Regulation 28: Prevention of Future Deaths report

Leonard David MOAVEN (died 26.07.23)

	THIS REPORT IS BEING SENT TO: **1. [redacted]** **Commissioner** **London Fire Brigade** **169 Union Street** **London SE1 0LL**
1	**CORONER** I am: Coroner ME Hassell Senior Coroner Inner North London St Pancras Coroner's Court Camley Street London N1C 4PP
2	**CORONER'S LEGAL POWERS** I make this report under the Coroners and Justice Act 2009, paragraph 7, Schedule 5, and The Coroners (Investigations) Regulations 2013, regulations 28 and 29.
3	**INVESTIGATION and INQUEST** On 8 August 2023, I commenced an investigation into the death of Leonard Moaven, aged 61 years. The investigation concluded at the end of the inquest on 15 January 2024. I made a determination at inquest of death by suicide. Dr Moaven jumped from the roof of his block of flats at 5.33pm on 26 July 2023. He had got onto the roof by using a ladder to reach his attic and, when he got there, punching a hole through the roof tiles.
4	**CIRCUMSTANCES OF THE DEATH** Before he jumped off the roof, Dr Moaven called the Metropolitan Police Service (MPS), who in turn called the London Fire Brigade (LFB).

	When police officers tried to negotiate with him, Dr Moaven appeared receptive to the idea of coming down off the roof safely. Police officers were reluctant to suggest that he return the way he had come, as by now it was raining and they were concerned that he would slip, and so he waited on the roof for firefighters to escort him.
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. Dr Moaven rang police at 4.33pm, exactly one hour before he actually jumped off the roof. Police attended immediately and sought firefighter assistance immediately. However, they reported to me at inquest that there was some delay in the attendance of LFB. 2. Upon attendance, firefighters recognised that their ladders would not reach the roof of the flats and so called for an extended height ladder appliance. This had to travel from further afield and Dr Moaven became more agitated during the wait. It had not arrived at 5.33pm when he jumped. The police were especially concerned that the extended height ladder appliance had not been requested from the outset, given that the call was in respect of a person on the roof of a block of flats. I did not take evidence from any firefighters at inquest, and so I appreciate that there may be elements of which I am unaware.
6	**ACTION SHOULD BE TAKEN** In my opinion, action should be taken to prevent future deaths and I believe that you 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 18 March 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 following. • [redacted], wife of Leonard Moaven • [redacted], sister of Leonard Moaven • HHJ Thomas Teague QC, the Chief Coroner of England & Wales 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	**DATE** **SIGNED BY SENIOR CORONER** 18.01.24 *ME Hassell*