Her Majesty's Coroner for the
Northern District of Greater London
(Harrow, Brent, Barnet, Haringey and Enfield)

North London Coroners Court,
29 Wood Street,
Barnet EN5 4BE

Telephone 0208 447 7680
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| | **REGULATION 28 REPORT TO PREVENT FUTURE DEATHS**<br><br>**THIS REPORT IS BEING SENT TO:**<br>Barnet Council<br>2 Bristol Ave,<br>London<br>NW9 4EW<br>. |
| 1 | **CORONER**<br><br>I am Andrew Walker, senior coroner, for the coroner area of Northern District of Greater London |
| 2 | **CORONER'S LEGAL POWERS**<br><br>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**<br><br>On the 23rd May 2019 I opened an investigation touching the death of Sonny Bob Parmar aged 3 years old. I opened an inquest on the1st July 2019. The inquest concluded on the 3rd March 2020. The conclusion of the inquest was "Road traffic collision ". The medical cause of death was 1a Head Injury. |
| 4 | **CIRCUMSTANCES OF THE DEATH**<br>On the Twenty-Second of May 2019 Sonny Bob Parmar was walking with his mother when when they approached a Pelican crossing on the East End Road when Sonny would usually then sit in a buggy for the rest of the journey home. It is likely that Sonny ran behind his mother and then into the road where he stopped. His mother reached to grab him and he moved further away just past the zig-zag line and was struck as was his mother by a car. Sonny was taken to the Whittington Hospital where he died from his injuries. |
| 5 | **CORONER'S CONCERNS**<br><br>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.<br><br>The **MATTERS OF CONCERN** are as follows. –<br><br>That there is no limitation for the speed of the road adjacent to the curtilage of the school as is seen in other areas where traffic is slowed at times where children are arriving and leaving the school. |

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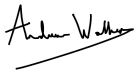
| 6 | **ACTION SHOULD BE TAKEN**<br><br>In my opinion action should be taken to prevent future deaths and I believe you [AND/OR your organization] have the power to take such action. |
| 7 | **YOUR RESPONSE**<br><br>You are under a duty to respond to this report within 56 days of the date of this report, namely by the 19th May 2020 I, the coroner, may extend the period.<br><br>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**<br><br>I have sent a copy of my report to the Chief Coroner and to the following Interested Persons;-<br><br>The Family.<br><br>I am also under a duty to send the Chief Coroner a copy of your response.<br><br>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 | **24-3-2020**  |