IN THE SURREY CORONER'S COURT

IN THE MATTER OF: JORDAN MICHAEL AIRA

The Inquest Touching the Death of JORDAN MICHAEL AIRA

A Regulation 28 Report – Action to Prevent Future Deaths

	THIS REPORT IS BEING SENT TO: • **Andrew Haines CEO Network Rail** • **Mark Hopwood Managing Director South Western Railway** • **The Right Honourable Gavin Williamson Secretary of State for Education**
1	**CORONER** Caroline Topping HM Assistant Coroner, for the County of Surrey
3	**INVESTIGATION and INQUEST** An inquest into the death of Jordan Michael Aira was opened on 4th April 2019 and resumed and concluded on 24th January 2020. Evidence in respect of matters pertaining to this report was heard on the 21st February 2020. I concluded that Jordan Michael Aira died on the 23rd March 2019 at Ashford Railway Station, Surrey and that the medical cause of his death was; 1a Electrocution on railway line and electrical burns. I concluded he died of an accident.
4	**CIRCUMSTANCES OF THE DEATH** Jordan Aira was walking home from a party in the early hours of the morning on the 23rd March 2019. He gained access onto the platform of Ashford Station, sat for over an hour on a bench and then walked down an unsecured ramp onto the railway lines. He fell onto the live third rail and was electrocuted.

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. – The evidence showed that: 1. There were no physical boundaries at the end of the platform preventing members of the public accessing the railway tracks. 2. The emergency telephone which may be used by members of the public is located adjacent to the railway track. 3. The warning signs in place which are standard in the rail industry do not in terms warn of the risk of immediate death if you touch the live rail. 4. There is no requirement in the national curriculum to teach pupils about the risk posed by the live rail. .
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe your organisation has 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 25th May 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 the following Interested Persons; [redacted] 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	**Signed:** **Caroline Topping** **Dated this 30th March 2020.**