Regulation 28: Prevention of Future Deaths report

Andrew PHRYDAS (died 04.06.12)

	THIS REPORT IS BEING SENT TO: **1. [redacted]** **Managing Director** **London Underground** **Palestra** **197 Blackfriars Road** **London SE1 8NJ**
1	**CORONER** I am: Coroner ME Hassell Senior Coroner Inner North London St Pancras Coroner's Court Camley Street London N1C 4PP
2	**CORONER'S LEGAL POWERS** I make this report under the Coroners and Justice Act 2009, paragraph 7, Schedule 5, and The Coroners (Investigations) Regulations 2013, regulations 28 and 29.
3	**INVESTIGATION and INQUEST** On 6 June 2012, my predecessor, Shirley Anne Radcliffe, commenced an investigation into the death of Andrew Phrydas (aged 23 years). The investigation concluded yesterday. The medical cause of death was 1a multiple injuries, and the jury returned a narrative conclusion, a copy of which I attach.
4	**CIRCUMSTANCES OF THE DEATH** Andrew Phrydas died when he was struck by a London Underground train on the line just outside Finsbury Park Station. He had jumped off the platform and run into the tunnel, then crossed over from the Victoria Line onto the Piccadilly Line, which is where the collision took place.

5	**CORONER'S CONCERNS** During the course of the inquest, the evidence revealed matters giving rise to concern. There may be 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** raised by the jury are contained in their narrative as follows. Three minutes and 49 seconds passed between Andrew leaving the platform and him being struck by the train. Although a person in the tunnel was an unprecedented event, there was a failure by London Underground to have a process in place to shut down both lines simultaneously at a station where two lines intersect. There was also a failure by London Underground to alert the driver in the most direct and effective method about Andrew's presence on the track.
6	**ACTION SHOULD BE TAKEN** I believe that you and London Underground have the power to take action that may prevent future deaths.
7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of the date of this report, namely by 20 January 2014. 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 following. • HHJ Peter Thornton QC, the Chief Coroner of England & Wales • [redacted] • [redacted] Barnet Enfield & Haringey MentalHealth Trust • [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 Senior Coroner, at the time of your response, about the release or the publication of your response by the Chief Coroner.
9	**DATE** **SIGNED BY SENIOR CORONER** 15.11.13