REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** 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 4th and 5th September 2014 I held an Inquest before a jury into the death of William Dennis FRANCE who died at Athelney Railway Crossing on the 21st March 2013. The jury returned a narrative Conclusion namely:- "Dennis William France died on the 21st March 2013 when his car was struck by a High Speed Train when he attempted to drive across a railway crossing at Athelney when the Automatic Half Barriers were down. In all probability the decision to do so was influenced by a desire to get to work on time pending his retirement and the prolonged period the barriers had been

	down due to an earlier movement of an engineering train."
4	**CIRCUMSTANCES OF THE DEATHS** The circumstances were that the deceased who was on his way to work either thought that he had time to cross the main Taunton to Westbury railway line before the arrival of a train and/or the automatic half barriers had not been functioning correctly. Whilst crossing the Upline the deceased's car was hit by a high speed train going from Exeter St Davids to Paddington at a speed of approximately 100 miles per hour. The car not being visible to the driver of the train until 1 or 2 seconds before impact. Whilst the accident was entirely brought about by the deceased's own actions, part of the problem was due to the automatic half barriers being down for a period between 75 and 103 seconds, instead of the normal 29 seconds. This had been caused initially by an earlier Tamper train activating the strike in treddle whilst proceeding in the wrong direction on the Upline. As the treddle only had one arm, the mechanisms had become out of synchronisation causing the barriers to come down and 4 minutes later rising again and setting signal E93 at red. At either this stage or a later testing by the signalman at Exeter led a cyclist to cross the line when the barrier was down. However the lowering of barriers prior to the deceased's death was the result of the signalman at Exeter setting sign at E93 at green so as to clear the yellow signal UA136 prior to the arrival of the Paddington bound train. The Rail Accident Investigation Branch prepared a very detailed report that was published on the 24th February 2014 and I assume that you are in possession of a copy.

	Subsequently the strike in treddle on the Upline which is located 1.1 miles from the crossing has been fitted with a two armed lever which if it had been installed prior to the accident would have prevented the long delay. There is also concern that :- (1) Motor vehicle drivers approaching the crossing from either side have to go up a rise and their visibility towards Taunton is obstructed in part by the barrier controls and the road crossing which is also at an angle. (2) Although not a factor in the death the telephone at the level crossing was some 8 metres beyond the pedestrian stop line.
6	**ACTION SHOULD BE TAKEN** (a) Consideration should be given as to whether or not it is possible to improve the visibility for approaching motorists although to a degree this is hampered by a bridge immediately on the downside of the level crossing. (b) Consideration should be given to repositioning the telephone and amending the warning sign to draw driver's attention the need to use the telephone when the barriers have been down for an unusual length of time.
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	**DATE 18th September 2014** **SIGNED BY CORONER**