HER MAJESTY'S CORONER

For the West Yorkshire (Western) Coroner Area

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. [redacted], Health and Safety Manager, Calderdale Council, [redacted]** **2. [redacted] Rights of Way Department, Calderdale Council, [redacted]**
1	**CORONER** I am Crispin Oliver, Assistant Coroner, for the Coroner area of West Yorkshire, Western Division.
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 15th July 2020 I commenced an investigation into the death of Daphne Ann McKenna, aged 65. The investigation concluded at the end of the inquest on 1st October 2020. The conclusion of the inquest was that Ms McKenna died from multiple injuries resulting from an accidental fall from a height of 40 metres.
4	**CIRCUMSTANCES OF THE DEATH** Ms McKenna was pronounced dead at 11.30am on 13th July 2020 at the scene of the accident at the bottom of Hells Rock Cliff, Hell Hole Woods, near Beckitts Close, Heptonstall. The evidence from the investigating police officer was that she had fallen from a point on a footpath close to the viewing point at the end of Beckitts Close. She suffered injuries that would have probably caused instantaneous death upon impact with the ground. The land is owned by Calderdale Council and is crossed by several public footpaths and rights of way. The place was familiar to her, and she had visited there previously, including the day before. This was definitely not a suicide, and this is reflected in the evidence and conclusion of the Inquest. The accident occurred at between 9.50am and 10.40am. It was unwitnessed, but there is no evidence of third party involvement, or anything suspicious about it. Ms McKenna was in good health and fit. Her phone was found to be in her pocket, and therefore she was not distracted by it at the time of her fall. The cause of the accident was that either she tripped on the path and fell over the edge of the cliff, or twisted her ankle and fell, or stepped on vegetation at the cliff edge side of the path thinking it was solid ground when in fact it was over the edge. Given the angle at which she fell, Ms McKenna probably bounced off a partial ledge in the cliff and continued to fall to the bottom of the cliff. Mountain Rescue who attended the scene informed the police that the fall was 40 metres. The cliff is part of a former quarry and is popular with local rock climbers. It was reported by the investigating police officer that it had been suggested on social media after the accident that there had been a non-fatal accident in the relatively recent past involving a fall from the same spot.

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 could 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) This was a fatal fall from a public footpath that passes close to a severe drop near a reasonably well frequented viewing spot. (2) That some form of safety related signage would alert members of the public to the danger.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you have the power to take such action.
7	**YOUR RESPONSE** You are under a duty to respond to this report by 26th November 2020, namely by 26th November 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 [redacted], Husband of Daphne Ann McKenna. I have also sent it to Detective Sergeant [redacted] of Calderdale CID who investigated the death, who may find it useful or of interest. 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	**DATE: 1st October 2020** **SIGNED BY ASSISTANT CORONER:**