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. Metropolitan Police General enquiries Metropolitan Police Service New Scotland Yard Broadway London SW1H 0BG 2. Department of Health Ministerial Correspondence and Public Enquiries Unit Department of Health Richmond House 79 Whitehall London SW1A 2NS 3. RSSB Enquiry Desk RSSB 1 Torrens Street London, EC1V 1NY 4. LAS Legal Services London Ambulance Service NHS Trust 220 Waterloo Road London SE1 8SD
1	**CORONER** I am Andrew Walker, 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 13th Day of January 2102 I commenced an investigation into the death of Daniel Maurice McMahon aged 30 years old. The investigation concluded at the end of the inquest on 23rd September 2013. The conclusion of the inquest was a narrative conclusion; the medical cause of death was head injuries. On the 11th January 2012 Daniel Maurice McMahon suffered severe head injuries as a result of being hit by a train at Willesden Junction Station, Station Approach. Daniel had been on leave from Park Royal Hospital whilst undergoing treatment under

	the Mental Health Act. The Jury concluded that, on the balance of probabilities the train could have been stopped in time if the correct information regarding the location had been entered,(by police taking the call from a member of the public)
4	**CIRCUMSTANCES OF THE DEATH** Mr McMahon has been seen by a member of the public falling from a bridge over a section of the over-ground railway track next to Willesden Junction London Underground Station. Mr McMahon was seen to strike the overhead cables and then fall onto the track. Mr McMahon then moved under the bridge but still in the line of sight of the member of the public who by now was on his mobile phone talking to police. Mr McMahon appeared to move in front of, and was struck by a train leaving Willesden Junction Station sustaining fatal injuries. The Court appointed expert was of the view that, despite the fatal injury received by Mr McMahon from the collision, it was potentially dangerous to use bilateral needle decompression of the chest, currently performed where necessary by the London Ambulance Service, without a valve.
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. – (1) Metropolitan Police :- That steps should be taken to ensure that when report is passed to the police concerning a person who is seen to be trespassing on the railway line that correct information is gathered to locate that person and the section of the track that person is on so that this information can be passed to those responsible for contacting the network covering that section of the track. This is in addition to the attendance location and the incident location normally recorded when a 999 call is made. (2) Department of Health:- Consideration to be given to using a feedback form, where a patient is on S17 of the MHA 1983 leave, to be completed by those caring for the patient in the community and the professional staff at the hospital to ensure that any difficulties that a patient has while on leave are picked up (3) RSSB:- The Rule book be amended to require that trains stop, (signals are set to danger), when a person who is identified as being unwell or there is reason to believe might be unwell is trespassing on the line. (The current position would be to set the signals to caution). (4) London Ambulance Service:- The LAS consider the guidance on the use of lung decompression needles and whether these should be used with a valve.
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 Tuesday 17th December 2013. 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] 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	21 OCT 2013