REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** [redacted], Area Customer Service and Performance Manager, Network Rail.
1	**CORONER** I am John Hobson, an Assistant Coroner for the coroner area of West Yorkshire (Eastern).
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 23 April 2021 an investigation was commenced into the death of Mr Gregory James Barber, aged 34. An inquest was opened on 29 April 2021 and the investigation completed at the conclusion of the inquest on 13 December 2021. The medical cause of death established at the inquest was that Mr Barber died from severe head injuries secondary to blunt force impact. A conclusion of suicide was recorded.
4	**CIRCUMSTANCES OF THE DEATH** On 12 April 2021, Gregory James Barber, who had a history of mental health difficulties and suicidal ideation, died as a result of [redacted], having lain [redacted]. Paramedics attended but his death was confirmed at 1717hours. On appraisal and consideration of the evidence at the inquest on the relevant standard of proof, a conclusion of suicide was recorded. During the course of the inquest I heard witness evidence presented in relation to an investigation undertaken by the British Transport Police. A section of a document entitled 'Post Incident Site Report [PISV] – Lineside' [ref: DOCU-2021-0590] contained a section entitled: 'Considerations which could help to prevent further similar incidents/Agreed actions' [p7 of 9]. Any such matters are set out in a table set down on a pro forma. The first column identifies a 'Problem', the second column is entitled 'Mitigation Measure'. A third column refers to 'Owner(s)'. The completed columns read as follows: <u>Problem:</u> '[redacted] is not easy and fencing is for the most part adequate. The Google image and photograph above show there is a [redacted].'

	Mitigation Measure: 'Additional fencing along the stone parapet run up to the [redacted] as indicated on the google image above. There needs to be an inner line of fencing behind the stone parapet which is far enough away from the parapet to mean that the stonework cannot be used to climb over the fencing. Owner(s): Network Rail. Whilst it was noted that no 'quick time intervention/rectification was required at the location', the report goes on to state that: 'To support the Coroner Inquest process we respectfully request that stakeholders submit a response to the considerations detailed in the report and any other activity planned for the location using the available section below within **60 working days** from the date of the incident'. At the date of the inquest, the section of the report entitled 'Considerations response' had not been completed by Network Rail and returned to the British Transport Police. Upon further investigation at the inquest, it was confirmed that the report was sent to Network Rail on 7 May 2021. The 'Problem' identified by BTP followed an appraisal of the scene, with the 'weak spot' identified as being '…the most likely access point and would benefit from improved fencing' [pp6/7 of 9].
5	**CORONER'S CONCERNS** In my opinion there is a risk that future deaths will occur unless action is taken. In the circumstances it is my statutory duty to report to you. The matter of concern is as follows: The BTP investigation identified a clear problem and recommended a mitigation measure to which there has been no meaningful response, or at all, from Network Rail within the terms of the specific request to so respond within 60 days of the incident. On the evidence that I heard at the inquest, it would appear that the weakness identified by the British Transport Police remains as it was at the time of their investigation and I am concerned that access to the railways tracks is not sufficiently curtailed at the location identified, as recommended. I am under a duty to report this matter upon consideration of the evidence.
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 18 February 2022. I, John Hobson, 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, to the family who were an Interested Party at the inquest and to British Transport Police.

	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	**24 December 2021**  **John Hobson (Assistant Coroner)**