ANNEX A

REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

*NOTE: This form is to be used **after** an inquest.*

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** 1. **Kirklees Council** **Flint Street** **Fartown** **Huddersfield** **HD1 6LG**
1	**CORONER** I am Kevin McLoughlin, Senior Coroner, for the Coroner area of West Yorkshire (East)
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 25/6/2019 I commenced an investigation into the death of Jessica Louise Duckworth aged 23. The investigation concluded at an Inquest on 2 December 2019. The conclusion of the Inquest was that she committed suicide by falling from a motorway bridge on the B6114 Saddleworth Road at Junction 22/23 of the M62 motorway on 16.6.19.
4	**CIRCUMSTANCES OF THE DEATH** Jessica Louise Duckworth had previously attempted suicide by taking an overdose of tablets. The evidence admitted at the Inquest included a statement from a police officer which refers to the Scammonden Bridge over the M62 motorway as a "notorious location for people to jump from and commit suicide." Ms Duckworth has fallen approximately 120 feet onto the carriageway. Her body was subsequently struck by passing vehicles.
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. – As the location has achieved notoriety as a suicide spot consideration should be given to installing fencing or other measures to prevent people falling from the bridge.

6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe 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 3 February 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. 1. [redacted] (Father of the deceased) [redacted] I have also sent it to the following who may find it useful or of interest. 1. [redacted] (Partner of the deceased) [redacted] 2. West Yorkshire Police [redacted] Huddersfield Police Station. 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	**4th December 2019** Kevin McLoughlin