REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. South Western Railway** **2. Mr Davies' family** **3. [redacted] – BTP Fatal Investigations Officer**
1	**CORONER** I am Christopher Wilkinson, senior coroner for the coroner area of Hampshire, Portsmouth and Southampton
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 5 May 2021 I commenced an investigation into the death of Alun John Davies, aged 50 years. The investigation concluded at the end of the inquest on 1 June 2022. The conclusion of the inquest was that Mr Davies had died as a result of extensive injuries consistent with being struck by a train and that he had taken his own life whilst suffering from acute anxiety and chronic depression.
4	**CIRCUMSTANCES OF THE DEATH** The Deceased died instantly when he jumped from the platform at Portchester railway station into the path a non-stopping train at 18.47 on 4 May 2021. The events were captured on the forward-facing CCTV camera in the cab of the train when, on approaching the station, at 18.47 he is seen at the end of the platform, closest to the oncoming train on the left-hand side to squat and then jump onto the tracks before placing himself into a position to lie on the tracks before the oncoming train. No CCTV from the station or platform was available. He was known to have left his nearby hotel at 17.17 that evening (where he was seen leaving on CCTV) and to have walked to the nearby station of Portchester. [redacted]. It is believed that he had been at the station for some time before the incident occurred. The evidence established that at the time of his death he was suffering acute and heightened anxiety following a recent arrest and release on bail and a marriage breakup. He had been suffering chronic anxiety and depression related to concerns about his health, his career and family relationships. Previous use of a hair loss product, may have contributed to his lower mood, decline in his mental health and suicidal ideation. He had not disclosed the full extent of his mental health difficulties to family or professionals nor had he sought professional support.

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) The post-incident site report presented by British Transport Police (in conjunction with the Design Out Crime Unit) and completed on 22 July 2021 identified that there was (and remains) limited staffing and CCTV surveillance at Portchester Railway Station and limited visibility of the platforms - requiring a security risk assessment with a view to increasing staffing (at the ticket office and on the platform) with increased RCO Patrols and platform surveillance and that additional CCTV installation and coverage was required (of the platforms and public areas) with real time capability. (2) The post-incident site report further identified that Portchester Railway station is an impending 'escalated' location. Since 2017 there have been 2 previous fatalities in similar circumstances at the station – which is now recognised as having lower levels of surveillance – with Mr Davies' death being the third. Although recommendations were made after the first incident, the above recommendations and identified risks (at 1) have not yet been (fully) addressed or implemented. (3) The post-incident site report further identified the lack of public security and welfare announcements at the station (and within the station concourse) aimed at providing direction in the event of illness or of assistance being required. There is a lack of information/announcements to other members of the public as to how to obtain assistance if they are concerned by someone else's condition or actions. It is not clear to what extent this has been further considered or addressed.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you as an 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 Friday 9 September 2022. I, the coroner, may extend the period if required. 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. Mr Davies' family. 2. British Transport Police. 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 June 2022** **Christopher Wilkinson**