Regulation 28: REPORT TO PREVENT FUTURE DEATHS (1)

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

REGULATION 28 REPORT TO PREVENT DEATHS

THIS REPORT IS BEING SENT TO:

1. **Managing Director Network Rail (Wessex)**

1 CORONER

I am Jason PEGG, Area Coroner for the area of Hampshire, Portsmouth and Southampton

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 22nd September 2020 I commenced an investigation into the death of **Callum Rhys EVANS** aged 17. The investigation concluded at the end of the inquest on 18th May 2021. The conclusion of the inquest was: Accident

4 CIRCUMSTANCES OF THE DEATH

The deceased died on 15th September 2020 at Hinton Admiral Railway Station, Hampshire. The deceased was on the railway tracks when he fell onto the live rail in consequence of which the deceased was electrocuted. The deceased was intoxicated with alcohol which contributed to the death.

5 CORONER'S CONCERNS

The MATTERS OF CONCERNS are as follows:

A friend in the company of the deceased at the railway station indicated a lack of knowledge of the presence of a live electrified (third) rail at the railway station and stated that if it had been known that there was a live rail they would not have gone onto the railway tracks.

The deceased and his friends had gone onto the railway tracks by dropping down from the central part of the platform.

The railway station has an absence of signage stating the presence and risk to life of a live rail on the railway tracks which can be seen by those entering the railway station or whilst on the central part of the platform. The only sign referring to the live rail is at the far sloped end of the platform, some distance from the station entrance and central part of the platform, which states "Do not touch live rail".

There is signage stating "No trespassing" but nothing effectively communicating the presence of a live rail or the risk to life from that live rail.

6 ACTION SHOULD BE TAKEN

In my opinion action should be taken to prevent future deaths and I believe you 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 13 July 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:
The parents of Callum EVANS

I have also sent it to: [redacted] (DOCU) British Transport Police 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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Jason PEGG
Area Coroner for
Hampshire, Portsmouth and Southampton
Dated: 18 May 2021