REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

*NOTE: This form is to be used **after** an inquest.*

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1.** Department of Transport **2.** Transport for London **3.** Rail Safety Board
1	**CORONER** I am Mr Andrew Walker, senior coroner for the coroner area of Northern 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 24th May 2024 I commenced an investigation into the death of, Robert Grey English, aged 32. The investigation concluded at the end of the inquest on 10th June 2025. The conclusion of the inquest was Consequences of a failure to follow the proper process to recover a person from a stretch of railway. The medical cause of death was 1a Electrocution.
4	**CIRCUMSTANCES OF THE DEATH** On the 19th May 2024 Robert Gray English was electrocuted when the power supply to the rails was Switched on over a section of track between Hendon Central Station and Burnt Oak Underground, (covering Colindale Station), which he had been travelling down on foot in the dark. A train, that had been held stationary, began to search the track, then ran over Mr English who had passed some 400 to 600 meters from Colindale Station. The train was not adequately equipped to conduct such a search in darkness and this response was inadequate. A little earlier in the evening two police officers had followed Mr English into Colindale railway station having formed the view that he may be unwell and sought to contain him rather than restrain him. Mr English, who may have been confused by the actions of the police, ran to the platform where the police again tried to contain him. Mr English then left the platform and made his way into the night beyond the station. The Local Station Manager asked for the power supply to the track to be turned off. The police officers saw him climb up a part of the fence but was not able to say whether he had climbed over. Members of the public, when the officers passed them, gave in answer to their questions the impression that Mr English had left the trackside and was in the park. This was factually incorrect as neither officer saw

	Mr English climb over the fence into the park. The officers believed that this might have been the case and made their way to the park where they were told by a member of the public that a person has been seen on the railway side of the fence. Whilst the officers had left to look for Mr English in the park the Local Station Manager was asked to go to the platform and confirm that the police officers were still on the platform by a Service Manager and for confirmation that Mr English had left the track area. The Local Station Manager confirmed that the police had left and that the passenger was nowhere to be seen and that the police did say that he climbed over the fences and has left the tracks. The Service Manager asked the Local Station Manager to contact the controller on his behalf so the power to the track can be switched on. The requirements within the rule book when switching the power supply to the rails were not followed in particular telling all the relevant people that the power supply to the rails is about to be switched on. This would have given the Police and British Transport Police an opportunity to confirm that Mr English had not been found and was likely still on the railway side of the tracks. It is likely that had this step been followed the power supply would not have been switched on and a proper search, which was also possible, is likely to have found Mr English and returned him safely to the station.
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 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. – The provision to protect a trespasser at night are the same as those during the day. The ability to locate a person close to or on the railway lines at night is made more difficult by the absence of suitable lights on the track or the train. In this case Mr English was not seen and run over by the train that has been asked to look for a person on the line .
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you [AND/OR your organization 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 Friday 19th September 2025 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] Family Legal Representative Met Police British Transport Police I am also under a duty to send a copy of your response to the Chief Coroner and all interested persons who in my opinion should receive it. I may also send a copy of your response to any other person who I believe may find it useful or of interest. 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.
9	**DATE: 25th July 2025**