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

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. Network Rail**
1	**CORONER** I am Andrew Cox, the Senior Coroner for the coroner area of Cornwall and the Isles of Scilly.
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 12/5/23, I concluded an inquest into the death of Tamsin Dolamore who died on 9/1/18 at the age of 24. . The medical cause of death was recorded as: 1a) Effects of multiple injuries 1b) 1c) II) I recorded an Open Conclusion as the evidence of her intent was not sufficiently clear on a balance of probabilities.
4	**CIRCUMSTANCES OF THE DEATH** Tamsin had reported a rape to police in October 2017. She had been referred to both Outlook South West and the Community Mental Health Team. She was not receiving active support from either at the time of her death. She had undergone a Needs Assessment at the Women's Centre but there was a five month wait for support.
5	**<u>CORONER'S CONCERNS</u>** 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. –

	Tamsin fell approximately 21.5' from Menacuddle Hill/North Street railway bridge in St Austell. During the course of the investigation, enquiries were made relating to the parapet at the bridge. Please find attached: - Report of [redacted] at Strange, Strange & Gardner, Consultant Engineers, dated 30/8/18. You will note his view that the parapet does not meet the obligations of the Railway Clause Consolidation Act 1845; - Email from [redacted] dated 14/12/18; - Email from [redacted] dated 24/5/19; - Email from [redacted], Cormac, dated 15/7/19.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you [AND/OR your organisation] have the power to take such action. I consider the action that is necessary is to raise the height of the existing parapet so it complies with legal requirements.
7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of the date of this report, namely by 14/7/23. 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: [redacted] – parents of Tamsin [redacted] – brother Cornwall Partnership Foundation Trust 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	**[DATE] 16.5.23** **[SIGNED BY CORONER]**