ANNEX A

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. [redacted]** **2. HM Principal Inspector of Railways** **3. Office of Rail and Road** **4. 2nd Floor** **5. 2 Rivergate** **6. Temple Quay** **7. Bristol BS1 6EH**
1	**CORONER** I am Andrew Bradley, senior coroner for the coroner area of Hampshire North East
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** On7 October 2016 I commenced an investigation into the death of Derek Edward Hope THOMAS aged 83. The investigation concluded at the end of the inquest on 24 January 2017. The conclusion of the inquest was that he died of multiple injuries sustained when he crossed the railway line at the pedestrian crossing at Alice Holt Bentley in Hampshire on his mobility scooter and was struck by a train.
4	**CIRCUMSTANCES OF THE DEATH** The deceased was a local resident who used the crossing regularly. He used a mobility scooter. On fifth October 2016 he used the foot crossing at Bentley station. He did not appear to see or hear the approaching non-stopping train which struck him causing him catastrophic injury.
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) The crossing is unmanned and unprotected (2) The only direct warning is the horn being sounded by the driver some 400 m from the crossing (3) Visibility is obscured by a fence although remedial action has been taken to reduce the height of it thereby improving visibility
6	**ACTION SHOULD BE TAKEN**

	In my opinion action should be taken to prevent future deaths and I believe you and 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 27 March 2017. 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] his daughter. I have also sent it to [redacted] 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	**27 January 2017** **CORONER**

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