REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

(Before Inquest)

REGULATION 28 REPORT TO PREVENT FUTURE DEATHS

THIS REPORT IS BEING SENT TO:

Managing Director
Northern Railway
5th Floor
Northern House
9 Rougier Street
York
YO1 6HZ

1 **CORONER**

I am Jeremy Chipperfield, senior coroner for the coroner area of Durham and Darlington

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/contents/made made

3 **INVESTIGATION**

I have commenced investigations into the deaths of the following persons:

	Collision and death	Investigation commencement
Glenn Jacques	14-Feb-24	15-Feb-24
Ben Robert Whiteman	03-Jun-24	05-Jun-24
Callum CLARK	05-Jul-24	08-Jul-24

. The investigations have not yet concluded and the inquests have not yet been heard.

4	**CIRCUMSTANCES OF THE DEATH** Each of the deceased persons died after being struck by a train travelling through [redacted] railway station, County Durham; in each case, the person is reported to have put himself into the path of the train by deliberate, intentional action.
5	**CORONER'S CONCERNS** **During the course of the investigation my inquiries 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 – [redacted] railway station appears to be, and to be known as, a convenient location for suicide. In response to a Prevention of Future Deaths Report dated 10-Dec-18, (which followed a death by suicide at [redacted] railway station), you stated that "the station does not classify as a hot spot under British Transport Police's definition which is used nationally to focus the work of cross industry working groups. Such locations are defined as having 3 or more suicides/attempted suicides in 12 months". The incidents referred to herein took place within 12 months.
6	**ACTION SHOULD BE TAKEN** In my opinion urgent action should be taken to prevent future deaths and I believe you or your organisation has 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 10-Sep-24I, 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 Interested Persons to these investigations. 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. She may send a copy of this report to any person whom she 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	**16-Jul-24** JS Chipperfield