ANNEX A

REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** 1. **Mark Carne, Chief Executive, Network Rail**
1	**CORONER** I am Philip Barlow assistant coroner, for the coroner area of Inner South London.
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 5 October 2015 I commenced an investigation into the death of Richard Hinchliffe, age 31. The investigation concluded at the end of the inquest on 21 June 2016. The conclusion of the inquest was one of accident. The medical cause of death was 1a Electrocution. II Under the influence of alcohol.
4	**CIRCUMSTANCES OF THE DEATH** Richard Hinchliffe died on 2 October 2015 after walking down the train tracks between Blackfriars and London Bridge stations, having gained access from platform 1 of Blackfriars station at 02.48 (from CCTV). He fell and suffered fatal electrocution. An investigation into the death was conducted by [redacted] of BTP. I attach a copy of this report to assist with the background. The evidence at the inquest was that Mr Hinchliffe was under the influence of alcohol. He entered Blackfriars station at 01.51 and may then have fallen asleep on platform 1 until 02.48/02.49 when CCTV showed him going through the barrier gate onto the rail lines.
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. – (1) The evidence at the inquest was that the barrier gate from platform 1 onto the rail lines was clearly marked with warning signs and "witches hat" matting. [redacted] evidence was that normal practice is also to secure the barriers with a cable tie to deter unauthorised access but to allow reasonable emergency access when required. However, the evidence suggested that at the time of the PFSS visit the gate was tied shut using a shoe lace. This visit was several days after the incident and is not necessarily indicative of the situation on 2 October. However, the evidence at the inquest also suggested that Mr Hinchliffe gained access through the barrier with some ease which might suggest that the barrier was not secured. It is not clear how often the

	barriers onto the lines are checked to ensure appropriate security is in place. (2) Mr Hinchliffe was seemingly asleep on the platform for approximately one hour before gaining access onto the line. The evidence was that Blackfriars station is staffed 24 hours. It is not clear whether his presence would have been noted and flagged as a possible security/safety concern.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe your organisation have the power to 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 by 23 August 2016. I, the coroner, may extend the period. 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 Mr Hinchliffe's family as Interested Persons. 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	**24 June 2016** **Philip Barlow**