REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. [redacted],Chief Executive Officer, Durham County Council**
1	**CORONER** I am Jeremy Chipperfield, senior coroner for the coroner area of Durham and Darlington
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. https://www.legislation.gov.uk/ukpga/2009/25/schedule/5/enacted https://www.legislation.gov.uk/uksi/2013/1629/regulation/28/made https://www.legislation.gov.uk/uksi/2013/1629/regulation/29/made
3	**INVESTIGATION and INQUEST** On 28 June 2021 I commenced an investigation into the death of Joseph William DENT, aged 18. The investigation concluded at the end of the inquest on 02 September 2021. I found that the deceased died as a result of sustaining multiple injuries after falling from the bridge known as Newton Cap Viaduct ("the bridge"), Bishop Auckland and recorded an open conclusion (it was unclear how he came to fall).
4	**CIRCUMSTANCES OF THE DEATH** Joseph was seen to park a car close to the bridge in the early hours of 20 June 2021 and his body was found close to its base shortly after 08:00 hrs.
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. – All concerns relate to the bridge, which carries a road and two footpaths up to around 30m (100ft) above the River Wear (1) the bridge's parapet and railing is accessible to pedestrians on the bridge; (2) the bridge is frequently discussed on social media as suitable location for suicide by jumping; (3) there is absence of monitored CCTV and lighting or other means of detecting those at immediate risk; and (4) there is a risk of death to persons falling AND to those near the foot of the bridge at any time when persons fall

	Detective Sergeant [redacted] gave evidence that: (a) there is pedestrian access to either side of the bridge; (b) the bridge lacks effective measures to prevent persons climbing over the parapet; (c) the bridge is "a well-known area for suicide" (and is openly discussed as such on social media); and that (d) police frequently (possibly as much as daily) have to attend the location in response to concerns about persons falling from the bridge. Photographs reveal that the area around the foot of the bridge, where falling objects or persons may land, is accessible to pedestrians. My records indicate that there have been four other deaths of persons falling from this bridge in the past five years; the conclusions in all of their inquests were suicide.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you or your organisation have 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 02 November 2021. 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: [redacted] I have also sent it to the Chief Constable of Durham Constabulary and DS [redacted] who may find it useful or of interest. I am also under a duty to send a copy of your response to the Chief Coroner and all interested persons who in my opinion should receive it. I may also send a copy of your response to any other person who I believe may find it useful or of interest. 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.

9	Signed by:  **JEREMY CHIPPERFIELD** **H M Senior Coroner for** **County Durham and Darlington** **Dated: 6th September 2021**