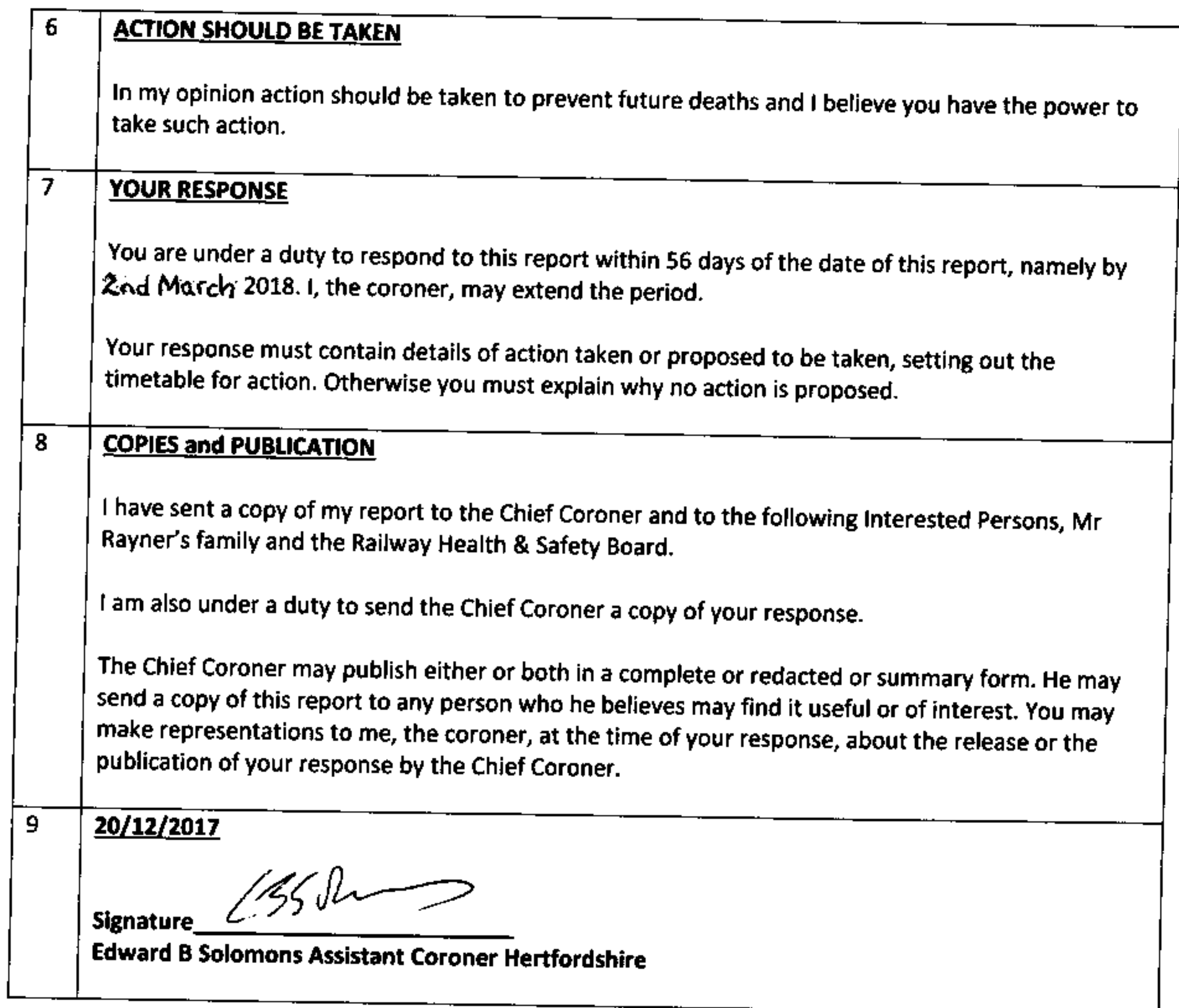
CORONER'S OFFICE
AREA OF HERTFORDSHIRE

Assistant Coroner Mr Edward SOLOMONS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO: Network Rail**, Company Secretary, 1 Eversholt St. London
1	**CORONER** I am Edward B Solomons Assistant Coroner for **Hertfordshire**
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. http://www.legislation.gov.uk/ukpga/2009/25/schedule/5/paragraph/7 http://www.legislation.gov.uk/uksi/2013/1629/part/7/made
3	**INVESTIGATION and INQUEST** On the 28th April 2017 I commenced an investigation into the death of Scott RAYNER. The investigation concluded at the end of the inquest 20th December 2017. The conclusion of the inquest was Misadventure. On the 16th April 2017 Scott Rayner trespassed on the railway track near Watford Junction Station, where he was struck by a train. 1a. Multiple Traumatic Injuries
4	**CIRCUMSTANCES OF THE DEATH** On the 16th April 2017 the driver of the 19:19 train from Oxonholme to London Euston saw Scott Rayner standing in the middle of the track at Watford Junction Station. Mr Rayner was facing the train holding his arms out to the side. Although the driver applied the emergency brakes his train struck Mr Rayner. Mr Rayner had been suffering from long term mental health problems. Paramedics confirmed death at the scene. BTP SOCO confirmed ID via fingerprints.
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. British Transport Police investigating revealed that fencing beside the railway track was inadequate especially at the rear of a scrap metal dealer located off St Albans Road and Bedford Street, leading to a risk that adults and children may trespass on the line where the speed limit is 100mph.



6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you 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 2nd March 2018. 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, Mr Rayner's family and the Railway Health & Safety Board. 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	**20/12/2017** **Signature**____________________ **Edward B Solomons Assistant Coroner Hertfordshire**