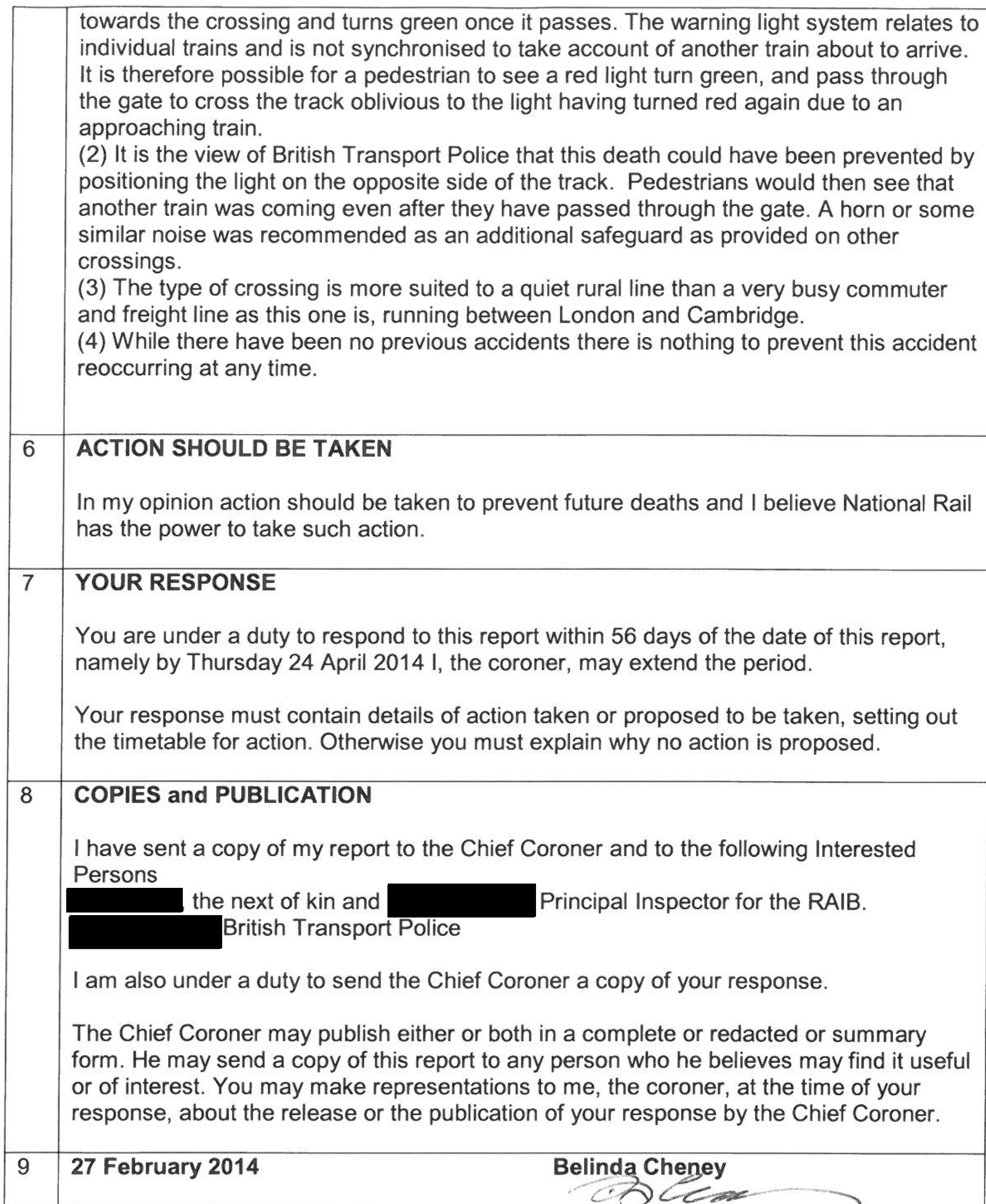
	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** 1. [redacted] **Route Managing Director, Network Rail**
	CORONER I am Belinda Cheney, assistant coroner, for the coroner area of South and West Cambridgeshire
2	**CORONER'S LEGAL POWERS** I make this report under paragraph 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 9 October 2013 I commenced an investigation into the death of Malcolm James Ernest Potter aged 76 years. The investigation concluded at the end of the inquest on 6 February 2014. The conclusion of the inquest was that: 1. The medical cause of death was: 1(a) Multiple injuries predominantly neck fracture 2 Diabetes mellitus, coronary artery atherosclerosis, hypertension 2. Narrative Conclusion: On 3rd October 2013 Mr Potter took his regular walk across the Dernford Crossing, "a user-worked crossing". After the South bound train passed Mr. Potter proceeded to cross but was struck by a North bound train at around 0920hrs. He had no opportunity to see the light change from red when triggered by the arrival of the North bound train. This was due to configuration of the crossing. Life was pronounced extinct at 0948hrs.
4	**CIRCUMSTANCES OF THE DEATH** Mr Potter was a regular walker in his local area. On 3.10.13 he approached the Dernford railway crossing while out walking. He waited for a south bound train to pass then he crossed the track and was struck by a north bound train which he did not apparently see or hear.
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) The warning light for pedestrians is positioned before the gate through which the pedestrian passes before crossing the track. A red light is triggered by a train coming



	towards the crossing and turns green once it passes. The warning light system relates to individual trains and is not synchronised to take account of another train about to arrive. It is therefore possible for a pedestrian to see a red light turn green, and pass through the gate to cross the track oblivious to the light having turned red again due to an approaching train. (2) It is the view of British Transport Police that this death could have been prevented by positioning the light on the opposite side of the track. Pedestrians would then see that another train was coming even after they have passed through the gate. A horn or some similar noise was recommended as an additional safeguard as provided on other crossings. (3) The type of crossing is more suited to a quiet rural line than a very busy commuter and freight line as this one is, running between London and Cambridge. (4) While there have been no previous accidents there is nothing to prevent this accident reoccurring at any time.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe National Rail has 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 Thursday 24 April 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 Chief Coroner and to the following Interested Persons █████, the next of kin and █████ Principal Inspector for the RAIB. █████ British Transport Police 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	**27 February 2014** **Belinda Cheney**