REGULATION 28 REPORT TO PREVENT FUTURE DEATHS

THIS REPORT IS BEING SENT TO:

1. Network Rail
2. [redacted] Mother of the Deceased

1 CORONER

I am Ian Frank Goldup assistant coroner, for the coroner area of North East Kent

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

An investigation into the death of Taiyah-Grace Sharon Peebles was commenced on the 1st August 2017 and the investigation concluded at the end of the inquest on 18th July 2018. The conclusion of the inquest was the death was the result of an accident.

4 CIRCUMSTANCES OF THE DEATH

The deceased in an intoxicated state turned in the wrong direction on dismounting from a train at Herne Bay Station and instead of heading for the designated exit, stumbled down an un-barriered slope of the platform where she became disorientated and made contact with the live rail carrying the electric current that killed her

5 CORONER'S CONCERNS

During the course of the inquest the evidence revealed matters giving rise to concern. The absence of an end of platform barrier and the existence of a live rail at ground level that might be accessible to members of the public may in my opinion create a risk that future deaths will occur unless action is taken. In the circumstances it is my statutory duty to report to you.

The Assistant Coroner understands that a barrier has since been constructed at Herne Bay Station to help prevent deaths in similar circumstances but that other platforms in the area have no such barrier. His further understanding is that in other parts of the country trains are powered by electric current supplied by way of overhead cables rather than live rails at ground level thereby making contact with the power supply less likely

6 ACTION SHOULD BE TAKEN

In my opinion action should be taken to prevent future deaths and I believe you and your organisation 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 September 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) and to the LOCAL SAFEGUARDING BOARD (where the deceased was under 18).

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.

Date 24th July 2018

SIGNED BY CORONER