Regulation 28: Prevention of Future Deaths report

Benjamin Michael HADDON-CAVE (died 21.03.19)
Patrick Thomas BOLSTER (died 21.03.19)

	THIS REPORT IS BEING SENT TO: **1. Mr Andrew Haines** **Chief Executive Officer** **Network Rail** **1 Eversholt Street** **London NW1 2DN**
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 26 March 2019, one of my assistant coroners, Sarah Bourke, commenced an investigation into the death of Ben Haddon-Cave and Paddy Bolster, aged 27 and 26 years respectively. The investigations concluded at the end of the inquests earlier today. I made a narrative determination at each inquest, which I attach now.
4	**CIRCUMSTANCES OF THE DEATH** These two young men climbed on top of a freight train near Hackney Wick Station in the small hours of 21 March 2019 and were electrocuted. This was an impulsive act. They reached the train by way of a gap in the track perimeter fence giving on to a well worn path leading to trackside.

5 **CORONER'S CONCERNS**

During the course of the inquests, 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.

Paddy and Ben died on 21 March 2019. The last time the broken fence was checked was 27 October 2016. In the intervening two and a half years, reasonable endeavours had not been made to inspect (and repair) the fence.

1. The fence was marked down for annual inspections because there was no history of problems in that area. However, the inspectors conducting the inspections on 27 October 2017 and 27 October 2018 (a different inspector on each occasion) did not consider the relevant part of the fence because dense vegetation blocked their view from trackside.

   Neither inspector attempted to view the fence from the other (public) side, which they could easily have done.

   This represents a failure of the two individuals and/or a failure of their training and/or both. There are only four inspectors at Tottenham, so two inspectors represents half the inspections workforce.

2. Both inspectors inputted their inspection onto a computer system, but neither submitted a paper form as they were meant so to do.

   This represents a failure of the two individuals and/or a failure of their training and/or both. In any event, such a system of dual submission was inherently flawed.

3. As a consequence of no paper forms being submitted, the track engineer did not see the evidence of the failure to inspect the fence, and so was not in a position to challenge this.

   This represents a system failure.

4. As a consequence of no paper forms being submitted, the internal auditors did not see the evidence of the failure to inspect the fence or the evidence of the failure to challenge, and so were not in a position to highlight this.

   This represents a system failure.

	5. Network Rail identified the gap in the fence within a week of the deaths but, despite what was described as a full internal investigation, the system failures I have described were only discovered after the inquest had resumed on 30 August 2019. Their original investigation was inadequate. Network Rail had been operating for the previous five and a half months on the basis that this was a localised problem. Even after an adjournment to facilitate further investigations, a senior Network Rail representative gave evidence to that effect on 13 September 2019. Yet the reality is that Network Rail does not know if it has a national system failure of fencing inspection. Paddy and Ben were adults who had responsibility for their own actions, but the fence gap was accessible to children and appeared to be worn. And I heard no evidence that the two had planned to go up onto trackside. A determined effort can be difficult to thwart, but an impulsive action (with judgement and motor skills impaired through alcohol) might well be avoided if the route to danger is not so very easily taken.
6	**ACTION SHOULD BE TAKEN** In my opinion, action should be taken to prevent future deaths and I believe that 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 by 25 November 2019. 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 Mark Lucraft QC, the Chief Coroner of England & Wales • The Office of Road and Rail • [redacted], Ben's parents • [redacted], Paddy's mum

	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** 25.09.19