IN THE WEST YORKSHIRE WESTERN CORONER'S COURT
IN THE MATTER OF:

**The Inquests Touching the Death of Jordan Ryan Sheils**
**A Regulation Report – Action to Prevent Future Deaths**

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| | **THIS REPORT IS BEING SENT TO:**<br>**Chief Executive – Calderdale Metropolitan Borough Council**<br>[redacted] **– Highway Asset Manager – Calderdale Metropolitan Borough Council** |
| 1 | **CORONER**<br>Martin Fleming HM Senior Coroner for West Yorkshire Western |
| 2 | **CORONER'S LEGAL POWERS**<br>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**<br>On 7/4/17 I opened an inquest into the death of **Jordan Ryan Sheils** who, at the date of his death was aged 19 years old. The inquest was resumed and concluded on 15/10/18<br>I found that the cause of death to be: -<br>1a. Multiple injuries<br><br>I concluded with a narrative conclusion of Suicide |
| 4 | **CIRCUMSTANCES OF THE DEATH**<br>On the evening of 3/4/17 Jordan went missing from his father's home address. Thereafter mother, father and girlfriend received several worrying text messages from him between 10.35pm and 11.02pm, prompting his sister to report him missing to the police at 11.13pm and urgent attempts to locate him were made. Subsequently the next day of 4/4/17 at approximately 3.23pm, Jordan's body was found by a passing witness immediately beneath the North Bridge. Upon the arrival of the police he was recovered face down in the water and was found to have passed away. The pathologist found that he had sustained multiple injuries internal injuries consistent with a fall from a great height. It was found that he had jumped from the bridge with the intention of taking his own life and that third party involvement can be excluded. |

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| 5 | **CORONER'S CONCERNS**<br>During the inquest I heard very helpful evidence from [redacted], Highway Asset Manager, who told me that the council are currently in the process of considering of obtaining planning permission for anti-climbing mesh at the location, although it is not thought it will be implemented until early next year.<br>The **MATTER OF CONCERN** is as follows. –<br>• To review the existing measures for deterring such tragedies with a view to expediting their introduction particularly with regard to prominently displayed CCTV cameras overlooking the bridge. |
| 6 | **ACTION SHOULD BE TAKEN**<br>In my opinion action should be taken to prevent future deaths and I believe that the Chief Executive has the power to take such action. |
| 7 | **YOUR RESPONSE**<br>You are under a duty to respond to this report within 56 days of its date; I may extend that period on request.<br><br>Your response must contain details of action taken or proposed to be taken, setting out the timetable for such action. Otherwise you must explain why no action is proposed. |
| 8 | **COPIES**<br>I have sent a copy of this report to:<br>• [redacted] – Mother<br>• [redacted] - Father<br>• [redacted]<br>• Chief Coroner |
| 9 | **DATED this 16/10/18** **Senior Coroner – West Yorkshire - Western Division**<br>M. D. Fleming |