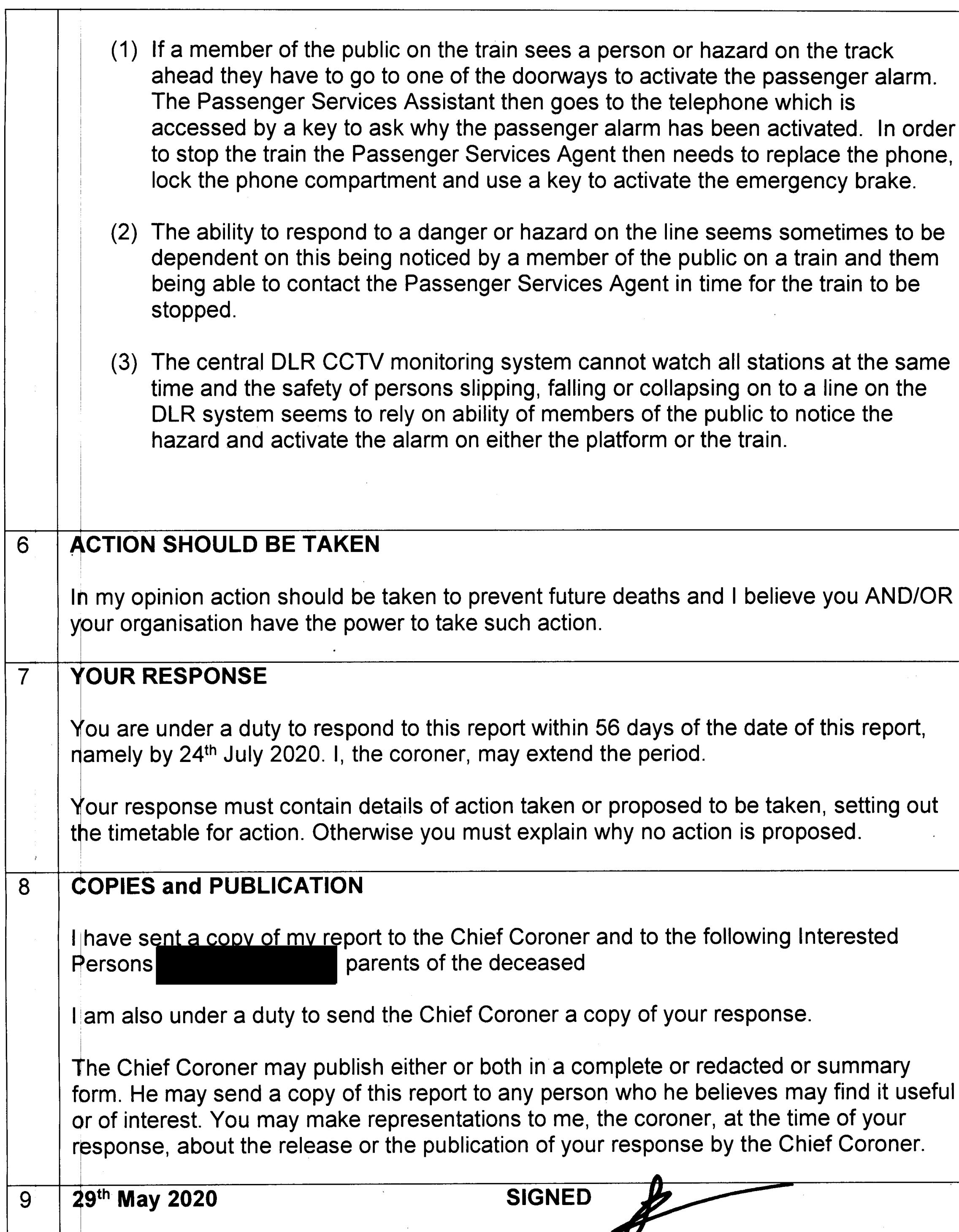
	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** 1. **[redacted] H M Inspector Assistant of Railways, The Office of Rail & Road** 2. **Transport for London** 3. **[redacted] Head of Train Services, DLR**
1	**CORONER** I am JONATHAN STEVENS, assistant coroner, for the coroner area of Inner North 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 10th January 2020 Senior Coroner Hassell commenced an investigation into the death of FLORA SHEN [age 36]. The investigation concluded at the end of the inquest on 18th May 2020. The conclusion of the inquest was that the deceased died on 6th January 2020 at Lime House station having fallen from the platform resulting in her being struck by a train which caused her to sustain fatal injuries.
4	**CIRCUMSTANCES OF THE DEATH** On 6th January 2020 Flora Shen travelled to Lime House DLR station. CCTV showed that she arrived alone and went and stood at the far end of the platform behind the yellow line. She than appears to move forward slightly and then appears to drop or fall onto the track. The CCTV appears to show her arm reaching up on to the platform. The evidence was unclear as to whether she was trying to stop a fall or climb out. A witness was seated in the front of the train as it approached the station and saw someone drop onto the tracks. He could not find any way to stop the train before it struck the woman. Another witness was at the station and noticed someone a bit dazed or woozy and heard them trip or fall. The woman on the tracks was not capable of getting up so this witness ran to and pressed the emergency button but it was too late to stop the train. There are 41 DLR stations and only 4 are staffed. The DLR trains are driverless and have a Passenger Services Agent on board.
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. –



	(1) If a member of the public on the train sees a person or hazard on the track ahead they have to go to one of the doorways to activate the passenger alarm. The Passenger Services Assistant then goes to the telephone which is accessed by a key to ask why the passenger alarm has been activated. In order to stop the train the Passenger Services Agent then needs to replace the phone, lock the phone compartment and use a key to activate the emergency brake. (2) The ability to respond to a danger or hazard on the line seems sometimes to be dependent on this being noticed by a member of the public on a train and them being able to contact the Passenger Services Agent in time for the train to be stopped. (3) The central DLR CCTV monitoring system cannot watch all stations at the same time and the safety of persons slipping, falling or collapsing on to a line on the DLR system seems to rely on ability of members of the public to notice the hazard and activate the alarm on either the platform or the train.
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.
7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of the date of this report, namely by 24th July 2020. 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] parents of the deceased 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 May 2020** **SIGNED**