Regulation 28: REPORT TO PREVENT FUTURE DEATHS

NOTE: This form is to be used **after** an inquest.

	REGULATION 28 REPORT TO PREVENT DEATHS **THIS REPORT IS BEING SENT TO:** **1 City of Bradford Metropolitan District Council**
1	**CORONER** I am R MAHMOOD, HM Assistant Coroner for the coroner area of West Yorkshire Western Coroner Area
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 12 June 2019 I commenced an investigation into the death of Leah BARBER aged 15. The investigation concluded at the end of the inquest on 28 April 2023. The conclusion of the inquest was that: on 3 June 2019, Leah Barber was found deceased at the Bolton Woods Quarry, Bolton Hall Road in Bradford. Leah was suffering a range of mental health pressures in the last 18 months of her life, and her mental health fluctuated in the terms of the nature and severity of those pressures. She had previous thoughts of taking her own life and had tried to do so on two occasions. [redacted] On the morning of 3 June 2019 Leah left a note at her home address for family which indicated an intent to take her own life. From the location within the quarry at which she was discovered and a post-mortem examination it was apparent that Leah had fallen from a height of around 30 metres. The evidence showed that Leah had taken her own life. The medical cause of death was: 1a. Multiple injuries with inhalation of water 1b. Fall from a height
4	**CIRCUMSTANCES OF THE DEATH** As per box 3 (immediately above).
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: (brief summary of matters of concern) A detailed review of the evidence in this case, which included evidence from two Schools ([redacted]), as well as from Bradford Children's Social Services, the TRACKS Education team (at Bradford Council), the SCIL Team and the Council's SEND Team, revealed that no one person or department at

	Bradford Council had an overview of Council's involvement in relation to Leah (prior to her death). Of greater concern was that that remained so after each of the Council departments involved were notified that Leah had passed away. Every organisation which had contact with the Coroner's service in relation to Leah's death, with the exception of Bradford Council, was able to provide the Court with an overview/analysis of their involvement with Leah prior to her death and (where appropriate) the lessons they had learnt as a result their involvement with Leah. The Police and the local Mental Health Trust were examples of two public bodies who had and were able to provide an overview/analysis to the Court in terms of their involvement with Leah and confirm whether there were any lessons to be learned by them. The evidence provided by witnesses from the various Bradford Council teams which were involved with Leah, showed a clear disconnect in the involvement of the various Council departments. That was not caused by those individuals who had provided written statements to the Court or the two who attended to provide oral evidence. Whilst the Inquest hearing did not identify actions/omissions on the part of individuals/teams within the Council which more than minimally, negligibly or trivially contributed to Leah's death, the concern is that Bradford Council appeared not to have a system/process in place which allowed anyone (whether an individual / a team) within the Council to have an overview of deaths where there had been previous Council involvement with the deceased (in this case a child). In the apparent absence of such oversight Bradford Council would not be able to learn lessons from such cases (or even know if there were lessons to be learned). The absence of such a single point of oversight as was apparent in Leah's case, contributes to the risk that future deaths could occur unless action is taken.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you (and/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 September 15, 2023. 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 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 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 by the Chief Coroner.
9	**Dated: 03/08/2023**  **R MAHMOOD** **HM Assistant Coroner for** **West Yorkshire Western Coroner Area**