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** 2. **Highways England**
1	**CORONER** I am Oliver Robert Longstaff, HM Assistant Coroner for the coroner area of West Yorkshire (Western District)
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 17th September 2018 I commenced an investigation into the death of Muhammed Wajid, aged 29. The investigation concluded at the end of the inquest on 7th January 2020. The conclusion of the inquest was that Mr Wajid's death was due to multiple injuries sustained in a fall from Scammonden Bridge onto the westbound carriageway of the M62 motorway, and the jury concluded that the death was a suicide.
4	**CIRCUMSTANCES OF THE DEATH** On 12th September 2018, Mr Wajid was observed by passers by to be standing adjacent to the fence of Scammonden Bridge in a manner giving rise to concerns for his safety. Police officers attended, and he was safely removed from the scene pursuant to the provisions of s.136 of the Mental Health Act 1983. Following an assessment at Airedale Hospital, Mr Wajid agreed to be admitted to Lynfield Mount Hospital, Bradford, as a voluntary patient. On the following morning, Mr Wajid was permitted unaccompanied leave from Lynfield Mount, and took a taxi to Scammonden Bridge, where he was seen to jump to his death.
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. (1) Scammonden Bridge is a locally notorious location for suicides. (2) Reports to prevent future deaths have been made to Kirklees Council and Highways England under the above statutory provisions following deaths occurring in similar circumstances. (3) Kirklees Council and Highways England have reported proposed steps to prevent future deaths to the coroner following a similar report. The coroner is not aware whether those steps have been fully actioned.

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 6th March 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: Mr Wajid's family and the Bradford District Care NHS Foundation Trust. 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	**10th January 2020** **Assistant Coroner**