Regulation 28: Prevention of Future Deaths report

Hassan Zubair (died 2nd December 2021)

	THIS REPORT IS BEING SENT TO: 1. [redacted] Chief Executive Network Rail One Eversholt Street, London, NW1 2DN
1	**CORONER** I am: Acting Senior Coroner Graeme Irvine The Coroner's Court 127 Ripple Road Barking IG11 7PB
2	**CORONER'S LEGAL POWERS** I make this report under the Coroners and Justice Act 2009, paragraph 7, Schedule 5, and The Coroners (Investigations) Regulations 2013, regulations 28 and 29.
3	**INVESTIGATION and INQUEST** On 3rd December 2021, this court commenced an investigation into the death of Hassan Zubair, The investigation concluded at the end of the inquest on 11th May 2022. I arrived at a narrative conclusion, "Mr Hassan Zubair was declared deceased at 14.06 on 2nd December 2021 at Goodmayes Railway station after he was [redacted]. Mr Zubair deliberately [redacted] at the station but it has not been possible to determine his intentions at the time." The medical cause of death was: 1.a. Multiple injuries 2. Alcohol Intoxication

	CIRCUMSTANCES OF THE DEATH Goodmayes station consists of four platforms, 1-4. The station is oriented east to west, Platform 1 situated to the south, Platform 4 to the north and platforms 2 & 3 occupying a central island between the lines. At 13:40 on 2 December 2021, Network Rail was made aware of a concern for welfare by a report from the driver of train 2W34 staionary at Platform 4, who reported seeing a member of the public on Platform 3 of Goodmayes station with no shoes on, carrying a blanket. That person was later identified as Hassan Zubair. The call resulted in two actions; 1. At 13:43, the Signaller advised the driver of train 2W59 (the next train due into Goodmayes station on the Up Electric line on Platform 3) to approach at caution because of a concern for welfare. 2. The operator of Goodmayes station was contacted to alert staff at the station and the local security team of the concern. Moments later, Mr Zubair was struck at 13:45 by the 13:33 London Liverpool Street to Southend Victoria, train 1K50 on the Down Main line ([redacted]). Critically, this train had received no warning to approach with caution and accordingly was travelling at a speed estimated to be between 80-85 mph. Mr Zubair was killed instantly.
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. 1. The failure of the signals controller to advise trains travelling through [redacted] to proceed with caution.
6	**ACTION SHOULD BE TAKEN** In my opinion, action should be taken to prevent future deaths and I believe that your organisation has 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 15th July 2022 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 following. The Zubair family. The Rt Hon Grant Shapps MP, Secretary of State for Transport Department for Transport Great Minster House 33 Horseferry Road London SW1P 4DR United Kingdom 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	**DATE 19th May 2022** **SIGNED BY ACTING SENIOR CORONER GRAEME IRVINE**