REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. Department of Health**
1	**CORONER** I am Mr Andrew Walker, HM 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 22nd July 2024 I commenced an investigation into the death of Sidi Chax Bojang, aged 34. The investigation concluded at the end of the inquest on the 22nd July 2025. The conclusion of the inquest was Consequences of an untreated mental health condition. The medical cause of death was 1a Multiple Injuries.
4	**CIRCUMSTANCES OF THE DEATH** On the 19th July 2024 at about 16.41 Sidi Chax Bojang left the platform at Oakleigh Park Railway Station and was struck by a fast train passing through the station. Mr Bojang was clearly unwell and had attended the Accident and Emergency department the day before complaining of a "wooshing" sound and seeing flashes of light when he was triaged. He had attended with feelings of self harm and had reported an attempt to cut his wrist and stab himself [redacted] Mr Bojang had sought help from the hospital but after assessing him and, as he said he felt better and agreed to see his GP, was allowed to leave. It is likely that Mr Bojang was seriously ill, and may have had auditory and visual hallucinations and this was not recognised when he was examined. The symptoms may have been incorrectly attributed to his use of cocaine taken the week before and drinking beer and whiskey 2-3 times a week. On the day he died Mr Bojang called an ambulance at 04.53 in the morning saying he had cut himself [redacted] and was taken to the A&E Department at 07.30 but had left the hospital by the time the psychiatric liaison team had arrived.

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. – Where there is a significant change in presentation when assessed suggesting that the patient is now well, when either the same day, or a short time before presentation, acts of self harm, suicidal behaviour or thoughts were present. That a psychiatrist did not review the person presenting before discharge. The discharge of the person in these circumstances fell to a senior psychiatric nurse.
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 26th 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: Family Members. Barnet Psychiatric Liaison Team 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	**1st August 2025**