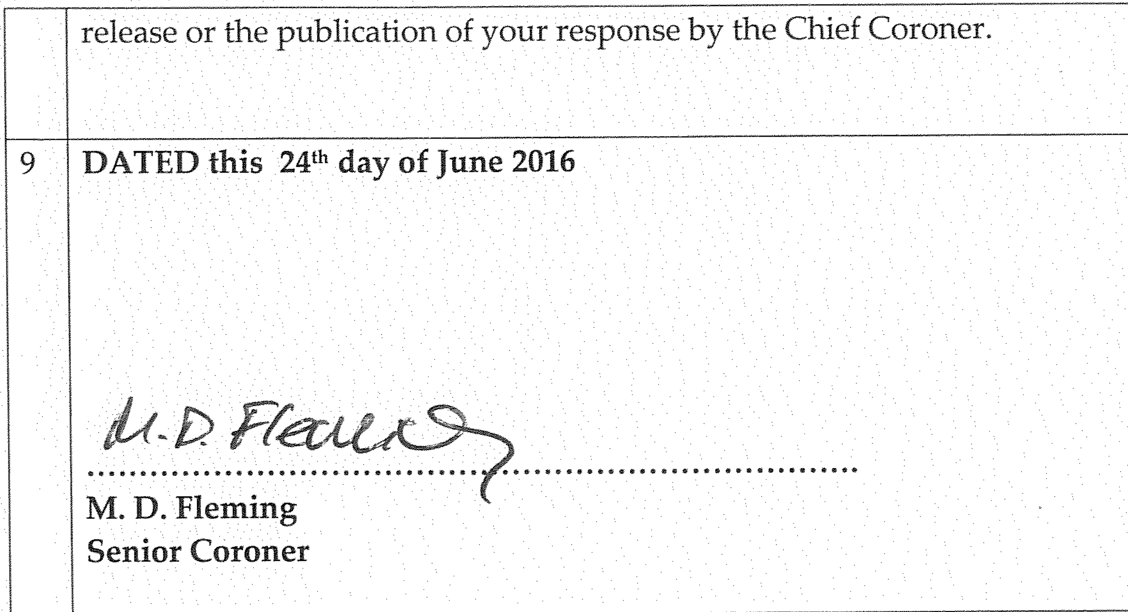
IN THE WEST YORKSHIRE WESTERN CORONER'S COURT
IN THE MATTER OF:

The Inquest Touching the Death of Beverley Anne Devanney
A Regulation Report – Action to Prevent Future Deaths

	THIS REPORT IS BEING SENT TO: **West Yorkshire Police**
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 26th January 2016 I opened an inquest into the death of **Beverley Anne Devanney** who, at the date of her death, was aged 39 years. The inquest was resumed and concluded on 20th June 2016. I found that the cause of death to be: - 1a. Multiple Injuries The conclusion of the inquest was Suicide
4	**CIRCUMSTANCES OF THE DEATH** At approximately 01.32 hours on Tuesday 19th January 2016, [redacted] and [redacted] were called to attend a report of a female standing on the wrong side of the barrier on Burdock Way flyover Halifax. Miss Devanney had a history of mental ill health and drug and alcohol misuse. Notwithstanding [redacted] best actions and efforts to persuade her to safety, she suddenly jumped and fell from the bridge causing her to sustain multiple injuries consistent

	with a fall from a considerable height.
5	<u>**CORONER'S CONCERNS**</u> During the course of the inquest although it was apparent that careful and measured approach to Miss Devanney was beyond reproach, he informed me that there was no formal police training to cover Officers when faced with such circumstances. The **MATTER OF CONCERN** is as follows: – • I would request West Yorkshire police to give consideration to the appropriateness of such training.
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 within 56 days of its date; I, the Coroner, 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: • - mother • • • • Chief Coroner 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	**DATED this 24th day of June 2016** M. D. Fleming .... **M. D. Fleming** **Senior Coroner**