REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **The Chief Executive, Network Rail, Kings Place, 90 York Way, London N1 9AG**
1	**CORONER** I am Michael Richard ROSE, Senior Coroner for the West Somerset area
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 the 5 June 2014 I held an Inquest before a Jury into the death of Antony Shane Ponting, a 34 year old man who died from Extensive Multiple Traumatic injuries.
4	**CIRCUMSTANCES OF THE DEATHS** The deceased was killed when using an authorised pedestrian crossing over the Bristol to Taunton railway line near Springfield Road, Highbridge, Somerset on the 11 July 2013. The jury returned a verdict of "Accidental

	Death" but found the deceased's failure to observe the approaching train was influenced by the considerable amount of morphine (otherwise heroin) the deceased had in his blood.
5.	**CORONER'S CONCERNS** The office of Rail Regulation report dated 13 August 2013 revealed several matters which although in no way responsible for this death could cause a potential risk to other users namely:- (i) reduced sighting line caused by track side vegetation growth for pedestrians crossing from the upside to up trains and on the downside for both up and down trains at the S.H.I sign (ii) the S.H.I boards should have been positioned 3 metres from the line. (iii) Tripping hazards on the crossing surface
6	**ACTION SHOULD BE TAKEN** Although the vegetation was cut back shortly after this accident, the matters revealed in 5(ii) and (iii) should be attended to if not already dealt with. AND in future items 5(i) and (iii) looked at regular intervals
7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of the date of this report. 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 . 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	**DATED 8 July 2014**  **SIGNED BY CORONER**