Signed by Geoffrey Sullivan
Title Senior Coroner
Jurisdiction Hertfordshire

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO: London North Western Railway**
1	**CORONER** I am Geoffrey Sullivan Senior Coroner for **Hertfordshire**
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 the 4th January 2018 I commenced an investigation into the death of Daniel James O'Mahony. The investigation concluded at the end of the inquest 22nd August 2018. The conclusion of the inquest was Suicide. Medical cause of death: 1a) Multiple Traumatic Injuries
4	**CIRCUMSTANCES OF THE DEATH** On the 18th December 2017 the driver of the 11:15hrs Manchester to London Euston service was on the approach to Hemel Hempstead Railway Station, where he was not due to stop. Ahead he saw Daniel O'Mahony approximately half way down the platform. As the train neared Mr O'Mahony jumped from the platform onto the track and sat down facing the train. Mr O'Mahony was struck by the train. Police and paramedics attended and his death was confirmed at 13:20 hours.
5	**CORONER'S CONCERNS** During the course of the inquest the evidence revealed matters giving rise to concern. The matters outlined below were not found to have caused or contributed to the death. In my opinion, however 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) Samaritan Signage has not been reviewed and updated around the station. (2) Anti-trespass measures have not been installed at the end of platforms, to prevent ready access from the end of the platform to the railway lines. (3) Cross hatching yellow paint is not present on the fast line platforms 1 and 2. To clearly demark the area. (4) Anti-trespass Signage has not been replaced at the end of platforms to be more visible. (5)There are gaps in the mid-section fencing between platforms 2 and 3. (6)There are no gates at the access point to platform 2 and 3 at the top of the stairs, to prevent any unauthorised access to platform 2.

6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you London North Western Railway 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 Friday November 16th 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 [redacted] **mother of the deceased** **British Transport Police** 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	30/08/2018 Signature_____ Geoffrey Sullivan Senior Coroner Hertfordshire