VERONICA HAMILTON-DEELEY DL,
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Her Majesty's Senior Coroner
for the City of Brighton & Hove

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CORONERS SOCIETY OF ENGLAND AND WALES

ANNEX A

REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

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

	THIS REPORT IS BEING SENT TO: 1. **Govia Thameslink Railways** 2. **Network Rail**
1	**CORONER** I am Veronica HAMILTON-DEELEY, Senior Coroner, for the City of Brighton and Hove
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 Thirty first day of December 2018 I commenced an investigation into the death of Carl Richard KLIMAYTYS. The investigation concluded at the end of the inquest on 1ST August, 2019.The conclusion of the inquest was MISADVENTURE.
4	**CIRCUMSTANCES OF THE DEATH** See Record of Inquest
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: – I found that Carl died instantly as a result of electrocution when he came in contact with the electric rail at 0557 hrs on the 23 December, 2018.

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His body was decapitated and then disrupted by a train which arrived on the line upon which he was lying at 0611 hrs. One or two minutes later that train departed Preston Park Station carrying Carl's body with it for approximately 50 yards.

Whilst this occurred following Carl's death (approximately fifteen minutes later) the Inquest evidence indicated that there were several matters, the continuation of which could lead to future fatalities.

In the letter accompanying this Report you will find more information about those matters.

This Regulation Report relates to Signage on the platform.
The Inquest heard that both further north in England and Wales and overseas the current to enable the trains is carried by overhead arrangements.
Carl and his family had come from Darlington and of course many visitors, tourists and persons from abroad visit the Brighton area including Preston Park Station.
It is therefore reasonable to suppose that if they think about it at all they may assume that the electric current for the railway is carried overhead.

I should like to invite Govia Thameslink to consider and indeed the other railways operating on ground laid electric rails to consider the question of notification to their customers of that fact.

In addition one of the recommendations contained in British Transport Police's post incident site report (see page 2 – recommendation 1) there was a suggestion that painting or otherwise installing yellow cross hatchings on the coping stones between the platform edge white line and the tactile paving on the platform and including the words KEEP CLEAR to be included at every 20 metres would warn passengers that non stopping services regularly pass through stations. People on the station may stray too close to the platform edge (without this warning).
It was discussed at the Inquest that such signage may possibly be helpful in keeping members of the public away from the edge of the platform in any event.

This Regulation 28 Report is sent both to the Railway Company, Govia Thameslink and to Network Rail, not because Network Rail would be carrying out any such works but because it is understand that Network Rail are the 'landlords' for GTR who would therefore need to seek their permission to carry out these works.

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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 25th October 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 Persons 1. [redacted] (via Solicitors) 2. British Transport Police 3. Office of Road and Rail 4. Gatwick Express Services 5. Southern Rail 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	**Date: 7th August 2019** **SIGNED BY:** V. Hamilton-Deeley **HM Senior Coroner Brighton and Hove**

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	THIS REPORT IS BEING SENT TO: **1. Govia Thameslink Railways**
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4	**CIRCUMSTANCES OF THE DEATH** See Record of Inquest
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: – Three Bridges Regional Operating Centre (ROC) A member of the public arriving at Preston Park Station saw Carl's body at Platform 2.

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	He used the help phone pressing the emergency button to inform of this. The call was answered promptly by the initial call taker called a Resilience Customer Ambassador (RCA). This person had not been given the safety critical communication training. He had only been employed recently as an agency person to provide cover in the RCA over the Christmas period. The Inquest heard that when an emergency call comes in to the ROC there is a red flashing light and a buzzer to announce that this is an emergency call. The Inquest heard that the RCA should have picked up the telephone and handed it to his team leader who was shadowing him and sitting opposite him doing his own work. At 0602 the member of the public pressed the emergency button at the help phone. In fact the RCA answered the member of public's call, took details from him which were correct as to the location of Carl's body, said goodbye and terminated the call which lasted eleven seconds. The Inquest heard that almost immediately he passed information that the body was not on Track 2 but on Track 1. The Inquest heard that the Team Leader tried to phone the member of public back on the help phone but could not get an answer. It was not until 0609 hrs that the Team Leaders was able to speak to the member of public and ask for confirmation of the location of Carl's body. This time the member of public appears to be saying that the body is straddling Tracks 1 and 2 (in fact he was straddling Tracks 3 and 2). The Team Leader should have known from the information available to him in the ROC that for Carl's body to be straddling Tracks 2 and 1 was a physical impossibility since they are separated by a large island Platform. His call to the member of public lasted nineteen seconds. As a result of this incorrect and impossible information it was believed that Carl's body would not be disrupted by the train 9T90 approaching from Brighton and due to arrive in Preston Park Station on Line 2 at 0611. The plan was to prevent the train stopping at the station for reasons which were explained at the Inquest, but because of the inputting of the wrong headcode and the fact that the train describer system was down the driver of 9T90 was not contacted, came into Preston Park Station arriving on the track where Carl's body was lying, decapitating and then disrupting it, stopping at the station for approximately two minutes before leaving carrying Carl's body with it. The other matter which caused concern from the point of view what was going on in the ROC was that they apparently did not have up to date contact details for

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	Bronze. Having set out these facts the purpose of this Regulation 28 Report is to refer to the failings in the ROC and to request that actions are taken regarding appropriate training and use of resources for those who work in that operating centre.
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 25th October 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.
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	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	**Date:** **7th August 2019** **SIGNED BY:** V. Hamilton-Deeley **HM Senior Coroner Brighton and Hove**