	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. Northern Rail Ltd 1 Ely Place, London EC1N 6RY (1 Admiral Way, Doxford International Business Park, Sunderland)**
1	**CORONER** I am Jeremy Chipperfield, Senior Coroner for the Coroner area of Country 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 26th July 2018, I commenced an investigation into the death of Christopher Lewis McGUFFIE (26yrs). The investigation concluded at the end of the inquest today, the 10th December 2018. The conclusion of the inquest was SUICIDE, and I found that the deceased stood on the rails of the Northbound railway line at Chester le Street station where he was struck by a London to Edinburgh service.
4	**CIRCUMSTANCES OF THE DEATH** At around 19:39hrs, the deceased stood between the rails beside Platform Two where he waited for about five minutes prior to collision. During that period, members of the public (most of whom were school children) attempted to call him off the rails and raise an effective alert. One young boy left the station and knocked at the home of a local resident to request that she alert the police. Police were notified less than two minutes prior to the collision and by making a telephone call to Network Rail achieved a block on the rail line around three minutes therafter. I was told by a DS of British Transport Police : (i) no platform staff were on duty at the time; (ii) no emergency help point exists at this station; and (iii) the station in question is "considered a hot spot for rail fatalities".
5	**CORONER'S CONCERNS** During the course of the inquest the evidence 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. The absence, at railway stations, of:- (1) the means to raise an immediate and effective alert regarding persons on the line; AND (2) Alternative means of detecting persons on the line and triggering appropriate response.

6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you and 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 Wednesday 6th February 2019. 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] I have also sent it to the Office for Rail and Road, who may find it useful or of interest. 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:10 December 2018** **Signed .....** **JEREMY CHIPPERFIELD** **HM SENIOR CORONER** **COUNTY DURHAM AND DARLINGTON**