REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. Rossendale Borough Council** **2. [redacted]** **3. Health and Safety Executive**
1	**CORONER** I am Emma Mather, area coroner, for the coroner area of Lancashire and Blackburn with Darwen.
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 9th October 2025 I commenced an investigation into the death of Brody O'Brien, aged 12. The investigation concluded at the end of the inquest on the 21st January 2026. The conclusion of the inquest was: Narrative conclusion: On the 7th October 2025 Brody O'BRIEN died at [redacted] on Market Street in Rochdale from hanging. [redacted] He did not intend to cause his death in doing so.
4	**CIRCUMSTANCES OF THE DEATH** The brief circumstances are that on the 7th October 2025 Brody [redacted], from which he was later found hanging. Brody had researched the [redacted] beforehand and the court heard that that this [redacted] is regularly used by young people as a place to meet. The area of the [redacted] is not well secured and the [redacted] itself it is treacherous and the access point used by the emergency responders was dangerous. Despite resuscitation efforts, Brody sadly was pronounced deceased.
5	**<u>CORONER'S CONCERNS</u>** During the course of the inquest the evidence 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. – (1) Brody was able to access the [redacted] as it remains unsecured and use the [redacted] to secure a ligature.

	(2) Emergency services found access to the [redacted], particularly with their equipment, difficult and treacherous. They had to scale a wall and once inside, the ground was very uneven and dangerous posing a significant risk.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe 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. 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](Brody's mother), [redacted](Brody's father), Lancashire County Council, and to the Local Safeguarding Board. I have also sent it to the Lancashire Constabulary 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 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	**9th February 2026** **Emma Mather**