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

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	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** HM Inspector of Railways Mainline Operators Team | Railway Safety Directorate | Office of Rail and Road One Kemble Street London WC2B 4AN
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 28th of November 2018 I opened an investigation touching the death of Priscilla Tropp. I opened an inquest on the 4th December 2018. The inquest concluded on the 23rd April 2019. The conclusion of the inquest was "Consequences of a fall down stairs at a railway station". The medical cause of death was 1a Traumatic Splenic Rupture, 11 Myeloproliferative disorder.
4	**CIRCUMSTANCES OF THE DEATH** On the Twenty-Seventh of November 2018 at a little before 16.30 hrs in the afternoon Priscilla Tropp fell down steps at Mill Hill Broadway Station and was taken to the Royal Free Hospital where Mrs Tropp died as a consequence of the injuries sustained in the fall . The nature of the access to the platforms, there being no step free access, resulted in Mrs Tropp falling despite using the handrail and being supported by her husband. The incident was not appropriately managed and Mrs Tropp was left to be treated as passengers made their way past with no steps taken to divert passengers.
5	**<u>CORONER'S CONCERNS</u>** 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 is no flow chart or plan for this station, taking into account its design and available public spaces, to cover the situations where a person is taken ill on the station, or in any of the area that are involved in moving around the station , that sets out a sensible series of steps that need to be taken by staff to mitigate

	any potential injury to the person who may themselves have been injured or to any one else using the station.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you [AND/OR your organization] 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 the 19th August 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;- Representatives for the Train Company, Network Rail, Department of Transport and the Family. 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	**24-6-2019**