

## MISS KALLY CHEEMA LLB HER MAJESTY'S SENIOR CORONER COUNTY OF CUMBRIA

|   | REGULATION 28 REPORT TO PREVENT FUTURE DEATHS  |
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|   | THIS REPORT IS BEING SENT TO: NETWORK RAIL INFRASTRUCTURE LIMITED  |
| 1 | CORONER  |
|   | I am Mr Robert Chapman Assistant Coroner for <b>County of Cumbria</b>  |
| 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 16 October 2018 I commenced an investigation into the death of Steven John Key. The investigation concluded at the end of the inquest on 25 February 2019. The conclusion of the inquest was that on the 14 September 2018 Mr Key laid down on the railway track in front of an oncoming train, approximately 1 mile South of Oxenholme Railway Station. He suffered multiple injuries from which he died at the scene.   |
|   | Cause of Death: Multiple Injuries  |
|   | Coroners Conclusion: Mr Key killed himself   |
| 4 | CIRCUMSTANCES OF THE DEATH  Mr Key left home on the afternoon of the 14 September 2018 and walked to the railway line approximately 1 mile south of Oxenholme Station, at Helme Lane, Natland LA9 7PS, in Cumbria. He was able to access the line by climbing over a low fence and up a banking. He then laid down on the track in front of a Virgin train travelling from Glasgow to London. The driver had no opportunity for avoiding him. He died from the injuries he received.   |
| 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) You have a duty under the Railway Safety (Miscellaneous Provisions) Regulations 1997 to prevent access to the railway line so far as is reasonably practicable.  (2) The fencing at the scene of Mr Key's death was a low wooden fence which was easy to climb over.  (3) The British Transport Police (BTP) report into the death, reference CRU 2018 1711 & BTP 404-14091, of which you received a copy, recommended replacing the fence and gate with a heightened palisade gate and fence. I agree with that recommendation.  (4) Trains regularly travel on this section of the track at speeds of 125 mph.  (5) Children and adults would, like Mr Key, be able to climb the wooden fence and be at risk of injury or death on the track from passing trains.  (6) It would be reasonably practicable for you to fence the track at this point in the way suggested in the BTP Report. |

## 6 **ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you Network Rail Infrastructure Limited 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 25 April 2019. 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** 8 I have sent a copy of my report to the Chief Coroner and to the following Interested Persons: **British Transport Police** I have also sent it to the following who may find it useful or of interest. Department for Transport Office of Rail and Road 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 25/02/2019 Mr Robert Chapman Assistant Coroner County of Cumbria