Regulation 28: REPORT TO PREVENT FUTURE DEATHS

REGULATION 28 REPORT TO PREVENT DEATHS

THIS REPORT IS BEING SENT TO:

1 LNER
2 Network Rail

1 CORONER

I am Oliver LONGSTAFF, Assistant Coroner for the area of County Durham and Darlington

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 Second April 2020 I commenced an investigation into the death of Clive OXLEY aged 62. The investigation concluded at the end of the inquest on Twenty-Third December 2020. The conclusion of the inquest was Suicide:

I a Multiple Traumatic Injuries

I b

I c

II

4 CIRCUMSTANCES OF THE DEATH

The deceased was tracked by CCTV at and around Durham railway station as entering the station via the main entrance on the southbound side, walking towards the viaduct along the southbound platform, passing the barrier to pedestrians at the end of the platform, and getting onto the track. He then scaled the viaduct parapet at a point where there is a gap between two lengths of a wire fence which increases the height of the parapet along the short length of the parapet over which it has been installed. The deceased then jumped from the viaduct onto North Road below.

5 CORONER'S CONCERNS

The MATTERS OF CONCERN are as follows: (brief summary of matters of concern)

1) It is accepted that the barrier to pedestrian traffic between the southbound platform and the viaduct makes it clear that pedestrians should not access the viaduct from the platform (as does the automatic voice alert which is activated as the barrier is passed). However, I am concerned that the barrier itself is not of a construction adequate to prevent a determined pedestrian such as the deceased from accessing the track at that particular point.
2) The impression of officers from the British Transport Police and Durham CID who gave evidence is that the wire fence that extends the height of the viaduct parapet wall runs along only a short length of the wall, and that there are in any event gaps between the sections of that fence, the deceased gaining access to the parapet

wall through one such gap.

3) Evidence was given at the inquest into two similar events (one in 2018, one in around 2012) which resulted in the death of one individual and the sustaining of catastrophic injuries by another.

6 ACTION SHOULD BE TAKEN

In my opinion action should be taken to prevent future deaths and I believe you (and/or 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 17 February 2021. 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]

who may find it useful or of interest.

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.

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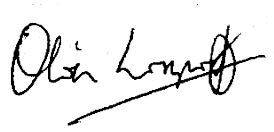

Oliver LONGSTAFF
Assistant Coroner for
County Durham and Darlington
Dated: 23 December 2020