	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. The legal representatives of the estate of John Robert Wright, deceased, namely Frisbys Solicitors;** **2. The legal representatives of Network Rail, namely Kennedys Solicitors;** **3. The Office of the Rail Regulator;** **4. The Rail Accident Investigation Branch; &** **5. Mr. [redacted] General Secretary, The Rail, Maritime and Transport Union**
1	**CORONER** I am Andrew McNamara, assistant coroner, for the coroner area of Nottinghamshire.
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 1 February 2014 I commenced an investigation into the death of John Robert Wright, 49. The investigation concluded at the end of the inquest on 15 October 2014. The conclusion of the jury following the inquest was that Mr. Wright's medical cause of death was: I a. Diffuse axonal injury & multiple organ failure (as a consequence of) b. Multiple traumatic injury. The summary of the facts was: John Robert Wright (Rob) died at Queens Medical Centre Nottingham at 17.35 31st January 2014. His death came as a result of multiple injuries sustained on 22nd January 2014 when he was in collision with a North bound East Coast train at Newark Northgate Station. The conclusion was: Accident.
4	**CIRCUMSTANCES OF THE DEATH** Mr. Wright was employed by Network Rail as a track maintenance man. On 22 January 2014 he was working with two fellow Network Rail employees, [redacted] and [redacted] and together they were charged with carrying out ultrasonic testing of rail track at, amongst other places, Newark Northgate station. This meant that they were testing track which formed part of the East Coast mainline where locomotives can travel at speeds up to125 m.p.h. Mr. Wright was given the task of 'look out' whilst his colleagues carried out the testing. Whilst at Newark Northgate only [redacted] carried out the testing work and Mr. Wright was look out. Newark Northgate is a small station with three platforms and 4 lines passing through it: the 'Down' line going North passing platform 1; the 'Up' line going South passing platform 2; a combined 'Up' and 'Down' passenger loop to platform 3; and a goods 'Up' and 'Down' line. Messrs Wright and [redacted] were working on track south of the station where there was also a 'loop', akin to a siding, of track where rolling stock could be 'parked'. Shortly after 11.30 an East Coast Train (the 10.08 from London Kings Cross to Newark), driven by [redacted] approached from the South traveling along the 'Up' line. The Train was due to stop at platform 3 which meant that it had to cross the 'Down' line and then join the 'Up and Down' passenger loop. On approach the driver of the train sounded the horn as he passed a signal and again as

	he crossed the first set of points taking him onto the 'Down' line. As he did so Mr. Wright was positioned in the section of track known as a siding or 'loop' which had been designated a 'place of safety'. [redacted] acknowledged the approaching train which was slowing and was travelling at a speed below 30 m.p.h. as it neared the station. Mr. Wright did not acknowledge the approaching train, for example by turning and signalling to the driver. CCTV from the train demonstrates that, without seeming to appreciate its presence, Mr. Wright walked in front of the oncoming train and was struck by the front offside buffer as a result of which he sustained multiple injuries from which he did not recover. Despite treatment he died at the Queens Medical Centre, Nottingham on 31 January 2014.
5	**CORONER'S CONCERNS** During the course of the inquest the evidence revealed matters giving rise to concern, namely: 1. The safety briefing regarding the work at Newark Northgate appears to have taken place in the van whilst en-route. This gave an impression that it was perfunctory and merely routine. 2. Mr. Wright appeared oblivious to the approaching train which struck him or its destination, namely platform 3 at Newark Northgate. It is not clear if this was due to a hearing defect, the presence of hearing protection ([redacted] did not think the deceased was wearing hearing protection at the time), complacency, ignorance or lack of training. 3. The evidence also suggested that, due to the volume of trains which pass track side maintenance crew, they do not consult timetables whilst at work. 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 **MATTERS OF CONCERN** are as follows. – 1. Despite its obviousness I am concerned that track side maintenance crew need frequent reminders/training as to the need to maintain vigilance at all times when working in the vicinity of lines along which trains can pass. 2. When working in the vicinity of stations and/or points on the network where there are multiple lines, crews should be fully briefed as to the potential route of trains through stations or across any such lines, including, where reasonably practicable, consulting timetables; and safe methods of work are briefed and enforced. 3. Further, I am concerned that there needs to be a balance struck between the ensuring that track side maintenance crews are provided with personal protective equipment such as hearing protection and an ability to hear oncoming locomotives/trains.
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 7 January 2014. 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: 1. The representatives of the estate of John Robert Wright deceased;

	2. Network Rail; 3. The Office of the Rail Regulator; & 4. The Rail Accident Investigation Branch I have also sent it to Mr. [redacted] General Secretary of the RMT Union, 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.
9	**13 November 2014** **Signed: Andrew McNamara**