ANNEX A

REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

*NOTE: This form is to be used **after** an inquest.*

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. Chief Executive Officer [redacted]** **London & South Eastern Railway** **3rd Floor, 41-51 Grey Street** **Newcastle-Upon -Tyne NE1 6EE**
1	**CORONER** I am SONIA MARIE HAYES assistant coroner, for the coroner area of North East Kent
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. [HYPERLINKS]
3	**INVESTIGATION and INQUEST** On 2nd April 2020 an investigation was commenced into the death of WILLIAM STEVEN ISRAEL, 23. The investigation concluded at the end of the inquest on 24th November 2020. The conclusion of the inquest was ACCIDENT the medical cause of death electrocution.
4	**CIRCUMSTANCES OF THE DEATH** William Israel had visited a friend who lived near Canterbury East Railway Station. They had a drink before they travelled to a nightclub crossing from one platform to the other at Canterbury East Railway Station using an underpass at around midnight. The station was closed but the palisade gates at Platforms 1 & 2 were open routinely out of ours. William left the nightclub at around 03:30 hours alone with the keys to go back to his friend's flat. Toxicology evidence establishes he was intoxicated. He was seen on CCTV walking normally and entering the station through palisade gates. He then hopped down on the track and caught the toe of his shoe and tripped landing on the live rail at approximately 03:45 hours. He was found by a member of the public and the cause of death was given as electrocution.
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) Evidence heard from an experienced South Eastern Railway witness was that a national survey has found that there is a widespread assumption by members of the public that:

a. Power to the rail tracks is switched off at night
b. Power to the rail tracks is only switched on when trains are due

This supports that the risk of electrocution from train tracks is not well understood by the public. The risk of electrocution is from the live rail in such cases and the signage at Canterbury East Station relating to this is at each end of the platform. This signs in this vicinity contain the word 'Caution'; the font used warning of the risk of death was not highlighted and significantly smaller than the rest of the sign.

(2) There is insufficient signage warning of the risk of electrocution to the public from the live rail and none present at the palisade gates. The evidence at the inquest established that there has been recent national guidance indicating changes to warning signs at railway stations. Signage has not been updated at this station following this death in accordance with that guidance.

(3) The British Transport Police Designing Out of Crime Unit (BTP DOCU) investigated this incident and has made a recommendation to consider the placement of strategic under-platform warning signage that would be visible where a member of the public jumping or stepping down onto the tracks. This recommendation has not been implemented.

(4) The main entrance to the station is open between the hours of 06:00 -22:00 hours Monday to Saturday and 07:00 – 22:00 hours on Sunday during such hours the station is staffed. First and last trains run outside of the staffed hours. There is signage by the main entrance directing the public to an underpass allowing pedestrians to safely cross between Platforms 1 & 2. The station has steel fencing around part of the perimeter that is approximately 2 metres high with spikes at the top and there is a potential alternative egress and ingress comprising palisade gates set withing that fencing. When the station is open and staffed, the palisade gates are locked. When the station is unstaffed the palisade gates are open and there is no signage in that vicinity directing pedestrians to the underpass.

(5) It appears inconsistent that the palisade gates that deter public entering are closed when the station is open and staffed, then open when the station is unstaffed and after trains have stopped running.

(6) Whilst it is not disputed that William had used the underpass with friends to get to a nightclub that night. He had already been drinking prior to this journey, was not local to the area and was alone when he accessed the station through the palisade gates a few hours later. William was intoxicated at the time he attempted to cross the train tracks at Canterbury East Station, however there have been a number of incidents of individuals on the tracks over the last three years and the station is just meters from a nightclub. There is a significant risk that members of the public using the station as a cut through will be intoxicated.

(7) Evidence at the inquest from the BPT DOCU report was that London & South Eastern Railway staff had informed the investigator that:

a. staffing at the station during the entirety of operational hours was not possible due to the timings of the first and last trains, and
b. if the palisade gates were locked overnight and a member of staff did not then attend for work then the public would not be able to enter the station and catch a train
c. changes to the opening hours of the station would be complex and require lengthy consultation with staff
d. locking the palisade gates when the station was unstaffed would require some members of the public who lived in housing on the opposite sides of the track to the main town to take a detour at night

	(8) There appears to be an absence of a sufficient risk assessment of the risks to the public from electrocution from the live rail particularly when the palisade gates are open and, if the palisade gates should remain open, of any potential risk mitigation that might be implemented to ensure safe use of the underpass. (9) I understand that the configuration of a live rail is widespread in the South of England and also other areas of the country and many of those stations are unstaffed and accessible by the public out of hours, therefore this is a matter that is of relevance nationally and not just at Canterbury East Railway Station.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you and 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 27th January 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] (sister of William Israel). I have also sent it to [redacted] (London & South Eastern Railway), [redacted] (British Transport Police) and [redacted] (Network Rail) who may find it useful or of interest. I am also under a duty to send a copy of your response to the Chief Coroner and all interested persons who in my opinion should receive it. I may also send a copy of your response to any other person who I believe may find it useful or of interest. 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.
9	**3rd December 2020** S. M. Hayes **Sonia Marie Hayes** **Assistant Coroner North East Kent**