Central and South East Kent Coroners

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	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. Group General Counsel Network Rail** **2. Managing Director South Eastern Railway**
1	**CORONER** I am Patricia Harding Senior Coroner for **Central and South East Kent**
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 18/01/2017 I commenced an investigation into the death of Robert John MULLIS. The investigation concluded at the end of the inquest on 18th May 2017. The conclusion of the inquest was that Robert Mullis died on the evening of 6th January 2017 from injuries sustained when he was hit by a train after disembarking from a train on which he was travelling to London and wandering onto the railway track adjacent to platforms 5 and 6 of Ashford Domestic Railway Station. His reason for doing so cannot be determined but the fact that he was partially sighted and had Parkinsons and Vascular Dementia likely contributed. 1a **Multiple Injuries** b c II Conclusion: Accidental Death
4	**CIRCUMSTANCES OF THE DEATH** Robert Mullis who had Parkinsons, Vascular Dementia and was partially sighted was put on the South Eastern high speed train at Ramsgate in order to travel to London where he was to be met by his daughter at London St Pancras station. When he failed to arrive daughter became concerned and contacted police. Mr Mullis wore a GPS tracker which showed him to be in the vicinity of Ashford railway station. A police search was instigated and CCTV examined which showed Mr. Mullis to disembark the train shortly before it departed Ashford station and walk off the end of platform 6 onto the railway tracks at 17.45. He was thereafter struck by two trains, the latter causing the injuries from which he died.

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. I make this report with the knowledge that Network Rail and South Eastern are addressing the issue of track access from platforms nationally with Ashford being addressed in Autumn 2017
7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of the date of this report, namely by 19th July 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] 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	23/05/2017 Signature:  Patricia Harding Senior Coroner **Central and South East Kent**