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:** **1. [redacted] Head of Level Crossings and Public Safety** **2. [redacted] North West Route Director** **3. The Chief Coroner**
1	**CORONER** I am Anita BHARDWAJ, Senior Coroner for the coroner area of Sefton, St. Helens and Knowsley
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 27 August 2025 I commenced an investigation into the death of Sam Alexander Dudley, aged 29. The investigation concluded at the end of the inquest on 03 February 2026. The conclusion of the inquest was that: Sam Alexander Dudley died as a result of: 1a Multiple Injuries Conclusion of the Inquest: Accident
4	**CIRCUMSTANCES OF THE DEATH** Sam Alexander Dudley was a 29 year old gentleman who, on 24 August 2025 at approximately 11:07 hours, was struck by a train on the level crossing at Wheatstone Road, Formby, known as Hoggs Hill Level Crossing. The level crossing is accessed via a public path from Wheatstone Road leading to a pedestrian gate which needs to be opened manually; then prior to accessing the tracks, there is signage and a traffic light that shows red or green lights depending upon the approach of a train. When a train approaches, the red light will illuminate and a klaxon siren will sound. Prior to being struck by the train Sam was out running, wearing headphones. After he was struck his mobile phone was found which was displaying a warning that the music was too loud. CCTV from the train that struck him shows Sam appeared to approach the track and immediately appeared shocked at the sight of the train and tried to jump backwards, but it was too late and the train struck him. The investigation revealed Sam had entered the track through a level crossing via the pedestrian gate whilst a red light was displayed and a klaxon siren sounding. After the gate there is signage warning of the danger of incoming trains. The lights and sirens were found to be in working order. The crossing was safe, compliant, and operating as designed. There were no causal or contributory failings identified in the inspection, maintenance, or management of the crossing. It is more likely than not that Sam did not hear the klaxon because he was running whilst listening to loud music through his headphones. In all the circumstances it is more likely than not Sam was distracted, not fully

	attentive and proceeded onto the track.
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) Nationally there is signage once individuals pass through the gate, but there is limited signage on the gate itself as people enter the walkway, only a short distance from the "decision point." Increasingly, more people wear earphones and are therefore less aware of their surroundings. Introducing clear pictorial signage on the gate, before individuals enter the 'decision point' area, such as an image of earphones with a line through them, may help alert users at the right moment. Visual cues generally attract initial attention more effectively and support rapid comprehension, while sound cues tend to create a stronger emotional connection. However, using both visual and auditory cues may together provide a more effective form of communication.
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 March 31, 2026. 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] **(Mother)** **Network Rail** **British Transport Police** 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: 05/02/2026**

[redacted]

Anita BHARDWAJ
Senior Coroner for
Sefton, St. Helens and Knowsley