Regulation 28: REPORT TO PREVENT FUTURE DEATHS

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

	REGULATION 28 REPORT TO PREVENT DEATHS **THIS REPORT IS BEING SENT TO:** [redacted] **Network Rail** **East Coast Route Director** **George Stephenson House** **Toft Green** **York** **YO1 6JT**
1	**CORONER** I am Crispin OLIVER, Senior Assistant Coroner for the coroner area of County 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.
3	**INVESTIGATION and INQUEST** On 14/04/2025 12:38an investigation was commenced into the death of Jody Lee ROBB 30/04/1993. The investigation concluded at the end of the inquest on 26/06/2025 11:15. The conclusion of the inquest was that Died at 23.03 on 08 April 2025 on the carriageway of Station Approach, [redacted] having taken deliberate steps to end her own life [redacted].
4	**CIRCUMSTANCES OF THE DEATH** Died at 23.03 on 08 April 2025 on the carriageway of Station Approach, [redacted] having taken deliberate steps to end her own life [redacted].
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: (brief summary of matters of concern) I read and heard evidence from the investigating CID officer who had reviewed all available CCTV in relation to the incident. She reported that Jody had arrived on the south bound platform just over an hour before she jumped. She sat on a bench for a few minutes before making her way onto [redacted]. She was on the [redacted] for about one hour before she actually did so. A total of 11 trains passed her, north and southbound, during that hour. No report was made or received of her presence there by train crews of station staff attending on the station platforms for arrivals and departures. [redacted]. My concerns are:

	1. Access to the [redacted] from the platform is not sufficiently barred or impeded to the public. It is clear by means of signage that the public must not go beyond the end of the platform. There are what appear to be some sort of wheeled access stoppers on the platform at and around the fence at its end. But there is nothing to prevent even a moderately mobile person from going around the fence and [redacted]. The main resource preventing access is human by means of station staff intervention, which is necessarily reliant on their presence at the relevant time; 2. [redacted] are not ones designed to prevent, impede or discourage attempts at suicide [redacted]; 3. Eleven trains passed Jody, from north and south, while she was on [redacted] during the hour before she jumped. No reports were made by any train crew of her presence. It would be exceeeding the available evidence and unfair to infer that train crews and/or station staff deliberately or negligently ignored her presence there. More likely is that she was simply not visible. It was dark, being at night in April, and Jody was wearing relatively dark clothing. However, she seems to have been discernible on CCTV and from the British Transport Police images I have seen taken from approximately where a driver might have been placed, it is plausible to suggest that she might have been visible, even laterally, from the cab of a train either slowing to stop at the station or pulling out from it, with even moderately enhanced lighting on the viaduct. Obviously, had a report been made of her presence, some type of intervention could have been attempted [redacted].
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.
7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of the date of this report, namely by August 27, 2025. 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], Jody's Mother** **[redacted], Jody's Aunt** who may find it useful or of interest. 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 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 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	**Dated: 01/07/2025**

Crispin OLIVER
Senior Assistant Coroner for
County Durham and Darlington