IN THE WEST YORKSHIRE WESTERN CORONER'S COURT
IN THE MATTER OF:

The Inquests Touching the Death of George Terence Dyson
A Regulation Report – Action to Prevent Future Deaths

	THIS REPORT IS BEING SENT TO: **Calderdale Council**
1	**CORONER** Martin Fleming HM Senior Coroner for West Yorkshire Western
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 20 of the Coroners (Investigations) Regulations 2013
3	**INVESTIGATION and INQUEST** On 11th July 2017 I opened an inquest into the death of **George Terence Dyson** who, at the date of his death was aged 78 years old. The inquest was resumed and concluded on 29th May 2018. I found that the cause of death to be: - 1a. Multiple injuries 1b Fall After consideration of the evidence I arrived at a conclusion of Suicide
4	**CIRCUMSTANCES OF THE DEATH**
5	**CORONER'S CONCERNS** On 3/7/17 George Terence Dyson, who had been diagnosed with Alzheimer's disease and struggling to come to terms with its diagnosis, sustained fatal injuries after jumping from North Bridge, Halifax, West Yorkshire. He had previously left letters and documentation at his home address indicative of his intentions to take his own life and the evidence suggested that he jumped from a point on the bridge where there had been a previous like tragedy.

	The **MATTER OF CONCERN** is as follows. – • To urgently review and consider the appropriateness of protective safety measures on the bridge in order to prevent further like fatalities. • To urgently consider the implementation of immediate measures
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe that Calderdale Council has the power to take such action.
7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of its date; I may extend that period on request. Your response must contain details of action taken or proposed to be taken, setting out the timetable for such action. Otherwise you must explain why no action is proposed.
8	**COPIES** I have sent a copy of this report to: [redacted] (Brother) Chief Coroner
9	**DATED this 29/5/18** **Signature** MD Peers