REGULATION 28 REPORT TO PREVENT FUTURE DEATHS

THIS REPORT IS BEING SENT TO:

1.

Managing Director
South Western Railway,
South Bank Central,
4th Floor, 30 Stamford Street, SE1 9LQ.

2. Mr Ian Prosser
Chief Executive
The Office of Rail and Road
25 Cabot Square,
Canary Wharf,
LONDON, E14 4QZ.

1 CORONER

I am Heidi J. Connor, senior coroner for the coroner area of Berkshire.

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.

It is important to note the case of <u>R (Dr Siddiqui and Dr Paeprer-Rohricht) v Assistant Coroner for East London.</u> This case clarifies that the issuing and receipt of a Regulation 28 report entails no more than the coroner bringing some information regarding a public safety concern to the attention of the recipient. The report is not punitive in nature and engages no civil or criminal right or obligation on the part of the recipient, other than the obligation to respond to the report in writing within 56 days.

3 INVESTIGATION and INQUEST

I conducted an inquest into the death of James Joseph Fennell that was heard at Reading Town Hall on 17th October 2019. I recorded a conclusion of accident.

4 CIRCUMSTANCES OF THE DEATH

The family asked us to refer to the deceased as James at the inquest. I have reflected that request in this report.

Investigations revealed that James had spent the evening drinking with friends in Bracknell, before boarding a train from Bracknell towards Reading where the intention of the group was to visit a nightclub. It would appear that James had a change of heart, and left the train at Wokingham Station.

Rather than using the pedestrian footbridge to get to platform 1 (in order to catch a train back in the direction of Bracknell, where he lived) James climbed down onto the track to cross to the other side.

The incident happened when it was dark (between 23:00 and 24:00 hours). There was also snow on the tracks. It is clear from CCTV (and indeed from subsequent toxicology) that James was intoxicated at the time. We heard evidence that James had attempted to

get on to the tracks earlier that evening at Bracknell Station.

Tragically, although James appeared to step over the track (and third rail), he slipped, lost his footing and made contact with the third rail, resulting in his instant death. The cause of death at post mortem examination was given as electrocution.

The evidence of James' mother was that James was not aware, and she had never taught him, that there was a risk of electrocution in crossing the tracks. She suggested that James would have known it was dangerous to cross railway lines, but only from the point of view of oncoming trains.

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 could 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) We heard that power is supplied through the lines at this station by means of a "third rail". This, we heard, is not an uncommon set up in stations nationally. Whilst the third rail runs to the nearside of the track outside of stations, it is positioned to the offside of the track within stations.
- (2) Signage was reviewed at Wokingham Station following the incident by a Designing Out Crime Unit, and I have the report of in this respect. No recommendations were made with regard to signage at this station. We heard in evidence that there are small signs at either end of the platform at Wokingham Station, indicating that the lines should not be crossed because of the danger of electrocution. Neither of these signs would be visible from the main area where commuters stand to wait for trains. They are small and some distance away.
- (3) There is a yellow painted line indicating the safe area away from the platform edge, as well as a white line on the platform edge. There is no tactile paving or crosshatch marking between these two lines.
- (4) There is no warning of the risk of the live rail visible to commuters on the platform at this station. This is likely to be a situation which is replicated in many stations nationally.
- (5) It was suggested in evidence that most people are aware of the risks of crossing train tracks in this way. I accepted the evidence of James' mother that he was not aware of this and I am aware of other cases in recent national press in which that was found to be the case. If indeed it is felt that the public is well aware of this risk, then there seems to be little point in having signs at the ends of the platform to warn the public of this. It seems incongruous that the public should need to be warned in an area where there is unlikely to be any member of the public present, but no warning in the areas where most of the members of the public stand to wait for trains.
- (6) If the purpose of the signs at the ends of the platform is to warn the public of the risk beyond the platform areas (where the "third rail" is on the nearside of the track), then it seems to me that this risk is a much smaller one, given the much higher footfall in the platform areas where there are no signs, and no indication whatsoever of this exceptionally high risk.
- (7) I cannot conceive of many (if any) scenarios in which electrical power of this magnitude would be open and accessible without significant signage and

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warnings.

- (8) Whilst James did initially step over the rail, as seen on CCTV, I do not accept that is evidence that James knew of the risk of electrocution. It is human nature to step over a rail when walking, particularly given that the third rail is somewhat elevated.
- (9) I accept that excessive signage can carry its own risks. It is however surprising that there is no signage visible to members of the public, warning them of this risk, except in areas where they are unlikely to stand. Whilst members of the public may be aware that crossing a train line is dangerous, this may be because of a perception of the risk of oncoming trains, rather than the risk of electrocution.
- (10)Whilst it is undoubtedly the case that James was intoxicated at the time of these events, this is not the first case of this nature. I consider that there is a risk of future deaths and that other members of the public are likely to be unaware of the significant risk involved in crossing tracks in this way, save in relation to the risk of oncoming trains.
- (11)I believe this is an issue which is likely to be relevant to stations nationally, and not just to Wokingham Station.

6 ACTION SHOULD BE TAKEN

In my opinion action should be taken to prevent future deaths and I believe your organisation(s) 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 15th January 2020. 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 James' family. I have also sent a copy of this report to the following organisations:

(1) Rail Accident Investigation Branch.

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 19th day of November 2019

Mrs Heidi J. Connor Senior Coroner for Berkshire