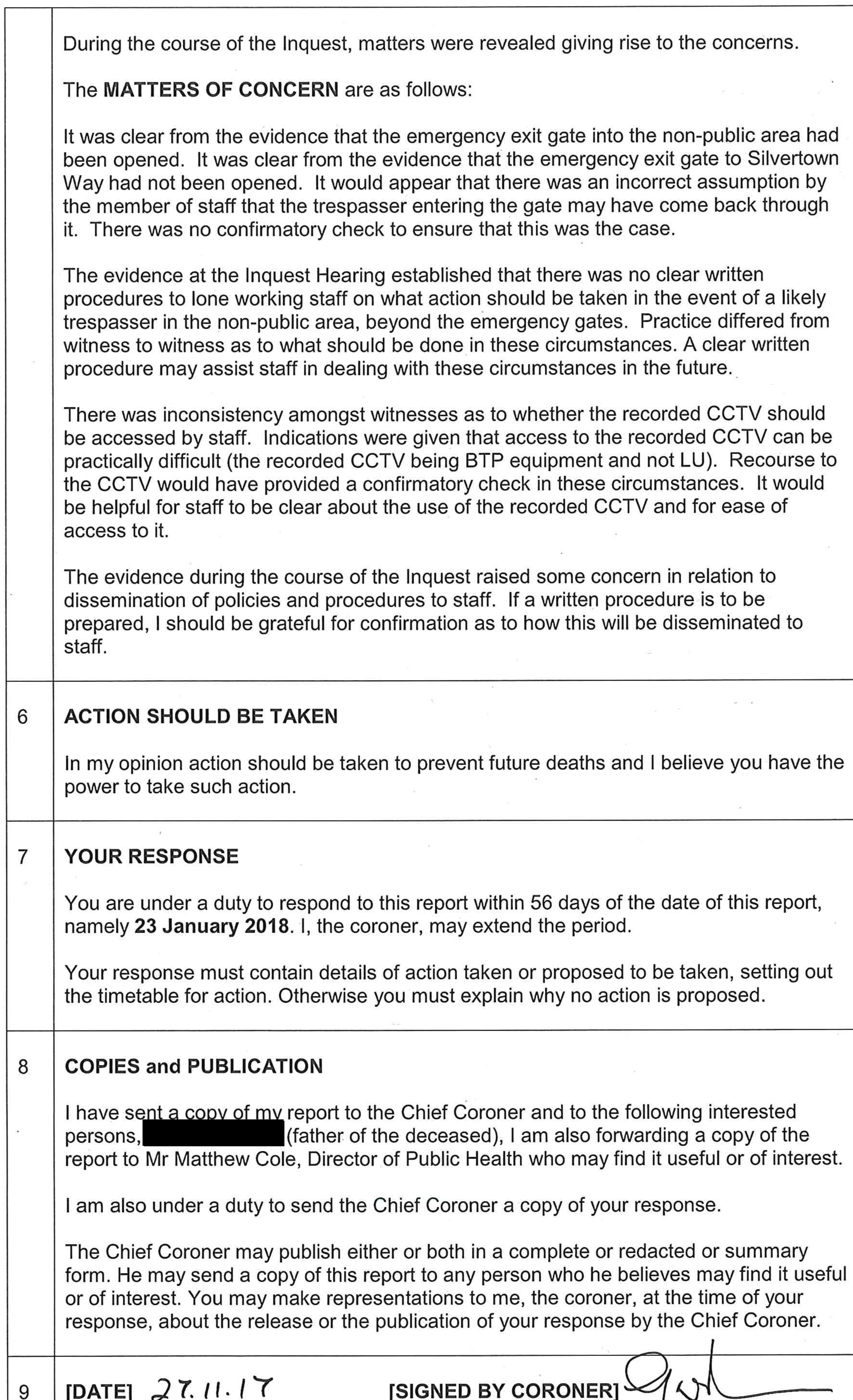
REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. [redacted] - Managing Director of London Underground, Palestra, Floor 11 B4, 197 Blackfriars Road, London, SE1 8NJ**
1	**CORONER** I am Nadia Persaud, Senior Coroner for the Coroner area of East 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. http://www.legislation.gov.uk/uksi/2013/1629/part/7/made
3	**INVESTIGATION and INQUEST** On the 8th February 2017 I commenced an investigation into the death of Bernard Aziengbe Ovu. The investigation concluded at the end of the Inquest on the 16th November 2017. The conclusion of the jury was a narrative conclusion: *Understaffing at Canning Town Station led to processes not being able to function as normal. Processes that were known in the event of an emergency door trigger were not followed. Had this process been carried out, it is possible that Bernard may have been located earlier.* *The fall itself was due to Bernard's physical state rather than environmental factors.* *Once the fall had occurred, it is unlikely that Bernard's death could have been prevented.*
4	**CIRCUMSTANCES OF THE DEATH** Bernard Ovu attended Canning Town Station at around 01:56 on the 22nd January 2017. Shortly after arrival at the station he went through an emergency exit barrier, followed by an alarmed emergency exit gate. Mr Ovu entered a non-public area of the station. A member of staff, lone working at Canning Town Station was asked to check the emergency exit area. The member of staff attended and noted the emergency exit gate had been opened. He closed the gate, thereby preventing re-entry from the non-public area. The member of staff looked around the platform/track area. Mr Ovu spent around 50 minutes in the non-public area of the station. He had returned to the emergency exit gate, but was now prevented from returning to the platform. At 02:49 on the 22nd January 2017, Mr Ovu is seen falling forward down the emergency exit stairs to the DLR platforms. He was found by staff at 08:44 on the 22 January 2017. Life was pronounced extinct by the emergency services. The post-mortem confirmed a cause of death of 1a: Head injury
5	**CORONER'S CONCERNS**



During the course of the Inquest, matters were revealed giving rise to the concerns.

The **MATTERS OF CONCERN** are as follows:

It was clear from the evidence that the emergency exit gate into the non-public area had been opened. It was clear from the evidence that the emergency exit gate to Silvertown Way had not been opened. It would appear that there was an incorrect assumption by the member of staff that the trespasser entering the gate may have come back through it. There was no confirmatory check to ensure that this was the case.

The evidence at the Inquest Hearing established that there was no clear written procedures to lone working staff on what action should be taken in the event of a likely trespasser in the non-public area, beyond the emergency gates. Practice differed from witness to witness as to what should be done in these circumstances. A clear written procedure may assist staff in dealing with these circumstances in the future.

There was inconsistency amongst witnesses as to whether the recorded CCTV should be accessed by staff. Indications were given that access to the recorded CCTV can be practically difficult (the recorded CCTV being BTP equipment and not LU). Recourse to the CCTV would have provided a confirmatory check in these circumstances. It would be helpful for staff to be clear about the use of the recorded CCTV and for ease of access to it.

The evidence during the course of the Inquest raised some concern in relation to dissemination of policies and procedures to staff. If a written procedure is to be prepared, I should be grateful for confirmation as to how this will be disseminated to staff.

6 **ACTION SHOULD BE TAKEN**

In my opinion action should be taken to prevent future deaths and I believe you 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 **23 January 2018**. 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, (father of the deceased), I am also forwarding a copy of the report to Mr Matthew Cole, Director of Public Health who may find it useful or of interest.

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]** 27.11.17 **[SIGNED BY CORONER]**