MR G IRVINE
SENIOR CORONER
EAST LONDON
124 Queens Road Walthamstow, E17 8QP
[redacted]

REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

[redacted]

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. [redacted] Commissioner, Transport for London ("TFL")** [redacted] **2. The Mayor of London,** [redacted] **3. [redacted], Secretary of State for Transport** [redacted]
1	**CORONER** I am Graeme Irvine, 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/ukpga/2009/25/schedule/5/paragraph/7 http://www.legislation.gov.uk/uksi/2013/1629/part/7/made
3	**INVESTIGATION and INQUEST** On 27/12/2023 this Court commenced an investigation into the death of Brian Mitchell aged 72 years. The investigation concluded at the end of the inquest held between 15/12/2025 & 17/12/2025. The court returned a short form conclusion of, "Accidental death" Brian's medical cause of death was determined as;

	1a Multiple Injuries 1b Blunt Force Trauma
4	**CIRCUMSTANCES OF THE DEATH** Mr Brian Mitchell was 72 at the time of his death On 26/12/2023 at 15:20 hours, Brian was discovered on tracks at platform 13 at Stratford Underground Station. Brian was declared deceased by paramedics having sustained traumatic injuries that were incompatible with life. CCTV was reviewed which showed the following: • At 13:56:53 on 26 December 2023, Mr Mitchell alighted from a London Underground Jubilee line train at Stratford station and sat down on a bench on platform 13. • At 14:45 hours Brian was seen to stand up and lurch towards the edge of the platform and fall onto the tracks. • Brian moved and tried to climb back onto the deserted platform. • At 14:50 hours, an incoming Jubilee Line train entered the platform and Brian was struck. • The impact went unnoticed. The train reversed out of the station over Brian. • Two further trains entered and left the platform each moving over Brian twice. • A member of staff unsuccessfully tried to prevent a fourth train moving over Brian as it entered Platform 13. The inquest heard that likely contributary factors to Brian's death were, firstly that Brian was heavily intoxicated by alcohol. Secondly, Jubilee Line trains use Automatic Train Operation (ATO). This means that Train Operators (TOs) do not drive the train. Acceleration and braking are automated. The expectation of TOs is that they pay close attention to the train and the tracks before them and override the ATO system and apply brakes if they observe an object on the tracks. In this case, at least 3 separate TOs failed to notice a man before them on the tracks or to override the automatic system. The court heard that the initial collision with Brian was likely to have been avoidable. The track layout would have allowed Brian's presence to have been noticed by an attentive TO. Additionally, it was asserted that a TO would have had sufficient time to react and bring the train to a stop many metres before Brian's location. The court heard that these omissions may have resulted from the fact that Platform 13 is a terminus platform which could result in a lowered level of attention on the part of TOs.
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. In the two years that have elapsed since Brian's death investigations have been

	conducted by the British Transport Police, The Rail Accident Investigation Branch ("RAIB") and TFL into the circumstances that led to this incident. There is no clear evidence to demonstrate that risks of fatal harm have been mitigated. 2. Recommended technological measures to detect and alert staff to the presence of persons on the tracks have not been implemented at Stratford station. 3. No clear data is available to demonstrate that training provided to train operators (drivers) to ensure that they concentrate and look at the tracks before them whilst operating trains using ATO has resulted in positive improvement in performance. 4. No clear data is available to demonstrate that station staff training has improved expedition or clarity of communication in emergency circumstances.
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 **25th February 2026,** 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 the family of Brian Mitchell. I am also under a duty to send a copy of your response to the Chief Coroner and all interested persons who in my opinion should receive it. I may also send a copy of your response to any other person who I believe may find it useful or of interest. 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.
9	**[DATE] 29/12/2025 [SIGNED BY CORONER]** [redacted]