<u>CORONER'S CONCERNS</u>** During the course of the inquest the evidence revealed matters giving rise to concern. In my opinion, there is a risk that future deaths could occur unless action is taken. In the circumstances, it is my statutory duty to report to you.

The **MATTERS OF CONCERN** are as follows:-

<u>To Network Rail, in particular:</u>

(1) I was provided with evidence that there have been three (non-fatal) incidents in the vicinity of the Hackney Central/Dalston Kingsland areas of the rail network in the 12 months prior to this incident on 23 September 2023 (British Transport Police Post Incident Site Report DOCU Reference: DOCU 2023 1576 refers). [redacted]. The concern here is that there is evidence to suggest that access to the railway tracks by members of the public may be a frequent issue in this vicinity.

(2) Evidence provided from CCTV footage and photographic evidence taken by the British Transport Police demonstrated that the particular piece of wall, which was used to access the railway network on 23 September 2023, was relatively low, despite an approximate drop onto the tracks below being 20 feet. The British Transport Police Post Incident Site Report sets out that the "Road over rail bridge has metal covers and hostile toppings on walls directly over the railway"; [redacted] This raises the concern that the mitigation/safety measures in place on the wall may not have been as effective as one might expect.

(3) The CCTV footage and photographic evidence presented to me, demonstrated that Ms Ford's access to the wall, and thereby the railway network below, [redacted]. In their oral evidence during the inquest, the Officer from the British Transport Police confirmed their view, which I accepted, that this electrical box makes access to the wall much easier than it should be. They also confirmed that this issue is unlikely to be confined solely to the [redacted] and that such items of street furniture may pose similar risks across the railway network.

<u>To Network Rail and the London Borough of Camden:</u>

(4) In addition to the [redacted] mentioned at (3) above, the evidence revealed numerous items of street furniture on the [redacted], [redacted] all of which could be used to facilitate easier access to the wall and the railway network. The concern here is that the siting of items of street furniture generally on this bridge poses risks to all manner of members of the public, from those contemplating suicide, to young children, and may undermine safety efforts to impede easy access to the railway network.

6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to 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 29 April 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 RESPONSE** I have sent a copy of my report to the Chief Coroner and to the following Interested Person: • [redacted] (Vanessa Ford's husband) 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	**Ian Potter** **HM Assistant Coroner, Inner North London** **4 March 2024**