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 National Highways** **2 Salford City Council**
1	**CORONER** I am Michael James Pemberton, HM Assistant Coroner for the coroner area of Manchester (West).
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 10 May 2024 I commenced an investigation into the death of Emma Victoria HARPER aged 52. The investigation concluded at the end of the inquest on 09 September 2024. The conclusion of the inquest was Suicide, and the medical cause of death was: I a Blunt Force Chest Trauma I b I c II
4	**CIRCUMSTANCES OF THE DEATH** The deceased had a complex mental health history with a number of suicide attempts and self-harm having occurred in the months leading up to her death. The most recent occurred on in March when she swallowed batteries and was admitted to Salford Royal Hospital for a period between 25 March 2024 and 12 April 2024. A subsequent attendance following ingestion of batteries occurred on 26 April 2024. On discharge from hospital on 12 April there were delays in being referred to an appropriate mental health team in the community. On 1 May 2024, the deceased presented at Salford Royal Hospital and underwent a mental health assessment with the mental health liaison team, this resulted in a low risk assessment despite the previous attempts to take her own life and a referral to Living well was made. A referral was made to the urgent assessment team on 2 May 2024 by staff at the listening lounge after it was reported by the deceased that she did not feel she could keep herself safe. On 3 May 2024 she was assessed and accepted by the Home Treatment Team and daily

	visits were arranged with a care plan being agreed. The deceased left home at some point from the evening of 3 May 2024 and was subsequently seen on CCTV at approximately 5:25 on 4 May 2024 walking towards the bridge under which she was found She was discovered below a footbridge on the M602 on 4 May 2024 having fallen onto a crash barrier at the side of the motorway from the bridge above and no signs of life were observed. Death was declared at 06:40. On the balance of probabilities, the deceased fell from the foot bridge above having intended to do so to take her own life. The injuries she sustained in the fall caused her death.
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) 1. During the course of evidence it was stated that the foot bridge which the deceased fell from had not been considered suitable for amendments to be made to the level of barrier which would prevent a pedestrian crossing the bridge from easily climbing over and falling onto the highway below. 2. Other bridges in the locality were considered and selected for an increase in the height of the barrier or other works to prevent the risk of falling from the bridge onto the M602 motorway. 3. It was unclear on what basis the foot bridge that the deceased fell from has been excluded from such works and there is a risk that this bridge may still be accessed by people who may be at risk of falling as an alternative to other bridges were works had been undertaken in the locality.
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 November 05, 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] **Greater Manchester Mental Health Trust**

	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: 11th September 2024**  **Michael James Pemberton** **Assistant Coroner for** **Manchester West**