Her Majesty's Coroner for the Northern District of Greater London

(Harrow, Brent, Barnet, Haringey and Enfield)

North London Coroners Court, 29 Wood Street, Barnet EN5 4BE

Telephone 0208 447 7680 Fax 0208 447 7689

REGULATION 28 REPORT TO PREVENT FUTURE DEATHS

THIS REPORT IS BEING SENT TO

Transport For London, 14 Pier Walk, London, SE10 OES

1 CORONER

I am Andrew Walker, senior coroner, for the coroner area of Northern District of Greater London

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 7th December 2015 I opened an investigation touching the death of Ezharul Islam , 73 years old. The inquest concluded on the 24th May 2016 The conclusion of the inquest was "Narrative", the medical case of death was 1a Aspiration Pneumonia,1b Rehabilitation and treatment following Chronic Subdural Haematoma and in 11 Chronic Subdural Haematoma

4 CIRCUMSTANCES OF THE DEATH

On the 23rd October 2015 at about 10.44 Ezharul Islam fell and struck his head as the bus he had just boarded moved forward from the bus stop. Mr Islam was downstairs on a 191 bus and may have been in the process of sitting down when the bus moved causing him to fall.

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 will occur unless action is taken. In the circumstances it is my statutory duty to report to you.

The MATTERS OF CONCERN are as follows. -

That there was no system to alert passengers that the 191 bus was about to move. In the past the signal that a bus was about to move would have been the conductor saying hold on tight and sounding a bell twice in rapid succession. Consideration should be given to introducing a system that alerts passengers that the bus they are on is about to move.

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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 Monday the 1st August 2016. 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;-

Representatives of the family Representatives of the London General Bus Company

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 6th June 2016