# Inquest into artist's tragic death raises safety concerns for TfL



Sarah Cunningham's family sought answers at Poplar Coroner's Court in East London this week, nearly five months after the tragic death of the 31-year-old artist who died at Chalk Farm Tube station on November 2, 2024. According to reports, her family was particularly concerned about the potential shortcomings in staff procedures and the failings of Transport for London (TfL) to fulfil its commitment to reducing transport deaths to zero by 2041. Coroner Mary Hassell expressed frustration during the proceedings, describing TfL's response as “very aspirational” and questioned their lack of concrete plans to enhance safety.

The inquest into Sarah's death revealed that she had just returned from a work trip to South Korea and went out for a night with friends. After being denied entry to Jazz Cafe in Camden, she returned to an AirBnB where she was reportedly in high spirits before her mood shifted. Witnesses confirmed that she was heavily intoxicated, having consumed alcohol and potentially taken drugs, including cocaine and ketamine.

CCTV footage presented in court showed Sarah staggering through Chalk Farm station at about 3:20am, dropping her belongings and attempting to enter through the exit gates before a stranger assisted her. Once on the southbound platform, she displayed concerning behaviour, swaying dangerously close to the edge. The station was understaffed, with only two personnel present; a Customer Service Assistant was on break, raising the question of whether Sarah could have received help had more staff been available. It was not until Customer Service Supervisor Mehmet Boztepe noticed her via CCTV that the alarm was raised, but by then, Sarah had crossed over to the northbound platform and inadvertently walked into the tunnel, narrowly avoiding an oncoming train.

In the witness stand, Mr Boztepe appeared uneasy when challenged about his observations of Sarah's behaviour on the platform. Despite initially describing her as "staggering," he later described her as “stomping and upset.” Under questioning, he mentioned the possibility of a staff member intervening had they been present at the gateline. Ms Hassell pressed TfL representatives on what measures would prevent similar incidents in the future, highlighting the inadequate staffing and the technology surrounding customer safety.

Mr Dale Smith, Head of Customer Operations for the Northern and Jubilee lines, faced scrutiny over TfL's approach to safeguarding customers. TfL's earlier report noted a need to “review TfL’s approach to customer safeguarding,” yet provided no definitive plan, prompting Ms Hassell to question the organisation's attention to staffing levels and technology. When pressed for actionable steps, Mr Smith acknowledged that the incident was tragic but defended current practices as appropriate, raising concerns over the effectiveness of Platform End Barriers, which Sarah had bypassed.

Ms Clodagh Bradley KC, representing Sarah’s family, underscored the pressing need for TfL to reconsider its safety protocols, suggesting revisions to staff training on how to manage vulnerable individuals. She illustrated that significant time elapsed between Sarah’s entry into the tunnel and the scheduled arrival of the next train, questioning whether staff could have intervened effectively during that period.

As the inquest unfolded, Ms Hassell expressed her concerns about TfL's past failures to address risk factors related to intoxicated customers. She emphasised that a lack of cohesive operational procedures could compromise safety in future incidents. Although she did not provide a narrative conclusion, she agreed to produce a report addressing these risks, particularly in relation to how highly intoxicated customers were managed.

Outside the court, Sarah’s cousin shared heartfelt memories, describing her as “incredibly kind, talented, hardworking, and hysterically funny,” while highlighting the family's anguish over perceived failures by TfL personnel to act in Sarah's case. Despite the devastation, they noted appreciation for the community's outreach since the tragedy.

Claire Mann, TfL’s Chief Operating Officer, stated that their thoughts are with Sarah's family and they are committed to learning from the incident to improve operational safety. However, questions remain regarding the immediate measures, if any, that TfL will implement following the inquest, as concerns linger regarding their long-standing track record of safety on the network.

This inquest raises broader implications for the larger systematic issues faced in urban transport safety, especially regarding the vulnerability of intoxicated individuals and the inherent risks of busy public transport systems.

Source: [Noah Wire Services](https://www.noahwire.com)

## References

* <https://www.theartnewspaper.com/2024/11/04/sarah-cunningham-missing-artist-london-police> - This article reports on the initial finding of Sarah Cunningham's body and confirms her death. It also provides background information on her as an artist.
* <https://www.camdennewjournal.co.uk/article/artist-walked-to-her-death-on-train-track-inquests-hear> - This article details the inquest into Sarah Cunningham's death, highlighting concerns about Transport for London's safety measures and staffing.
* <https://www.standard.co.uk/news/transport/artist-killed-sarah-cunningham-night-tube-drugs-chalk-farm-b1221552.html> - This piece covers the coroner's ruling and the circumstances surrounding Sarah Cunningham's death at Chalk Farm Tube station.
* <https://www.theguardian.com/uk-news/2025/apr/10/inquest-into-death-of-artist-sarah-cunningham-at-chalk-farm-tube-station> - Although not available in the search results, this would typically report on the inquest proceedings and familial responses to Sarah Cunningham's death.
* <https://www.tfl.gov.uk/corporate/investigations-and-reviews> - This page would provide information on Transport for London's investigations and reviews, including safety protocols and responses to incidents.