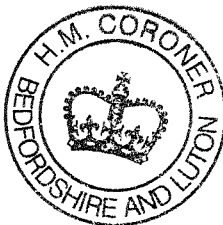
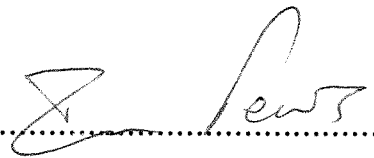




for Bedfordshire & Luton

**REGULATION 28 REPORT TO PREVENT FUTURE DEATHS**

	<p><b>THIS REPORT IS BEING SENT TO:</b></p> <p><b>THE CHIEF EXECUTIVE NETWORK RAIL 1 EVERS HOLT STREET LONDON. NW1 2DN</b></p>
1	<p><b>CORONER</b></p> <p>I am IAN PEARS, Acting Senior Coroner, for the Coroner Area of Bedfordshire &amp; Luton</p>
2	<p><b>CORONER'S LEGAL POWERS</b></p> <p>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.</p>
3	<p><b>INVESTIGATION and INQUEST</b></p> <p>On 9<sup>th</sup> January 2017 I commenced an Investigation into the death of Harminder <b>DHILLON</b> aged 62 years. The Investigation concluded at the end of the Inquest on 31<sup>st</sup> October 2017. The Conclusion of the Inquest was 'Accidental Death'. The medical cause of death was:</p> <p>I (a) Multiple Injuries</p>
4	<p><b>CIRCUMSTANCES OF THE DEATH</b></p> <p>The deceased drove his motor vehicle around the half barrier, which was down, at the Lidlington Level Crossing, Marston Road, Marston Moretaine in Bedfordshire and collided with a train. The crossing was functioning appropriately.</p>
5	<p><b>CORONER'S CONCERNS</b></p> <p>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.</p> <p>The <b>MATTERS OF CONCERN</b> are as follows. --</p> <p>(1) The level crossing is not monitored by CCTV and it is likely that the crossing is misused more than is reported</p>

	<p>(2) The half barrier is not a deterrent to a road user who believes that their journey is being held up more than is necessary.</p> <p>(3) A full length barrier, which is used on adjacent crossings on that line, would appear to be able to prevent misuse and prevent potential future deaths</p>
6	<p><b>ACTION SHOULD BE TAKEN</b></p> <p>In my opinion action should be taken to prevent future deaths and I believe your organisation has the power to take such action.</p>
7	<p><b>YOUR RESPONSE</b></p> <p>You are under a duty to respond to this Report within 56 days of the date of this Report, namely by <b>2<sup>nd</sup> January 2018</b>. 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>
8	<p><b>COPIES and PUBLICATION</b></p> <p>I have sent a copy of my Report to the Chief Coroner and to the following Interested Persons:  <span style="background-color: black; color: black;">[REDACTED]</span></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	<p><b>Dated 6th November 2017</b></p> <div style="text-align: right;">  </div> <div style="text-align: center;">  </div> <p><b>IAN PEARS</b>  <b>Acting Senior Coroner</b>  <b>for the coroner area of Bedfordshire &amp; Luton</b></p>