	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **Network Rail** **1 Eversholt Street** **London** **NW1 2DN**
1	**CORONER** I am Penelope Anna Schofield, Senior Coroner, West Sussex
2	**CORONER'S LEGAL POWERS** I make this report under Para 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 12th September 2014 I commenced an investigation into the death of Elliott Bignall, born on 10th May 1997, being 17 years of age. An Inquest was opened on 12th September 2014 and was concluded on 12th March 2015
4	**CIRCUMSTANCES OF THE DEATH** On 9th September 2014 Mr Bignall was hit by a train on the Langsmead Foot Crossing in Ferring, West Sussex. At the time of the incident it was believed that he was on the phone to his girlfriend. He died from multiple injuries. There was no evidence to suggest that Mr Bignall intended to take his own life. The Conclusion recorded by myself at the end of the Inquest was that Mr Bignall suffered an accidental death.
5	**CORONER'S CONCERNS** During the course of the inquest the evidence revealed matters giving rise for 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 make this report to you. The MATTERS OF CONCERN are:- Sergeant [redacted] the investigating officer from BTP gave evidence to the Inquest and described the foot crossing at Langmeads as horrendous. He said the location of the foot crossing was poorly lit and there was inadequate signage at the site warning pedestrians of the dangers associated with the crossings. My concerns are that individuals wearing headphones or on the phone, who are unaware of the dangers associated with the crossing, may not hear or see the high speed train approaching. This could lead to further fatalities.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you and your organisation, can 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 18th May 2015. I, the Coroner, may extent that period. Your response must contain details of action taken or proposed to be taken, setting out the timeline 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: [redacted] – Elliott's parents Inspector [redacted] on behalf of 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 representation to me, the Coroner, at any time of your response about the release or publication of your response by the Chief Coroner
9	**DATE:** 23rd March 2015 **SIGNED:**