ANNEX A

REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

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

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** [redacted] **Security and Route Crime Project Manager** **South West Trains** **Room 47, New Raft** **Waterloo Station** **London SE1 8SW**
1	**CORONER** I am David Clark Horsley, Senior Coroner, for the Coroner Area of Portsmouth and South East Hampshire.
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 11th June 2015 I commenced an investigation into the death of Steven Robert MURPHY, aged 41. The investigation concluded at the end of the inquest on 12th April 2016. The conclusion of the inquest was: Medical cause of death: Ia - Multiple Injuries Narrative Conclusion: Took his own life whilst suffering from long-term severe mental health problems.
4	**CIRCUMSTANCES OF THE DEATH** At about 14.25 hours on 6th June 2015 Steven Robert Murphy jumped from a footbridge at Liss railway station into the path of an oncoming train. He died instantaneously.
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. – At Mr Murphy's Inquest, I was told in evidence that following his death the British Transport Police submitted to South West Trains a Post Fatality Site Survey Report highlighting appropriate measures for the passage footbridge at Liss Station to reduce the risk of persons climbing over the parapet of the footbridge as Mr Murphy had done. I was also told that the British Transport Police had received no positive response regarding its report from South West Trains. I attach a copy of the British Transport Police report to this report. I believe that South West Trains should consider taking the

	measures set out in the British Transport Police report to prevent future deaths in similar circumstances to Mr Murphy's death.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe 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, namely by 22nd June 2016. 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: - [redacted] - [redacted] British Transport Police 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	**27th April 2016** **David Clark Horsley**