INQUEST TOUCHING THE DEATH OF EMMA ISABEL LIFSEY

REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** [redacted] **Chairman, Network Rail** **Mr Mark Carne, Chief Executive, Network Rail**
1	**CORONER** I am Heidi Julia Connor, assistant coroner for the coroner area of Nottinghamshire.
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 7 December 2012 I commenced an investigation into the death of Emma Lifsey, DoB 1 September 2008. The investigation concluded at the end of the inquest on 1 May 2014. The conclusion of the jury at the inquest was : Medical cause of death : traumatic brain injury Narrative conclusion : The conclusion of the death of Emma Isabel Lifsey is due to accident.
4	**CIRCUMSTANCES OF THE DEATH** Emma Lifsey was a 4 year old girl, travelling as a passenger in the rear seat of a car driven by her grandmother, [redacted] on Springs Road, on the approach to Beech Hill level crossing, near Finningley, North Nottinghamshire, on 4 December 2012. [redacted] gave evidence that she did not see the barrier or the wig wag lights at the automatic half barrier crossing until it was too late, and drove into the path of a train. Emma died the following day. [redacted] sustained serious injuries, but survived.
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. – We heard evidence from several witnesses about the effect of glare – both directly from the low sun and reflected from the road surface – and how this may have affected the visibility of the wig wag lights in particular. We heard that the wig wag lights at Beech Hill crossing had old-style 36W filament bulbs. The optical consultant described these lights as being "the worst he had seen", and less than half as bright as they should have been.

	Network Rail witnesses gave evidence about changes being implemented. In particular, we heard of the decision to change all 36W lights at level crossings to LED lights. We were told that 494 level-crossings have been identified as having the old-style lights. This information was available in December 2013. To date, 58 have had the lights changed to LEDs. The current plan, we were told, was to complete this by October 2015. We were also told that Network Rail is considering commissioning research into the effect of glare on signals. I heard evidence (in the absence of the jury) about RAIB recommendations made after collisions at Wraysholme in 2008, and Halkirk in 2009. These incidents were not identical factually to the collision at Beech Hill, but it is clear that the issue of sun glare and visibility of signals is not a new one. I noted at the inquest that Network Rail is seeking to reduce these risks, but my concern relates to timescale. The proposed changes and research are simply taking too long, and I am concerned that this risk will not be reduced quickly enough to avoid further tragedies.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you and your organisation have the power to take such action. I ask that you consider expediting the following : 1. Replacement of all 36W bulbs with LEDS at level crossings – currently scheduled to be completed by October 2015. 2. Research into determining objective criteria that those inspecting crossings can use to determine : a. How signal performance and the effect of glare can be objectively assessed in the field. b. How to set up a programme for keeping this under regular review. c. How to assess which crossings are most affected by sunlight and glare. In your response, I invite your commitment to clear, achievable deadlines.
7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of the date of this report, namely by 3 July 2014. I, the coroner, may extend the period, on written application by you in advance of this deadline. 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 : 1. Parents of Emma Lifsey 2. [redacted] 3. RAIB 4. ORR I have also emailed a copy to Network Rail's solicitor, [redacted] at Berryman Lace Mawer.

	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	**7 May 2014**