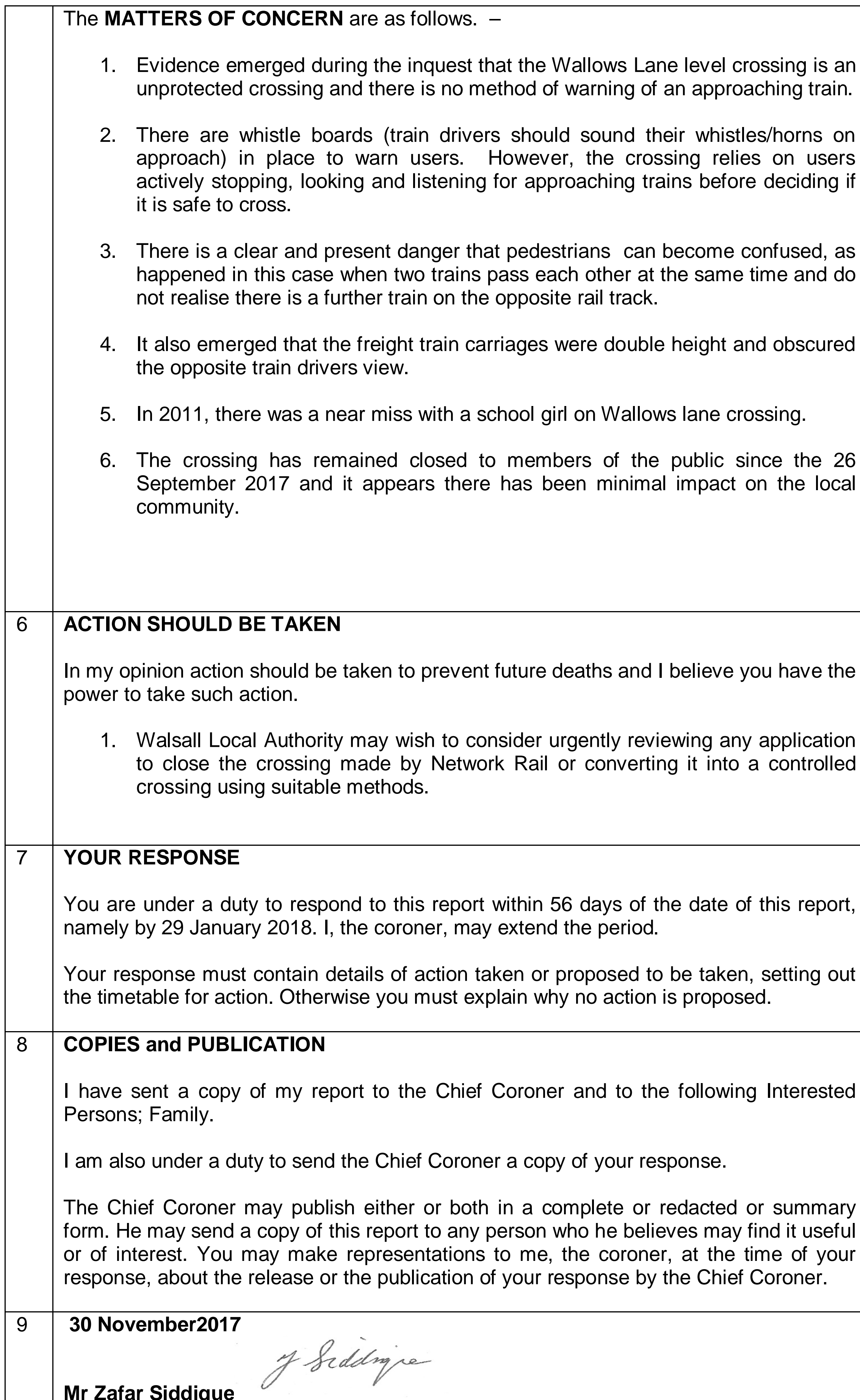
REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. Chief Executive, Walsall Local Authority** **2. Network Rail** **3. Office of Rail and Road (ORR), [redacted], HM Inspector of Railways**
1	**CORONER** I am Zafar Siddique, Senior Coroner, for the coroner area of the Black Country.
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 the 27 September 2017, I commenced an investigation into the death of school girl, Sarah Athersmith. The investigation concluded at the end of the inquest on 28 November 2017. The conclusion of the inquest was a short narrative conclusion of accidental death. The cause of death was: 1a Traumatic Head Injury
4	**CIRCUMSTANCES OF THE DEATH** i) On the afternoon of the 26 September 2017, Sarah was walking home after school with a school friend. ii) She stopped to feed some horses in a nearby field and then arrived at a train crossing gate at Wallows lane Footpath railway at approximately 3pm. This is an unprotected crossing and notices have been placed around the crossing to alert pedestrians to the dangers. iii) She initially stopped to let a freight train pass and then crossed the rail tracks but did not see another train coming in the opposite direction. iv) Sadly, Sarah was hit by the train sustaining fatal head injuries and died at the scene a short time later.
5	**<u>CORONER'S CONCERNS</u>** 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. Evidence emerged during the inquest that the Wallows Lane level crossing is an unprotected crossing and there is no method of warning of an approaching train. 2. There are whistle boards (train drivers should sound their whistles/horns on approach) in place to warn users. However, the crossing relies on users actively stopping, looking and listening for approaching trains before deciding if it is safe to cross. 3. There is a clear and present danger that pedestrians can become confused, as happened in this case when two trains pass each other at the same time and do not realise there is a further train on the opposite rail track. 4. It also emerged that the freight train carriages were double height and obscured the opposite train drivers view. 5. In 2011, there was a near miss with a school girl on Wallows lane crossing. 6. The crossing has remained closed to members of the public since the 26 September 2017 and it appears there has been minimal impact on the local community.
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. 1. Walsall Local Authority may wish to consider urgently reviewing any application to close the crossing made by Network Rail or converting it into a controlled crossing using suitable methods.
7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of the date of this report, namely by 29 January 2018. 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; Family. 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	**30 November2017** **Mr Zafar Siddique**

	Senior Coroner **Black Country Area**