REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1) *NOTE: This form is to be used after an inquest.*

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	THIS REPORT IS BEING SENT TO:		
	The Right Hon Patrick McLoughlin MP Secretary of State for Transport Great Minster House 33 Horseferry Road London SW18 4DR	The Chief Executive Association of Train Operating Companies ATOC Limited 2 nd Floor 200 Aldersgate Street London EC1A 4HD	
1	CORONER		
	I am Mr Tom Osborne , Senior Coroner, for the Coroner Area of Bedfordshire and Luton		
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.		
	http://www.legislation.gov.uk/ukpga/2009/25/schedule/5		
3	INVESTIGATION and INQUEST		
	On the 31 st January 2013 I commenced an Investigation into the death of Terence Vincent Anthony FERNANDES aged 36. The Investigation concluded at the end of the Inquest on 29 th of April 2014. The Conclusion of the Inquest was that the deceased had died as a result of : (medical cause of death)		
	I(a) Bilateral Confluent Bronchopneumonia(b) Global Ischaemic Cerebral Damage as a result of Cardiac Respiratory Arrest		
4	CIRCUMSTANCES OF THE DEATH		
	Terence Vincent Anthony FERNANDES on the 23rd January 2013 collapsed on a train travelling from Blackfriars to Bedford; he had been drinking alcohol He was taken off the train at St. Albans Station at 00:50 hours; he had become unconscious and was carried to a Waiting Room where Paramedics attended. He suffered a cardiac arrest when he stopped breathing due to the occlusion of his		

	airway. He was taken to Watford General Hospital and transferred to Bedford Hospital where he died on 25th January 2013.	
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) Terence Fernandes had become seriously unwell during the journey from Blackfriars to St. Albans whilst a passenger on a train. He was taken off the train by the driver, security staff and staff in attendance at the station and yet none of the personnel had even basic first aid training. If someone had had even limited first aid knowledge they may have been able to recognise that Terence's airway had become partially occluded.	
6	ACTION SHOULD BE TAKEN	
	In my opinion action should be taken to prevent future deaths and I believe you, as the Chief Executive of The Association of Train Operating Companies and as The Secretary of State for Transport 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 the 4th JULY 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 The Chief Executive of The Association of Train Operating Companies The Bight Hop Patrick Mol aughlin MP. Secretary of State for Transport	
	The Right Hon Patrick McLoughlin MP - Secretary of State for Transport. and to the following Interested Person(s):	
	The Family First Connect	

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, redacted or summary form. He may also 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 Dated this 12th day of May 2014

Tom OSBORNE Senior Coroner Bedfordshire & Luton