ANNEX A

REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

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

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. Great Western Railway - Managing Director** **GWR Customer Support** **FREEPOST RSKT-AHAZ-SLRH** **Plymouth** **PL4 6AB**
1	**CORONER** I am Mr. John G. Tomalin, Deputy Coroner, for the coroner area of Exeter and Greater Devon.
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. [HYPERLINKS]
3	**INVESTIGATION and INQUEST** On 10th December 2015 I commenced an investigation into the death of Michael Dean YOUNGHUSBAND, aged 22. The investigation concluded at the end of the inquest on 2nd June 2016. The conclusion of the inquest was given as Mr Younghusband died as a result of an accident. Medical cause of death as Multiple Injuries.
4	**CIRCUMSTANCES OF THE DEATH** Mr Younghusband had attended RMB Lympstone to undertake a course. He successfully completed that course with a distinguished pass. He and others went out to celebrate the end of the course and visited various public houses in and around Exmouth and Topsham. Mr Younghusband became detached from his friends and it was believed that he was making his way back to camp along the railway, between Exmouth and Lympstone. His body was found close to a pedestrian crossing across the railway tracks. His body was hit by a train and he suffered non-survivable injuries. His blood alcohol level was 245mg/100ml of blood when the Post Mortem sample was tested by laboratory. Mr Younghusband's family were concerned as to how someone who had been drinking a large quantity of alcohol had managed to walk the distance he did from when he'd last been seen to where his body was found. Of greater concern was the poor state of repair of the crossing very near the point where the body was struck by the train. The evidence given at the Inquest by Mr Younghusband's brother who, with his father and others had been taken to the crossing near where Mr Younghusband's body had been found, expressed their concerns about the poor state of repair at the crossing only one month after Mr Younghusband had been struck by the train.

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. – [BRIEF SUMMARY OF MATTERS OF CONCERN] (1) The poor state of the crossing point was oof concern to Mr Younghusband's family as they believed it was a potential tripping hazard as they had observed a metal section, on the Lympstone side of that crossing, standing proud of the track bed.
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. An investigation to ascertain whether or not any repair works may be necessary to prevent persons using the crossing from tripping or falling and potentially suffering fatal injury if they are not able to move out of the path of an oncoming train.
7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of the date of this report, namely by 18/08/2016..... 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 the following Interested Persons: Younghusband's Family and [redacted] Ministry of Defence/Defence Inquests Unit. 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	**Dated:** 23/06/2016 **Signed by:** **Mr John G. Tomalin** **Deputy Coroner for Exeter and Greater Devon**