

for Bedfordshire & Luton

REGULATION 28 REPORT TO PREVENT FUTURE DEATHS

THIS REPORT IS BEING SENT TO:

The Chief Executive Network Rail 2nd Floor One Eversholt Street London NW1 2DN

1 CORONER

I am Ian Pears, Acting Senior Coroner for Bedfordshire & 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/7http://www.legislation.gov.uk/uksi/2013/1629/part/7/made

3 NVESTIGATION and INQUEST

On 03 January 2018 I commenced an Investigation into the death of Andrew Thomas **HANAHOE**, aged 41 years. The Investigation concluded at the end of the Inquest on 07 June 2018. The Conclusion of the inquest was 'Suicide'; he had sustained Multiple Injuries

4 CIRCUMSTANCES OF THE DEATH

At 10:30hrs on 29 December 2017 a Train was approaching Biggleswade Railway Station and just after the Station is a Crossing known as 'Lindsells Foot Crossing'. The deceased emerged from the left hand side, walked onto the crossing and stopped in the "four foot" which is between the rails, turned and stood still and looked directly at the train with his hands in his coat pockets. The Driver stated that no other person was anywhere nearby. His last text was saying Good Bye.

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 Post Incident Site Report states:

"Ideally this foot crossing should be closed. It crosses railway line that have trains regularly passing over it at speeds up to 125 mph.

"Biggleswade, like many towns, is growing in size and any future development in this area will bring housing closer to the crossing.

"Would the crossing be installed today?

"If the crossing is a recognised "foot path" then an enclosed foot bridge, to prevent items being thrown at or dropped on trains, should be installed, together with suitable fencing on both sides of the line adjacent to it, to prevent simple access to the tracks.

"Currently there is just "post and wire" fencing immediately next to the adjacent railway structure...

"If the crossing is to be retained, then "repeater lights" should be installed on either side of the crossing, so that users on the crossing can be made aware that a train is approaching".

"Additionally trespass deterrence "Pyramid matting" that has been approved for use by Network Rail ... or similar should be installed on either side of the crossing, to deter simple access to the railway. Additional fencing is also needed between the existing line side fencing and the trespass deterrence to prevent access to the embankment."

I understand that no decision has been made since this Report was made in January 2018, yet the risk of a future death remains.

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 **17 August 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.

COPIES and PUBLICATION I have sent a copy of my Report to the Chief Coroner and to the following Interested Persons: parents 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 19 June 2018

Ian PEARS
Acting Senior Coroner
for Bedfordshire & Luton