

Regulation 28: REPORT TO PREVENT FUTURE DEATHS

NOTE: This form is to be used before an inquest.

REGULATION 28 REPORT TO PREVENT DEATHS

THIS REPORT IS BEING SENT TO:

- 1 Tennant Investments
- 2 Canal And River Trust
- 3 Calderdale Council

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 29 of the Coroners (Investigations) Regulations 2013.

3 INVESTIGATION

On 9/6/21 I opened an inquest into the death of **Tomi Obi Solomon w**ho, at the date of his death was aged 13 years old. The inquest was resumed and concluded on 7/3/22.

I found that the cause of death to be: 1a Drowning (submersion in water)

The inquest arrived at a conclusion of Misadventure

4 CIRCUMSTANCES OF THE DEATH

At approximately 2.10pm on Tuesday 1/6/21 Tomi met up with a group of his friends at the location of a narrow bridge, accessed by Huntingdon Road to the East of Brighouse, which crosses a river section of the Calder and Hebble Navigation running from Sowerby Bridge to the West of Wakefield

The inquest heard that some 20-35 young teenagers eventually arrived and congregated on the bridge. I heard from several of Tomi's friends who suggested that the location was an attraction at a time of hot weather, since they would meet to socialise and to bathe and swim in the waters of the river under the bridge.

In addition, there was also a practice of jumping from the bridge into the river, which was achieved by climbing over a fence on the bridge and onto a concrete platform before then jumping in either individually and upon occasions girls and boys jumping whilst holding hands.

It is under these circumstances that Tomi also jumped voluntarily from the bridge, but tragically upon entering the waters he struggled to swim and he drowned.

5 CORONER'S CONCERNS

During the course of the investigation my inquiries 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:



During the course of the inquest the evidence revealed matters giving rise to concern given I heard that there is no signage on the bridge or on the surrounding embankments to the river prohibiting swimming at this location or using the bridge as a jumping off point. 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. -

Given the locations popularity with many teenagers in the area, I would ask you to
consider the appropriateness of the existing safety measures on the bridge and surrounding
area and whether you consider actions are necessary to deter such activities in order to
prevent further occurrences and like tragedies.

6 ACTION SHOULD BE TAKEN

In my opinion action should be taken to prevent future deaths and I believe Tenant Investments, Canal and River Trust and Calderdale Council has you 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 May 04, 2022. 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



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Local Safeguarding and Children's Board

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: 09/03/2022

M D FLEMING

HM Senior Coroner for

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West Yorkshire Western Coroner Area