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

The Inquest Touching the Death of Peter Jonathan Gledhill
A Regulation Report – Action to Prevent Future Deaths

	THIS REPORT IS BEING SENT TO: **Midgehole Working Mens Club**
1	**CORONER** Martin Fleming HM Senior Coroner for West Yorkshire Western
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 20 of the Coroners (Investigations) Regulations 2013
3	**INVESTIGATION and INQUEST** On 24/8/17 I opened an inquest into the death of **Peter Jonathan Gledhill** who, at the date of his death was aged 44 years old. The inquest was resumed and concluded on 13/8/18 I found the cause of death to be: - 1a. Multiple injuries I concluded with a narrative conclusion as follows: On 15 November 2017 Peter Jonathan Gledhill was found face down in Hebden Water, near Lee Mill Road, Hebden Bridge, after he had an unwitnessed fall from a height. Although it is found that he died from the multiple injuries he sustained in the fall and third party involvement can be excluded, the circumstances of the fall and his intentions remain unclear.
4	**CIRCUMSTANCES OF THE DEATH** On 15/11/18 Peter Jonathan Gledhill at approximately 3.45pm and 4pm sent worrying text messages to his wife. This prompted his wife to make several unsuccessful attempts to re contact him by phone. At approximately 4.30pm Mr Gledhill's phone was answered by a member of the public walking his dog along the river towards Hardcastle Craggs after finding it on the ground near to his coat. After providing details of

	of the public walking his dog along the river towards Hardcastle Craggs after finding it on the ground near to his coat. After providing details of the location, at Hebden Waters, near Lee Moll Road, Hebden Bridge, the witness then saw that Mr Gledhill had fallen 25 feet down an embankment and was face down in the river. Upon the arrival of police and paramedics to the scene Mr Gledhill was found to have passed away.
5	**CORONER'S CONCERNS** The **MATTER OF CONCERN** is as follows. – • To review safety aspects of the pathway running along the steep embankment overlooking the river and consider the appropriateness of fencing.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe that the Midgehole Working Mens Club, Halifax has the power to take such action.
7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of its date; I may extend that period on request. 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** I have sent a copy of this report to: • [redacted] – wife • [redacted] • Chief Coroner
9	**DATED this 27/8/18** **M.D. Fleming**