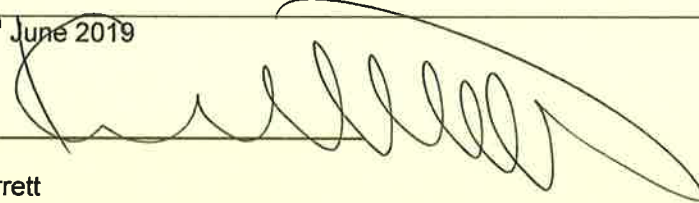




H M Senior Coroner for Gloucestershire  
Ms Katy Skerrett

	<p><b>REGULATION 28 REPORT TO PREVENT FUTURE DEATHS</b></p> <p><b>THIS REPORT IS BEING SENT TO:</b> <b>Network Rail, The Company Secretary, Network Rail Infrastructure Ltd, 1 Eversholt Street, London NW1 2DN</b></p>
1	<p><b>CORONER</b></p> <p>I am Katy Skerrett, Senior Coroner for Gloucestershire.</p>
2	<p><b>CORONER'S LEGAL POWERS</b></p> <p>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.</p>
3	<p><b>INVESTIGATION and INQUEST</b></p> <p>On the 14<sup>th</sup> February 2017 I commenced an investigation into the death of Colin Duncan Whistler Cameron. The investigation concluded at the end of the inquest on the 12<sup>th</sup> June 2019. The conclusion of the inquest was a hybrid conclusion of accidental death and a narrative conclusion. The medical cause of death was 1A multiple blunt force injuries to head and trunk.</p>
4	<p><b>CIRCUMSTANCES OF THE DEATH</b></p> <p>Colin Cameron "Colin" was a 60 year old, who was long term authorised user of the Frampton Mansell user worked crossing. On the 7<sup>th</sup> February 2017 he used the crossing in the morning as he drove to work at his campsite. [REDACTED] was his passenger. At approximately 1500 hours he was making the return journey crossing from the north side of the track from the Sapperton village direction, heading south towards Frampton Mansell. [REDACTED] exited the vehicle, and opened the gates on both sides of the crossing. At 15.02 hours Colin called the signaller to request permission to cross. The signaller was aware that there was a train in the track section containing the crossing. This was a high speed train travelling from Swindon, and approaching the crossing on the Down Line. Colin told the signaller that a train has passed a couple of minutes earlier. No train had passed. The signaller relied upon Colin's statement and gave permission to cross. The train driver saw Colin's vehicle enter the crossing and applied his emergency brakes. The train impacted with the vehicle at 15.03.20. Colin's vehicle was stuck under the train. The train came to a complete halt at 15.03.47. The train driver raised the alarm. Emergency services attended, and pronounced Colin deceased at 15.33 hours.</p>
5	<p><b>CORONER'S CONCERNS</b></p> <p>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.</p> <p>The <b>MATTERS OF CONCERN</b> are as follows. –</p> <ol style="list-style-type: none"><li>1. Whether sufficient consideration has been given to address the absence of any instructions to signallers on how to extract information from the user, and</li><li>2. Whether the relevant authorities and persons authorised to use this crossing have given sufficient consideration to whether this crossing can be closed.</li></ol>

6	<p><b>ACTION SHOULD BE TAKEN</b></p> <p>In my opinion action should be taken to prevent future deaths and I believe you have the power to take such action.</p>
7	<p><b>YOUR RESPONSE</b></p> <p>You are under a duty to respond to this report within 56 days of the date of this report, namely by 4pm 28<sup>th</sup> August 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.</p>
8	<p><b>COPIES and PUBLICATION</b></p> <p>I have sent a copy of my report to the Chief Coroner and to the following Interested Persons</p> <ul style="list-style-type: none"> <li>(1) [REDACTED]</li> <li>(2) Office of Rail and Road, [REDACTED] HM Assistant Chief Inspector of Railways, One Kemble Street, London WC2B 4AN</li> <li>(3) British Transport Police, [REDACTED], Bristol Temple Meads, Bristol BS1 6QF</li> <li>(4) RAIB, The Wharf, Stores Road, Derby, DE21 4BA</li> </ul> <p>I am also under a duty to send the Chief Coroner a copy of your response.</p> <p>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.</p>
9	<p>Dated 26<sup>th</sup> June 2019</p> <p>Signature </p> <p>Ms K Skerrett Senior Coroner for Gloucestershire</p>