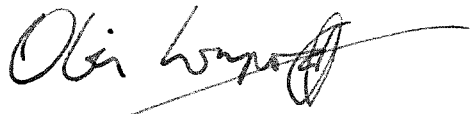
IN THE WEST YORKSHIRE (EASTERN) CORONER AREA

HM AREA CORONER OLIVER LONGSTAFF

IN THE MATTER OF LAURA GAWTHORPE

REPORT TO PREVENT FUTURE DEATHS

	THIS REPORT IS BEING SENT TO: Parking, Roads and Transport, Leeds City Council
1	**CORONER** I am Oliver Robert Longstaff, Area Coroner for the Coroner area of West Yorkshire (Eastern).
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 7th October 2022 I commenced an investigation into the death of Laura Gawthorpe 07/07/1987. The investigation concluded at the end of the Inquest on 30/04/2024. The conclusion of the Inquest was that Mrs Gawthorpe's death was a suicide.
4	**CIRCUMSTANCES OF THE DEATH** Laura Gawthorpe was a voluntary patient at the Becklin Centre, Alma Street, Leeds. On 13th September 2022, she left the Becklin Centre on unescorted leave and made her way [redacted], where CCTV tracked her making her way to levels [redacted] of the car park, and thence back down [redacted], from where she deliberately fell to the ground below, dying instantly from unsurvivable injuries.
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 will 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) The evidence of West Yorkshire Police was that, by the erection of extensive fencing and barriers, measures have been put in place on levels [redacted] at the car park to make it harder for people to fall from those levels, whether deliberately or accidentally. (2) The erection of similar measures on level [redacted] has been only partial. The point from where Mrs Gawthorpe fell was identified by correlating her location on the ground with the location on level [redacted] where she had left her phone before her fall. At that location, the parapet wall could still easily be climbed over.
6	**ACTION SHOULD BE TAKEN**

	In my opinion action should be taken to prevent future deaths and I believe you or 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 28/06/2024. 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] (Mrs Gawthorpe's husband), Leeds and York Partnership NHS Foundation Trust. 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	Signed:  OLIVER LONGSTAFF Area Coroner West Yorkshire (E) Date: 01 May 2024