REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

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

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1.** Chief Executive of Network Rail, 1 Eversholt Street London, NW1 2DN **2.** Chief Superintendent [redacted] of the British Transport Police, Force HQ, 25 Camden Road, London, NW1 9LN
1	**CORONER** I am Rachael Clare Griffin, Assistant Coroner, for the Coroner Area of Manchester West
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 13th March 2015 I commenced an investigation into the death of Adam Lee Connelly, born on the 13th June 1992. The investigation concluded at the end of the inquest on the 10th July 2015. The Medical Cause of Death was 1a Multiple Fatal Injuries. The conclusion of the inquest was that Adam Lee Connelly was found deceased on a railway track with injuries consistent with being struck by a train. The circumstances as to how those injuries came about are unclear.
4	**CIRCUMSTANCES OF THE DEATH** At around 7.00am on the 10th March the train driver of the Northern Train Service travelling from Manchester Victoria to Wigan, reported a body lying at the side of the railway line between Walkden and Atherton, near to foot bridge number 57, which is located between Engine Lane and Peel Lane, Atherton. The body was later identified to be Adam Lee Connelly and evidence confirmed that he had been struck by a train causing injuries that resulted in his death. Unfortunately despite a thorough investigation by the British Transport Police, the train which struck Adam was not identified, nor were the exact circumstances as to how Adam Lee Connelly came about his death.

5	**CORONER'S CONCERNS**

During the course of the inquest the evidence revealed matters giving rise to concern. 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. During the inquest evidence was heard that:

   i. On the 9th March 2015 Mr Connelly was seen to leave his home address in Tyldesley at around 8pm. His subsequent actions are not known until tragically he was found deceased by the side of the railway tracks, at around 7am on the 10th March.

   ii. Following a thorough investigation by the British Transport Police it is believed that it is most likely Mr Connelly had gained access to the railway tracks by climbing over the wall of the steps leading to the footbridge 57, which was near to where his body was found. The evidence given at the inquest was that this footbridge and the access to it, namely the steps and the walls, are owned by Network Rail.

   iii. [redacted] of the British Transport Police gave evidence that the wall of these steps is approximately 5 feet in height and that a person of reasonable athletic ability would be able to climb over the wall onto the railway tracks. There are identical steps on the other side of the footbridge with a public footpath or track running along each side of the railway line and the bridges.

   iv. [redacted] gave evidence that there was a risk of public access to the railway track at this section due to the height of the wall and that to reduce the risk of future fatalities, it would be beneficial if action was taken to restrict access to the railway track at this location. [redacted] explained that due to the steps the wall is easily accessible and he was able to climb over the wall several times during his investigation. It was explained that the bridge itself had a wall of approximately 8 feet in height which would be extremely difficult to climb over.

2. I have concerns with regard to the following:

   i. Due to the height of the walls of the steps which are used to access footbridge 57 on the railway line between Walkden and Atherton train stations, a person of reasonable athletic ability could gain access to the railway track, which could lead to future fatalities at this location on the railway

6	**ACTION SHOULD BE TAKEN** In my opinion urgent action should be taken to prevent future deaths and I believe you and/or 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, 11th September 2015. 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) Mr Connelly's father, [redacted] on behalf of the family 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** **17th July 2015** | **Signed** [redacted] **Rachael C Griffin**