**ANNEX A**

## REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

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

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| | **REGULATION 28 REPORT TO PREVENT FUTURE DEATHS**<br><br>**THIS REPORT IS BEING SENT TO:**<br><br>1. [redacted]<br>2. [redacted] **Historical Railways Estate, Highways England, Hudson House, Toft Green, York, YO1 6HP** |
| 1 | **CORONER**<br><br>I am Melanie Jane Williamson assistant coroner, for the coroner area of West Yorkshire (eastern) |
| 2 | **CORONER'S LEGAL POWERS**<br><br>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**<br><br>On the 30th January 2014 I commenced an investigation into the death of Fred Hudson, aged 87 years. The investigation concluded at the end of the inquest on 22nd April 2015. The conclusion of the inquest was Accidental Death and the medical cause of death was:-<br>1(a) Multiple injuries |
| 4 | **CIRCUMSTANCES OF THE DEATH**<br><br>During the early hours of the 28th January 2014 Mr Fred Hudson was walking along a path to a disused railway bridge, bridge number AB08, which is of a height from the ground of approximately 25 metres and is located at Barwick Road in Leeds. Mr Hudson fell from the said bridge, thereby sustaining multiple injuries. His death was certified at the scene at 4.44am the same day. |
| 5 | **CORONER'S CONCERNS**<br><br>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.<br><br>The **MATTERS OF CONCERN** are as follows. –<br><br>Railway bridge number AB08 has been disused for many years. It is accessible by a number of routes. No steps have been taken to prevent access to the said bridge. It is located next to a main road and is visited frequently by members of the public including children. |

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| 6 | **ACTION SHOULD BE TAKEN**<br><br>In my opinion action should be taken to prevent future deaths and I believe you [AND/OR your organisation] have the power to take such action. |
| 7 | **YOUR RESPONSE**<br><br>You are under a duty to respond to this report within 56 days of the date of this report, namely by 8th July 2015.<br>I, the coroner, may extend the period.<br><br>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**<br><br>I have sent a copy of my report to the Chief Coroner and to the following Interested Persons [NAMES] [and to the LOCAL SAFEGUARDING BOARD (where the deceased was under 18)]. I have also sent it to [NAMED PERSON] who may find it useful or of interest.<br><br>I am also under a duty to send the Chief Coroner a copy of your response.<br><br>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 | **13th May 2015**<br><br>[redacted]<br>**MELANIE J WILLIAMSON, Assistant Coroner, West Yorkshire (eastern)** |