

## REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	<p><b>REGULATION 28 REPORT TO PREVENT FUTURE DEATHS</b></p> <p><b>THIS REPORT IS BEING SENT TO:</b></p> <p>1. [REDACTED], British Transport Police, 1<sup>st</sup> Floor, South Wing, Axis House, 10 Holliday Street, Birmingham B1 1UP</p>
1	<p><b>CORONER</b></p> <p>I am Mr David Urpeth, Assistant Coroner, for the coroner area of Black Country.</p>
2	<p><b>CORONER'S LEGAL POWERS</b></p> <p>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.</p>
3	<p><b>INVESTIGATION and INQUEST</b></p> <p>On 23.6. 2015, I commenced an investigation into the death of Mr Ashley Aaron Matthews. The investigation concluded at the end of the inquest on 23 July 2015. The conclusion of the inquest was Death by Misadventure</p>
4	<p><b>CIRCUMSTANCES OF THE DEATH</b></p> <ol style="list-style-type: none"><li>1. On the 18.6.15, Ashley Matthews and friends accessed Bescot Traction Maintenance Depot in Wednesbury, via a gap in fencing.</li><li>2. He climbed over a railway bridge ( Bridge 26) and attempted to drop into a good wagon.</li><li>3. Whilst attempting to do so, he was electrocuted after making contact with a high voltage cable.</li><li>4. He was taken to hospital but his injuries were thought to be incompatible with life.</li><li>5. He died 19.6.15</li><li>6. The medical cause of death was given as:<ol style="list-style-type: none"><li>1a. Extensive full thickness burns incompatible with life</li></ol></li></ol>
5	<p><b><u>CORONER'S CONCERNS</u></b></p> <p>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.</p> <p>The <b>MATTERS OF CONCERN</b> are as follows. –</p> <ol style="list-style-type: none"><li>(1) During the course of the inquest, evidence suggested that access to the site was gained by insecure fencing.</li><li>(2) After the death of Ashley Matthews, the family were able to gain access to the site unchallenged by security.</li><li>(3) The family witnessed the security guard asleep in his car.</li></ol>

	<p>(4) Others had gained access and placed flowers on Bridge 26.</p> <p>(5) The family witnessed someone on the site walking with their dog and placing flowers on bridge 26.</p> <p>(6) Evidence suggested that some parts of the perimeter fencing were secured with cable ties.</p> <p>(7) Evidence suggested there were no warning signs on Bridge 26 warning of the dangers posed by high voltage cabling.</p> <p>(8) In light of the inquest findings, you may wish to consider the physical security of the site including fencing as well as the security patrols in place.</p>
6	<p><b>ACTION SHOULD BE TAKEN</b></p> <p>In my opinion action should be taken to prevent future deaths and I believe you have the power to take such action.</p>
7	<p><b>YOUR RESPONSE</b></p> <p>You are under a duty to respond to this report within 56 days of the date of this report, namely by 19.9.2015. I, the coroner, may extend the period.</p> <p>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.</p>
8	<p><b>COPIES and PUBLICATION</b></p> <p>I have sent a copy of my report to the Chief Coroner and to the following Interested Persons:-</p> <p>Mr Matthews family.</p> <p>I am also under a duty to send the Chief Coroner a copy of your response.</p> <p>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.</p>
9	<p><b>23.7.2015</b></p> <p>[REDACTED]</p>