REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **(1) British Transport Police** **(2) Network Rail**
1	**CORONER** I am NICHOLAS MOSS QC, assistant coroner for the coroner area of CAMBRIDGESHIRE AND PETERBOROUGH.
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. https://www.legislation.gov.uk/ukpga/2009/25/schedule/5 https://www.legislation.gov.uk/uksi/2013/1629/part/7/made
3	**INVESTIGATION and INQUEST** An investigation commenced on 5 February 2019 into the death of **Christine Elizabeth GOULD (Chris) aged 17.** The investigation concluded at the end of the inquest on **26 May 2021**. • The conclusion of the inquest was that Chris died by suicide when she deliberately stepped in front of a passing train on 26 January 2019. • Box 3 of the record of inquest recorded that: *"Chris was an informal patient at the Darwin Unit for Young People, Fulbourn, Cambridge. Shortly after 6.30 pm on Saturday 26 January 2019, she was permitted to leave the hospital for a cigarette break. She did not return to the unit as expected, but instead went to the nearby railway line. At about 7.35 pm Chris died when she deliberately stepped in front of a passing train, approximately 150 metres to the east of the Cherry Hinton Bypass Level Crossing"* • I gave a wider narrative conclusion together with factual findings delivered in open court. My narrative conclusion included that: *"Given the proximity of the Darwin Unit (and also the Fulbourn Hospital) and previous trespass incidents involving vulnerable patients:* *(i) Network Rail had made available a suitable and valuable facility for direct communication between CPFT and the signallers to slow the trains.* *(ii) Network Rail's fencing between and around the Cherry Hinton Bypass and Teversham Level Crossings was less than optimal. However, it would be mere speculation to conclude that this contributed to Chris' death."*
4	**CIRCUMSTANCES OF THE DEATH** My factual findings included that Chris may have accessed the railway line from the Cherry Hinton Bypass Level Crossing, from the Teversham Level Crossing or though or over the boundary fence between those level crossings. My factual findings further included that: 1) Network Rail had too readily assumed that Chris had accessed the railway via the Cherry Hinton Bypass Level Crossing.

	2) Both BTP and Network Rail fell into error in promoting that from a credible hypothesis into a firm assumption. 3) Network Rail in written evidence had gone so far as to state that "Access was made by Ms Gould at the crossing not via boundary [fencing]". There was no proper basis for such a firm assertion of Chris' route of access and this detracted from the otherwise careful evidence provided to the Court by Network Rail. 4) While compliant with standards, the fencing of the lower Class II type between the two level crossings near the Darwin Units should have been considered for upgrading given the proximity of the mental health units and the frequency of trespass incidents. 5) The boundary fencing at the time of Chris' death was less than optimal given the known risks. 6) It is to Network Rail's credit that they have now proactively decided to install 1.8m palisade fencing across the whole boundary area. 7) The annual inspections reporting the fencing as being in good condition did not appear to have captured the frequent cases of damage to the top line of the fencing. Such damage may not have rendered the fencing as in poor condition, but it pointed to trespassing incidents which ought to have been fed back into the risk assessments for the area. 8) In combination, the number of trespass incidents, and the frequent top-line level damage to the fencing should have led to the conclusion that the boundary measure was not preventing trespass. That should have led, but did not in fact lead, to the boundary fence being inspected every three months rather than annually. 9) I noted that Network Rail had already indicated in evidence that it would in future be inspecting the fence boundary every three months.
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 could 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) Following completed suicides on the railway network BTP and Network Rail are both involved in considering further mitigating measures that may be appropriate at the location to guard against further fatalities. (2) In Chris' case, earlier consideration to the fence boundary being a credible route of access may have led to the fence boundary being improved more quickly after her death. (3) I am concerned that your investigation into, and consideration of, Chris' death did not keep a sufficiently open mind that she may have climbed the boundary fence to access the railway line. If similar assumptions are made in other investigations, there is a risk of future fatalities: there is a risk that mitigating measures will be missed if BTP and Network Rail too readily assume that one point of access to the railway was used when the evidence permits of credible alternative routes of access. Accordingly, I am concerned that action should be taken in the sphere of guidance in keeping an open mind in post-death investigations but the nature of any appropriate action to be taken is for your organisations to consider.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe your organisations 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 **23 JULY 2021**. 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. NOTE – There are ongoing reporting restrictions that prevent the publication of details regarding the alleged abuser of Chris (and her sister Sam). You must not refer to that person's identity in any way in your response and you should contact the Coroner's Officer if you require further guidance in this regard.
8	**COPIES and PUBLICATION** I have sent a copy of my report to the Chief Coroner and to the following Interested Persons • [redacted](Parents) • Cambridgeshire and Peterborough Foundation Trust • Cambridgeshire Police • Cambridgeshire County Council and to the LOCAL SAFEGUARDING BOARD. I am also under a duty to send a copy of your response to the Chief Coroner and all interested persons who in my opinion should receive it. I may also send a copy of your response to any other person who I believe may find it useful or of interest. 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 usefulor 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.
9	**28 May 2021**