REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** The chief Executive Officer, Northern Rail,Northern House, 9, Rougier Street, York, YO1 6HZ
1	**CORONER** I am John Stanley Pollard,, Assistant coroner for the coroner area of Cheshire
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 24th May 2016 I commenced an investigation into the death of Thomas Coyne born 8th August 1959. The investigation concluded at the end of the inquest on 18th January 2017. The conclusion of the inquest was one of Accidental Death with the medical cause being 1a Multiple Injuries.
4	**CIRCUMSTANCES OF THE DEATH** On the 21st May 2016 the deceased attended a stag party and consumed a quantity of alcohol. He was later making his way home when he inadvertently entered Earlestown Railway station. He wandered across all three platforms and then progressed along platform three, down the unprotected slope, and on to the lines. a short time thereafter he was struck by a passing train as he walked along the left hand cess.
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. – I was informed by the representative of the British Transport police who gave evidence to me , that Northern Rail own the train which struck the deceased and they also own/manage Earlestown station. Two matters of concern arose:- 1. The CCTV installed at the station and which can be monitored by the staff on duty, does not actually cover all the platform areas, and thus the member of staff could not see Mr Coyne (who was the only passenger on the station at the time) as he mistakenly wandered on to the tracks. 2. There is apparently absolutely no physical barrier of any kind at the end of

	platform three, thus allowing unfettered access to the tracks at that point.
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 20th March 2017. 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 Person namely [redacted] (widow of the deceased). I have also sent it to R.A.I.B. who may find it useful or of interest. 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 19th January 2017** **SIGNED** **John Pollard.** **Assistant Coroner**