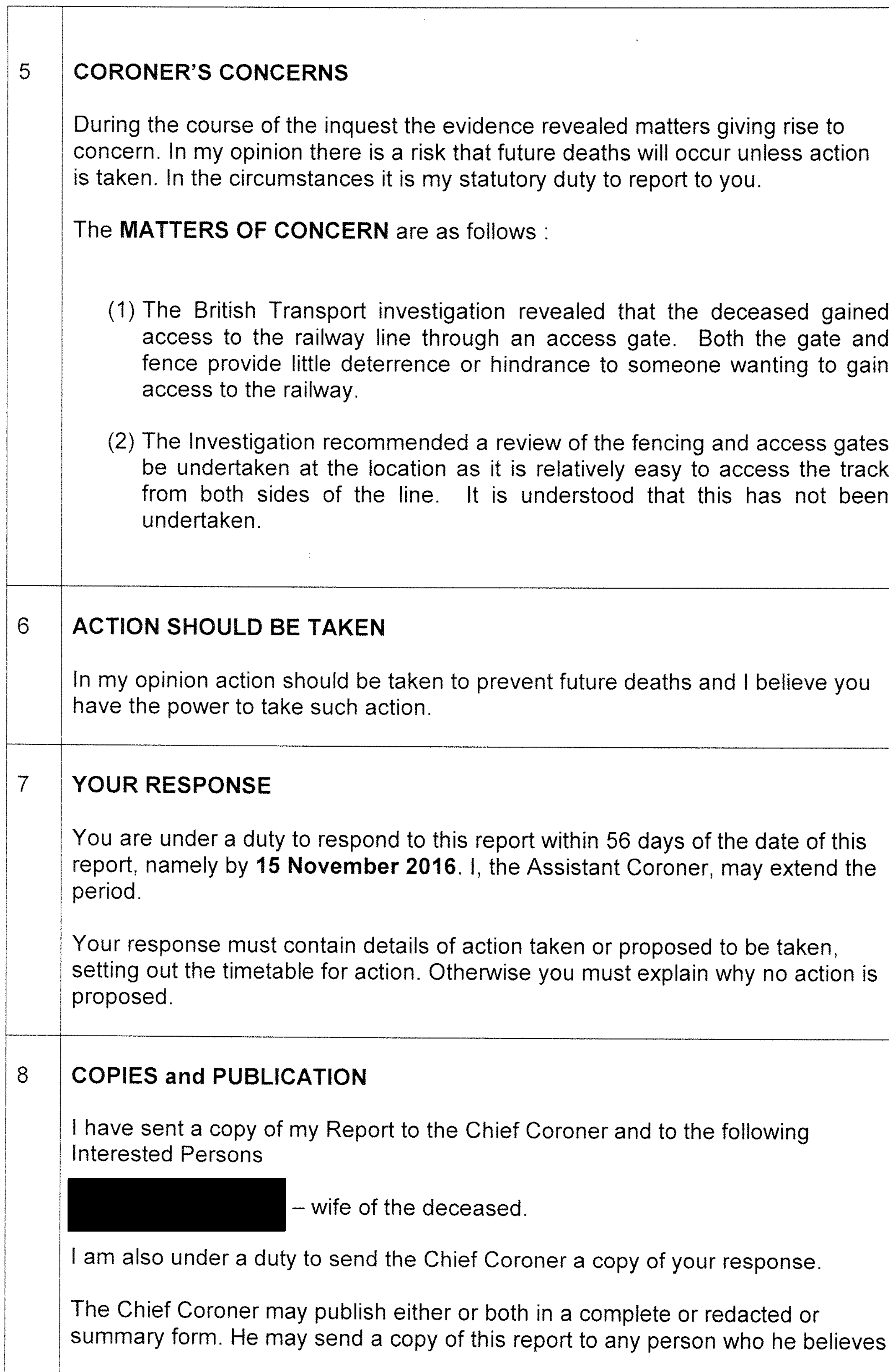
Ian Pears
Assistant Coroner for Bedfordshire and Luton

REGULATION 28 REPORT TO PREVENT FUTURE DEATHS

	THIS REPORT IS BEING SENT TO: **The Chief Executive** **Network Rail** **1 Eversholt Street** **London NW1 2DN**
1	**CORONER** I am Ian Pears, Assistant Coroner for Bedfordshire and Luton
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. http://www.legislation.gov.uk/ukpga/2009/25/schedule/5/paragraph/7 http://www.legislation.gov.uk/uksi/2013/1629/part/7/made
3	**INVESTIGATION and INQUEST** On 1st April 2016 I commenced an Investigation into the death of **Stephen Sean CAHILL** aged 55 years. The Investigation concluded at the end of the Inquest on 18 August 2016. The Conclusion of the Inquest was that he died as a result of 'Multiple Injuries'.
4	**CIRCUMSTANCES OF THE DEATH** On the 29th March 2016 the 2P49 Peterborough to London Kings Cross train was approximately half mile north of Sandy Railway Station when the driver saw the deceased walk from the left side of the track and lay face down on the track with his body over the rail. The train at this time was travelling at 75 miles per hour leaving the driver no time to stop. The train struck the deceased and his death was subsequently confirmed at the scene. A witness had earlier seen the deceased climb over a gate to walk on the track and lay down across the rail.



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 British Transport investigation revealed that the deceased gained access to the railway line through an access gate. Both the gate and fence provide little deterrence or hindrance to someone wanting to gain access to the railway.

(2) The Investigation recommended a review of the fencing and access gates be undertaken at the location as it is relatively easy to access the track from both sides of the line. It is understood that this has not been undertaken.

6 ACTION SHOULD BE TAKEN

In my opinion action should be taken to prevent future deaths and I believe you 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 **15 November 2016**. I, the Assistant 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.

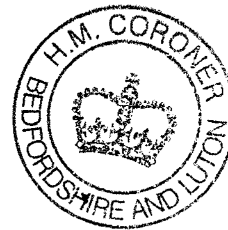
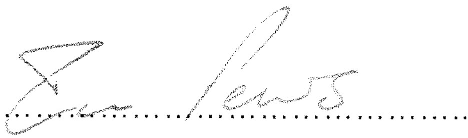
8 COPIES and PUBLICATION

I have sent a copy of my Report to the Chief Coroner and to the following Interested Persons

[redacted] – wife of the deceased.

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 August 2016   **IAN PEARS** **Assistant Coroner** **Bedfordshire and Luton**