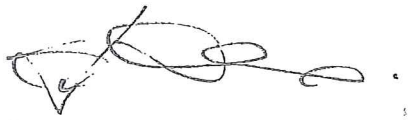
REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** Mr Mike Brown. Commissioner for Transport, Transport for London, 14, Pier Walk, London. SE10 0ES
1	**CORONER** I am Dr Fiona J Wilcox, HM Senior Coroner, for the Coroner Area of Inner West 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 23rd April 2019, evidence was heard touching the death of **Alfonso Sinclair.** Mr Sinclair was struck by a train in the Southbound Victoria tunnel approaching Oxford Street tube station and killed instantly. He was 29 years old at the time of his death. The findings of the court were as follows: **Medical Cause of Death** 1 (a) Multiple Injuries 11 Postictal confusion and cannabis use **How, when, where the deceased came by his death:** Mr Sinclair suffered with severe epilepsy following a head injury in 2009. This was complicated by post ictal confusion and cannabis misuse. On 31/8/2018 in a delirious state, he entered the Victoria Line tube tunnel at Warren Street station at approximately 11:00 am. He was struck by a train and killed at approximately 11:20. His body was found at approximately 16:30 and he was recognised as life extinct at the scene at 17:23 **Conclusion of the Coroner as to the death:** Postictal confusion in combination with accidental strike from a tube train.
4	**Circumstances of the death.** Extensive evidence was taken and accepted by the court. In summary:

	Mr Sinclair had been behaving oddly at the ticket barrier earlier, entering and re-entering 4 times in the course of a few minutes. He then travelled elsewhere, returning shortly and jumped over the ticket barrier. This overtly odd and then illegal behaviour went apparently unnoticed and unchallenged by staff. Evidence was taken that the appropriate number of staff were on duty and this usually include at least one member of staff at the barrier, and a manager located within the control where the CCTV monitors are sited. He then descended two escalators, ran across the concourse, down the platform and vaulted the barrier at the train entrance end, and then jumped down onto the tracks and walked into the tunnel at 11:00:29. He must have evaded around five trains before being struck at 11:20. This meant that he was in the tunnel for approximately 19.5 minutes before being killed. There are no alarms on the barriers on the end of the platforms, they are low and have swing gates. It was accepted by the court that making these barriers more secure would not prevent a person jumping down onto the tracks. There was extensive CCTV throughout the station, but none of Mr Sinclair's unusual or dangerous behaviour was noted by staff on duty at the time. His behaviour at the gates and time he spent in the tunnel before being struck were potentially lost opportunities to prevent this death.
5	**Matters of Concern:** 1. That there is no apparent system for staff to alert odd behaviour and then track an individual of concern on CCTV. 2. That there is no alarm at the barriers at the platform ends. 3. That if (1) and (2) were in place, odd behaviour and/ or entrance into tunnels by passengers via the barrier ends of platforms could be monitored by CCTV. This would have allowed staff to see Mr Sinclair enter the tunnel, and although not allow sufficient time to have prevented him from doing so, would allow time for the trains to be stopped and thus prevent the loss of life. False alarms at the barriers could be easily checked and eliminated by viewing CCTV. 4. That systems of work by station staff be reviewed to ensure monitoring of the ticket barriers as a place where irregular behaviour by passengers is more likely to be observed. 5. That ease of monitoring of CCTV be facilitated.
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. It is for each addressee to respond to matters relevant to them.
7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of the date of this report. 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] [redacted] Head of Network Delivery for London Underground, Palestra, 197, Blackfriars Road, London. SE1 8NJ. 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	**29th April 2019**  **Professor Fiona J Wilcox** **HM Senior Coroner Inner West London** **Westminster Coroner's Court** **65, Horseferry Road** **London** **SW1P 2ED** **Honorary Professor QMUL School of Medicine and Dentistry**