for Bedfordshire and Luton

REGULATION 28 REPORT TO PREVENT FUTURE DEATHS

	THIS REPORT IS BEING SENT TO: **Mr Andrew Haines** **Chief Executive** **Network Rail** **1 Eversholt Street** **London** **NW1 2DN**
1	**CORONER** I am Ian Pears, Assistant Coroner, for the Coroner Area of Bedfordshire & Luton
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 27th May 2018 I commenced an Investigation into the death of **Ryan John James WILLIAMS,** aged 26 years. The Investigation concluded at the end of the Inquest on 1st November 2018. The Conclusion of the Inquest was 'Accidental Death' following his sustaining multiple severe traumatic injuries.
4	**CIRCUMSTANCES OF THE DEATH** Ryan was born on 25th April 1992 and on the evening of 26th April 2018 he went out to Stevenage, Hertfordshire, to celebrate his birthday. He returned by train to Sandy Railway Station in the early hours of 27th April 2018. At the time Sandy Station was unmanned, but it was possible for the public to gain access. About an hour after Ryan had arrived at the station he was run over by a train.
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. It is of concern that a member of the public was able to be on the station premises for an hour without any supervision from a member of staff.

2. It is not uncommon for members of the public to be vulnerable due to intoxication. It is a concern that if stations do have to be kept open, but unmanned, that there is no means of supervising the use of the station by the public.

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 **11th January 2019**. 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**

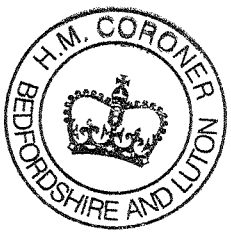
I have sent a copy of my report to the Chief Coroner and to the following Interested Person

[redacted] (step mother of Ryan).

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 Dated 6th November 2018



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IAN PEARS
Assistant Coroner
for the Coroner Area of Bedfordshire & Luton