REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

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

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. CEO of Network Rail**
1	**CORONER** I am Richard T Middleton, Assistant Coroner, for the Coroner Area of Dorset
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 the 11th November 2024, an investigation was commenced into the death of Simon Anthony Moore born on the 14th of July 1983 who was aged 41 years at the time of his death. The investigation concluded at the end of the Inquest on the 25th June 2025 The Medical Cause of Death was: 1a Polytrauma The conclusion of the Inquest recorded Suicide
4	**CIRCUMSTANCES OF THE DEATH** Mr Moore was a train driver. During the latter half of 2024 he experienced three occasions when his driving required further investigation by his employer. The final occasion was on 3rd November 2024. On 4th November 2024 he stepped in front of a moving train and was pronounced dead at the scene.
5	**<u>CORONER'S CONCERNS</u>** The **MATTERS OF CONCERN** are as follows: 1. During the inquest evidence was heard that: i. Mr Moore knew that the incident on 3rd November 2024 would lead to him having to surrender his train driver licence and undergo a period of further assessment.

	ii. Immediately following the incident on 3rd November 2024 Mr Moore spoke to a signaller employed by Network Rail using a GSM-R radio. During the conversation (which is recorded) Mr Moore expressed concern about losing his job and sounds understandably distressed. iii. The on-call Driver Manager employed by the Train Company is obligated to attend and in this scenario take the train driver licence from the driver. An initial account of the facts is taken as well as certain medical tests. iv. The on-call Driver Manager who attended following the incident involving Mr Moore met with him almost 2 hours after the incident. The on-call Driver Manager was unaware of the content of the conversation between Mr Moore and the signaller which occurred 2 hours earlier and soon after the incident. The contents of this conversation would have helped the on-call Driver Manager to assess the driver's welfare. v. The Network Rail Signaller has no means through which to relay the details of any discussions with drivers (in this instance Mr Moore) to the train company Control who could then pass this information on to the attending Driver Manager.
6	**ACTION SHOULD BE TAKEN** In my opinion urgent 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, 30th September 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 (via their legal representatives where appropriate). (1) Family (2) DFTO formerly known as South Western Railway 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	**Dated** **5th August 2025**	**Signed**  **Richard T Middleton**