

REGULATION 28 REPORT TO PREVENT FUTURE DEATHS
Re Jakovas Fofonovas, 01397-15 (died 23.05.15) (MM)

THIS REPORT IS BEING SENT TO:

1. [REDACTED] Director, Network Strategy and Planning, Network Rail
Kings Place, 90 York Way, London, N1 9AG

1 CORONER

I am Andrew Harris, Senior Coroner, London Inner South

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 INQUEST

On 28th May 2015 I opened an inquest into the death of **Mr Jakovas Fofonovas**, who died on 23rd May 2015 on the rails near Abbey Wood railway station.

I concluded the inquest at a full hearing on 7th January 2016.
The medical cause of death was

1a Multiple injuries

1b Struck by train

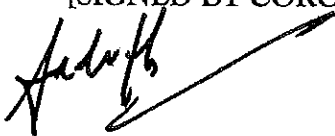
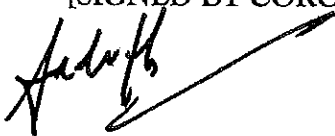
The coroner concluded he committed suicide

4 CIRCUMSTANCES OF THE DEATH

The deceased accessed the railway.

The British Transport Police Post Fatality Survey Report [REDACTED] found that at Bridge No 614A, Bostall Manorway, Abbey Wood:

- i) The stairs to the footbridge had low railings that enabled easy access to the track
- ii) There were temporary mesh extensions and fencing in poor condition
- iii) The mid elevation turn back was of great concern due to possible access to railway land
- iv) There are no measures in place to mitigate against the railings being climbed over
- v) Building materials under the bridge offer aids to climbing down

5	<p>CORONER'S CONCERNS</p> <p>The MATTER OF CONCERN is as follows. -</p> <p>Recommendations in The BTP Post Fatality Report to create a safer environment at the bridge and restrict public access to the railway had not been effected by the time of the inquest. The court did not have the benefit of Network Rail spokesperson in court to provide evidence of future plans</p>		
6	<p>ACTION SHOULD BE TAKEN</p> <p>In my opinion action should be taken to prevent future deaths and I believe that that if the Network Rail is in a position to do so.</p>		
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 Monday 25th April 2016. 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> <p>If you require any further information about the case, please contact the case officer, [REDACTED] If you require further information about the process of responding to this report my clerk [REDACTED] to whom your response should be sent.</p>		
8	<p>COPIES and PUBLICATION</p> <p>I have sent a copy of my report to the following Interested Persons: [REDACTED] [REDACTED] (wife). I am also sending a copy to the [REDACTED] Coroners Liaison for London South British Transport Police.</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	<table border="0"> <tr> <td data-bbox="300 1818 686 2047"> <p>[DATE]</p> <p>Written: 26.02/16</p> <p>Sent: 1/3/2016</p> </td> <td data-bbox="686 1818 1342 2047"> <p>[SIGNED BY CORONER]</p>  </td> </tr> </table>	<p>[DATE]</p> <p>Written: 26.02/16</p> <p>Sent: 1/3/2016</p>	<p>[SIGNED BY CORONER]</p> 
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