

REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

*NOTE: This form is to be used **after** an inquest.*

	<p>REGULATION 28 REPORT TO PREVENT FUTURE DEATHS</p> <p>THIS REPORT IS BEING SENT TO:</p> <ol style="list-style-type: none">1. National Rail2. [REDACTED] (Mother)3. [REDACTED] (Father)4. [REDACTED] (Partner)5. The Chief Coroner
1	<p>CORONER</p> <p>I am Lorna Tagliavini assistant coroner, for the coroner area of Inner London - South</p>
2	<p>CORONER'S LEGAL POWERS</p> <p>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. [HYPERLINKS]</p>
3	<p>INVESTIGATION and INQUEST</p> <p>On 2nd July 204 I commenced an investigation into the death of Mathew Lee Hoare, aged 29 years, The investigation concluded at the end of the inquest on 12th March 2015. The conclusion of the inquest was "Accidental Death" as a result of multiple injuries and severe burns.</p>
4	<p>CIRCUMSTANCES OF THE DEATH</p> <p>In the early hours of 25th June 2014 after a night out socialising with friends, Mr Hoare was found lying on the live rail near Wandsworth Road Train Station having been seen to enter Clapham High Street Station after hours and gained access to the platforms and tracks. He fell on the live rail and electrocuted and was also hit by an oncoming train, thereby sustaining fatal injuries.</p>
5	<p><u>CORONER'S CONCERNS</u></p> <p>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.</p> <p>The MATTERS OF CONCERN are as follows. –</p> <ol style="list-style-type: none">(1) The lack of effective security equipment preventing access to the station and tracks after the hours of operation.(2) The ease at which Mr Hoare was able to access the station and tracks by climbing through widely spaced yellow tape.
6	<p>ACTION SHOULD BE TAKEN</p> <p>In my opinion action should be taken to prevent future deaths and I believe your</p>

	organisation] have the power to take such action.
7	<p>YOUR RESPONSE</p> <p>You are under a duty to respond to this report within 56 days of the date of this report, namely by 22nd July 2015. I, the coroner, may extend the period.</p> <p>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.</p>
8	<p>COPIES and PUBLICATION</p> <p>I have sent a copy of my report to the Chief Coroner and to the following Interested Persons [REDACTED] [REDACTED] and [REDACTED] the parents and partner of the deceased</p> <p>I am also under a duty to send the Chief Coroner a copy of your response.</p> <p>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.</p>
9	<p>[DATE] [SIGNED BY CORONER]</p> <p>27 May 2015 LM Taglia [REDACTED]</p>